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MCHIP YEAR FOUR ANNUAL REPORT

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Abbreviations and Acronyms

| | |
|---------|---|
| AAP | American Association of Pediatrics |
| ACCESS | Access to Clinical and Community Maternal, Neonatal and Women's Health Services Program |
| ACNM | American College of Nurse-Midwives |
| ACOG | American Congress of Obstetricians and Gynecologists |
| AFRO | WHO Africa Regional Office |
| AIDS | Acquired immune deficiency syndrome |
| AMTSL | Active management of the third stage of labor |
| ANC | Antenatal care |
| ANMTC | Auxiliary Nurse Midwife Training Center |
| ARI | Acute respiratory infection |
| BCC | Behavior change communication |
| BEmONC | Basic emergency obstetric and newborn care |
| CA | Community agent |
| CCM | Community case management |
| CDC | U.S. Centers for Disease Control and Prevention |
| CHW | Community health worker |
| CI | Communications Initiative |
| CKMC | Community Kangaroo Mother Care |
| cMYP | Comprehensive Multi Year Plan |
| CPD | Continuing professional development |
| CRMA | Caribbean Regional Midwives Association |
| CSHGP | Child Survival and Health Grants Program |
| CYP | Couple years of protection |
| DRC | Democratic Republic of Congo |
| ECSACON | East Central and Southern Africa College of Nursing |
| EML | Essential Medicines List |
| EmONC | Emergency obstetric and newborn care |
| ENC | Essential newborn care |
| EPI | Expanded Program on Immunization |
| ERG | Evidence Review Group |
| FANC | Focused antenatal care |
| FIGO | International Federation of Gynecology and Obstetrics |
| FMOH | Federal Ministry of Health |
| FP | Family planning |
| FWA | Family Welfare Assistant (India) |
| GAPP | Global Action Plan for the Prevention and Control of Pneumonia/Diarrhea |
| GAVI | GAVI Alliance (formerly the Global Alliance for Vaccines and Immunization) |
| GDA | Global Development Alliance |

| | |
|-------------------|--|
| HBB | Helping Babies Breathe |
| HFS | Healthy Fertility Study |
| HIDN | Health, Infectious Disease and Nutrition |
| HIP | High-impact practices |
| HIV | Human immunodeficiency virus |
| iCCM | Integrated community case management |
| ICM | International Confederation of Midwives |
| IEC | Information, education and communication |
| IIP | Institute for International Programs |
| IMCI | Integrated management of childhood illness |
| IMNCI | Integrated management of neonatal and childhood illness |
| IP | Infection prevention |
| IPAC | Immunization Practices Advisory Committee |
| IPNC | Integrated postnatal care |
| IPTp | Intermittent preventive treatment during pregnancy |
| IRB | Institutional Review Board |
| ITN | Insecticide-treated net |
| IYCF | Infant and young child feeding |
| JHSPH IRB | Johns Hopkins Bloomberg School of Public Health Institutional Review Board |
| JHU | Johns Hopkins University |
| JSI | John Snow, Inc. |
| K4H | Knowledge for Health |
| KMC | Kangaroo Mother Care |
| LAC | Latin America and the Caribbean |
| LiST | Lives Saved Tool |
| M&E | Monitoring and evaluation |
| MAMA | Mobile Alliance for Maternal Action |
| MaMoni | Integrated Safe Motherhood, Newborn Care and Family Planning Project |
| MC | Male circumcision |
| MCH | Maternal and child health |
| MCHIP | Maternal and Child Health Integrated Program |
| MCP | Malaria Communities Program |
| MDG | Millennium Development Goal |
| MgSO ₄ | Magnesium sulfate |
| MIP | Malaria in pregnancy |
| MIYCN | Maternal, infant and young child nutrition |
| MLM | Mid-Level Managers |
| MMC | Medical male circumcision |
| MMI | Model Maternities Initiative |
| MNC | Maternal and newborn care |

| | |
|--------|--|
| MNCH | Maternal, newborn and child health |
| MNH | Maternal and newborn health |
| MOH | Ministry of Health |
| MOHFW | Ministry of Health and Family Welfare |
| MOHSW | Ministry of Health and Social Welfare |
| MOPHS | Ministry of Public Health and Sanitation |
| MSH | Management Sciences for Health |
| MSI | Mary Stopes International |
| NGO | Nongovernmental organization |
| NUVI | New and Under-Utilized Vaccines Introduction |
| OiU | Oxytocin in Uniject |
| ORS | Oral rehydration salts |
| ORT | Oral rehydration therapy |
| PAHO | Pan American Health Organization |
| PE/E | Pre-eclampsia/eclampsia |
| PEPFAR | U.S. President's Emergency Plan for AIDS Relief |
| PIE | Post-introduction evaluation |
| PIP | Program implementation plan |
| PITC | Provider-initiated testing and counseling |
| PMI | U.S. President's Malaria Initiative |
| PMTCT | Prevention of mother-to-child transmission of HIV |
| PNC | Postnatal care |
| PPC | Postpartum care |
| PPFP | Postpartum family planning |
| PPH | Postpartum hemorrhage |
| PPIUCD | Postpartum intrauterine contraceptive device |
| PPIUD | Postpartum intrauterine device |
| PSE | Pre-service education |
| PSI | Population Services International |
| PVO | Private voluntary organization |
| QoC | Quality of care |
| RBM | Roll Back Malaria |
| RCQHC | Regional Center for Quality Health Care at Makerere University |
| RDT | Rapid diagnostic testing |
| RED | Reach Every District |
| RH | Reproductive health |
| RHR | Dept. of Reproductive Health and Research (WHO) |
| RMC | Respectful maternity care |
| SBA | Skilled birth attendant |
| SBM-R® | Standards-Based Management and Recognition |

| | |
|----------|--|
| SC | Save the Children |
| SHOPS | Strengthening Health Outcomes through the Private Sector |
| SIA | Supplementary immunization activity |
| SITAN | Situation analysis |
| SMOH | State Ministry of Health |
| SNL | Saving Newborn Lives |
| SP | Sulfadoxine-pyrimethamine |
| TA | Technical assistance |
| TAG | Technical advisory group |
| TBA | Traditional birth attendant |
| TEN | Track Every Newborn |
| TF | Task force |
| TOR | Terms of Reference |
| TOT | Training of trainers |
| TWG | Technical working group |
| UN | United Nations |
| UNFPA | United Nations Population Fund |
| UNICEF | United Nations Children’s Fund |
| URC | University Research Co. |
| USAID | United States Agency for International Development |
| USG | United States Government |
| VCT | Voluntary counseling and testing |
| VMMC | Voluntary medical male circumcision |
| VSI | Venture Strategies Innovations |
| WHO | World Health Organization |
| WHO/AFRO | World Health Organization/Regional Office for Africa |
| WRA | White Ribbon Alliance |

Introduction

The Maternal and Child Health Integrated Program (MCHIP),¹ funded by the U.S. Agency for International Development (USAID), contributes to reductions in maternal, newborn and child mortality through increased coverage of key, high-impact interventions. MCHIP's global leadership role and mandate, the strong working relationships and dissemination channels established with regional partners and, perhaps most importantly, the direct reach to over 35 country programs worldwide allow MCHIP to not only influence policies that support improved health outcomes, but also to support countries in achieving their goals and in scaling up evidence-based approaches.

As MCHIP completes its fourth year, it does so at a time of increasing acknowledgement, at the highest global political level, of maternal and child health as a development priority. With 2015 approaching, there has been a growing urgency to take effective measures to achieve Millennium Development Goals 4 and 5. This past June, during the Child Survival Call to Action, the U.G. Government joined with the governments of India and Ethiopia and UNICEF in calling the world's attention to the ambitious but achievable challenge of eliminating preventable child deaths in a generation. As the global community prepares to move beyond 2015 and as MCHIP has been granted an extension through September 2014, MCHIP is well placed to continue its efforts in spearheading important global technical initiatives, to capture important lessons from the diverse settings and technical areas within which the project has been working and to make them available to the global health community.

There were 36 MCHIP country programs in implementation or planning mode at the beginning of PY4. In the first half of the project year, Senegal and Pakistan were added to the portfolio; Nigeria and Azerbaijan finished work and closed out; Malawi closed its primary program but added two smaller activities; and programs in Kenya, Tanzania, Rwanda, South Sudan and Zimbabwe expanded. MCHIP also responded to two Associate Award proposal requests from South Sudan and Pakistan.

New and expanding country programs: MCHIP continued to expand its work at the country level during this reporting period. Nine countries—Egypt, Kenya, Malawi, Pakistan, Rwanda, Senegal, South Sudan, Tanzania and Zimbabwe—were in planning, start-up or expansion mode during this reporting period. Planning for the **Egypt** program progressed when the final work plan was approved in May. USAID's increasing support for the introduction of new and under-utilized vaccines (NUVI) enabled MCHIP to finalize work plans with **Tanzania**, **Malawi** and **Senegal**, and increase its core support for ongoing work in Kenya, Zimbabwe, India and DRC. The MCHIP program in **Rwanda** was extended and its geographic coverage expanded at USAID's request. Also in expansion mode, **Kenya** absorbed the former ACCESS Uzima team and its maternal health, malaria and HIV/AIDS work—which will be expanded to at least one additional province during the second half of the year. Finally, **Zimbabwe** was allocated PMI funding for the first time this project year and began work on this new program component in its focus province.

Country programs finalized: Two longstanding MCHIP country programs—Malawi and Nigeria—closed out this year. Although immunization and Helping Babies Breathe (HBB) activities will continue in Malawi, MCHIP's successful maternal/newborn program and its experienced team completed their transition to USAID/Malawi's new bilateral health project in March. Likewise, teams in both Malawi and Nigeria held successful end-of-activity dissemination

¹ MCHIP is a five-year, \$600 million, Leader with Associate Award implemented by Jhpiego in partnership with Save the Children; John Snow, Inc. (JSI); Johns Hopkins University/Institute for International Programs (JHU/IIP); ICF Macro.; Program for Appropriate Technology in Health (PATH); Broad Branch Associates; and Population Services International (PSI).

events during this reporting period. Core-funded activities in Azerbaijan were completed and deliverables presented to stakeholders.

GLOBAL LEADERSHIP

Over Program Year 4, MCHIP has continued to contribute to advancing global thinking and country-level uptake of strategies to reduce maternal mortality from PPH and PE/E. Recognizing that what is measured gets attention and that what isn't doesn't, an important continuing area of focus has been on measurement of quality of care. Results of QoC studies conducted earlier in MCHIP have been widely shared through both conferences and the Internet, drawing greater attention to important, specific quality challenges, contributing to a growing emphasis, at global level, to quality—particularly for labor, delivery and immediate postnatal care. The Maternal Recall Indicator Validation Study, conducted in Mozambique, was completed and analyzed, and a paper has been submitted to *PLoS Medicine*. This study is expected to contribute to more robust measurement of aspects of quality of care, as measurable through population-based surveys. MCHIP has continued its work at global and country levels to incorporate a minimal set of quality-related indicators into routine program monitoring. As in other technical areas, part of MCHIP's contribution to maternal health at global level has been the development of tools potentially useful across a broad range of settings. In PY4, MCHIP completed the second draft of a Clinical Observer Learning Resource Package for training clinicians to observe and score clinical services as part of a quality of care assessment.

MCHIP repeated its multi-country PPH and PE/E program status analysis, this year covering 37 countries. This has helped draw more serious attention, at global, regional and country-levels, to progress (and needed progress) to these areas. The Asia Regional Meeting, held in Dhaka, repeated the success of the meeting held in Addis in PY3, advancing key technical priorities in the region and solidifying MCHIP/USAID credibility with regard to maternal health technical leadership. In PY4, MCHIP has made further use of malaria in pregnancy (MIP) country case-studies completed earlier, to share key lessons learned on strengthening implementation, helping to direct the focus of the work of the global MIP technical working group. MCHIP has also sought opportunities to advance global efforts in improving maternal newborn outcomes through delivery of nutrition-related interventions during pregnancy, particularly addressing iron-deficiency anemia. MCHIP took the lead in organizing and implementing a meeting in Dhaka, entitled, "Guidance on Implementing Effective Programs to Prevent Pre-Eclampsia and Anemia to Improve Maternal and Newborn Outcomes." MCHIP took the lead, with partners the CORE Group and SPRING, in spearheading a Multi-Sector Anemia Prevention and Control Task Force (TF), which was approved by USAID. MCHIP and partners the CORE Group, FANTA-3 and SPRING will act as the Secretariat for the Anemia Task Force.

MCHIP has continued to make wide use of scale-up maps, particularly in maternal health, but in other technical areas as well, to encourage program managers to take the big picture into account, anticipating major strategic tasks and charting progress in their scale-up efforts.

To contribute to expanded use of key newborn interventions in PY4, MCHIP: published and disseminated the Kangaroo Mother Care Implementation Guide; conducted two multi-country assessments, one of KMC and the other of PNC home visits for newborn survival—sharing the results of the second in a global meeting co-convened with WHO; provided technical assistance for the initiation of the new Survive and Thrive Global Development Alliance (GDA); as well as to the Born Too Soon preterm care teams on antenatal corticosteroids and KMC; and has provided continued leadership of the LAC Neonatal Alliance. MCHIP has also provided important leadership to the growing global effort to move chlorhexidine for umbilical cord care forward into routine program use, through participation in the global technical working group as well as advice provided to interested countries.

In Child Health, MCHIP continues to provide secretariat support for the global integrated community case management (iCCM) Task Force (TF), and to host the website used by the TF. In PY4, MCHIP started drafting a module for the widely used and updated version of WHO's Immunization in Practice training, which will address partnering with communities, and has contributed to the development or revision of several other global and regional planning and implementation tools.

MCHIP continued its global leadership in immunization in PY4. In collaboration with numerous partners (e.g., GAVI Alliance, USAID, U.S. Centers for Disease Control and Prevention [CDC], WHO, UNICEF, USAID bilaterals, and others), MCHIP served as a liaison among global, regional, and country levels. This role is taking on greater visibility through: the Global Vaccine Action Plan (for which regional and country input was incorporated), which was approved by the World Health Assembly in May 2012; new vaccine introductions planned in over 30 countries in the coming years; and existing partnerships (e.g., the Measles Rubella Initiative and with the Polio Eradication Initiative).

In collaboration with USAID and World Health Organization/Division of Reproductive Health Research (WHO/RHR), MCHIP-created "The Statement for Collective Action for Postpartum Family Planning." MCHIP has provided technical leadership in the area of postpartum IUDs (PPIUCD) by co-chairing a technical working group. MCHIP has also provided leadership through its active role in various global and regional forums, including: "WHO/UNFPA and Stakeholders' Technical Consultation on Programme Considerations for Postpartum Family Planning," and the second International Conference on Family Planning: Research and Best Practices, held in Dakar, Senegal.

MCHIP remains a global leader in the scale-up and implementation of voluntary medical male circumcision (VMMC) programs, supporting many countries in their successful implementation. An important contribution has been the development of key international VMMC reference and training documents and resources, including: "PEPFAR VMMC Site Operational Guide" and the VMMC "Models for Optimizing Volume and Efficiency" (MOVE) video.

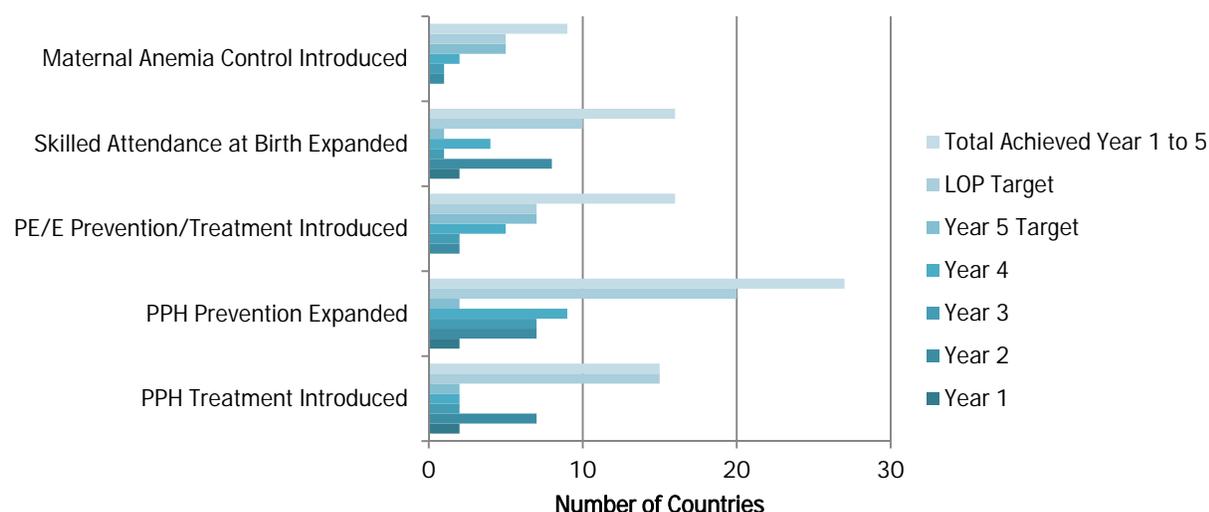
Across many of the technical areas in which MCHIP works, we have been actively involved and often exercising important leadership in the development of global guidance and statements from WHO and other global entities. These have included PPH, PE/E, postnatal care, immunization (routine, polio and introduction of new antigens) and task-shifting. Across several of our technical areas, MCHIP has actively participated in global efforts this year to better ensure supply of lifesaving commodities for women and children.

Detailed Year 4 Achievements by Results Pathways and Program Areas

MATERNAL HEALTH

During Year 4 of MCHIP, focus was placed on advancing global thinking and country-level uptake of strategies and approaches to reduce maternal mortality from the two leading causes: postpartum hemorrhage (PPH) and pre-eclampsia/eclampsia (PE/E). MCHIP supported 31 countries with maternal health components in 2012. Through the Quality of Care (QoC) studies in seven countries, the expanded use of scale-up maps to frame progressive thinking, the multi-country analysis (MCA) of 37 countries and the Regional Meetings in Asia, as well as our work on supporting global guidance and statements from the World Health Organization (WHO), we have helped shape global thinking, build national programmatic momentum and have gathered valuable information and insight to further support global priorities and guide national implementation. Progress made in high-impact maternal health interventions is illustrated in Figure 1. See Annex B for results supported by the Africa Bureau and Annex C for results supported by the Latin America and the Caribbean (LAC) Bureau.

Figure 1. Progress for High-Impact Maternal Health Interventions



Global Leadership

- Asia Regional Meeting on *Interventions for Impact in Essential Maternal and Newborn Care* on May 3–6, 2012, in Dhaka, Bangladesh:** At this meeting, MCHIP and others shared evidence-based approaches to maternal health programming. More than 400 participants from 30 countries (18 in Asia) attended the meeting and an additional 2,000+ people viewed the meeting online through webcasting and script. The reach of the meeting’s discussions and materials were widened with the inclusion of the CORE Group and PVO/NGO network. Individual follow-up with country teams was provided to support next steps and identify technical assistance needs. As a result of the meeting in late May, stakeholders in Pakistan met to draft an “Affirmation of Commitment: Introduction and Scaling up of Evidence-Based PPH Prevention and Treatment, Eclampsia, and Pre-eclampsia Management and Newborn Resuscitation Interventions” in addition to a “Way Forward” action plan. Following the meeting, MCHIP was invited to Yemen to support the MOH to roll out a comprehensive maternal health program including misoprostol for preventing PPH for women who give birth at home.



"I am happy this meeting focused on the issue of misoprostol, as it has been a battle in introducing it in Yemen, but now we have more information to take back home to introduce misoprostol at the community level."
 Jamela Al Raiby, Ministry of Health and Population, Yemen (participant)

- CORE Group actively helped promote the MCHIP Asia Meeting on *Interventions for Impact in Essential Obstetrics and Newborn Care* in Dhaka, and engaged and facilitated partner participation. CORE Group helped disseminate outcomes and began discussions with the Maternal Health Team for next steps and ways to extend workshop information to a wider audience. CORE also engaged and supported partners including the American College of Nurse-Midwives (ACNM), which presented during the Postnatal Home Visit session.
- **Development/Revision of Technical Guidelines:** MCHIP contributed to the technical discussions at WHO by participating in the technical consultations on PPH, PE/E, postpartum care (PPC)/postnatal care (PNC) and other relevant technical areas to provide technical assistance in the development/revision of technical guidelines. Specifically:
 - MCHIP attended a meeting from April 16–19, 2012, on Optimizing Access to MNH Services, and served as part of a group that was charged with development of task-shifting guidelines for key interventions in maternal and newborn health (MNH). The guidelines have not yet been finalized and there are plans to release them in 2013.
 - MCHIP collaborated with WHO, Pre-EMPT and USAID on the preparation of a brief for the new WHO PE/E Guidelines; as well as working with WHO on a similar brief for the revision of PPH recommendations. The PE/E document is being translated into French, Spanish and Portuguese to make the materials accessible to other regions.
 - MCHIP attended the PNC/PPC Guidelines meeting from September 3–5, 2012, to provide input into the updates to the PNC/PPC guidelines. The guidelines have not yet been finalized and there are plans to release them in 2013. Once released, MCHIP will develop a briefer and disseminate globally.
- **Support to the International Federation of Gynecology and Obstetrics (FIGO) to Expand the Use of PPH and PE/E Interventions:** MCHIP supported FIGO to expand the use of PPH and PE/E interventions through FIGO's work with national professional associations in six countries. This year, FIGO:
 - Identified and confirmed interest of six countries through the Leadership in Obstetrics and Gynecology for Impact and Change (LOGIC) Initiative for Maternal and Newborn Health (three-year project): Ethiopia, Mozambique, Nepal, Uganda, Nigeria and India. FIGO is now preparing letters of commitment from the six countries to be signed by the president of the local society, as well as Prof. Hamid Rushwan from FIGO.
 - Identified a consultant, Dr. Hani Fawzi, who will facilitate activities and tailor support to the countries. Dr. Fawzi made visits to two countries over the summer and set up a

schedule for further visits in Quarters 1 and 2 of Year 5. MCHIP met with Dr. Hani and the FIGO team at the FIGO global conference in October 2012 to discuss these plans and the way forward.

- **Maternal health indicators:** The set of recommended indicators has been largely finalized (the highest priority indicators being uterotonic use in the third stage, cesarian delivery and fresh stillbirths). Uterotonic use in the third stage has been incorporated as a recommended routine indicator in the draft WHO guidelines for PPH. MCHIP has supported finalizing a working document on recommended indicators. Making arrangements for a technical consensus meeting was delayed due to an unanticipated medical leave by our key WHO counterpart. MCHIP HQ staff working on MH indicators have moved discussions forward in several countries preparatory to in-country focused situation analysis and introduction of indicators, to be initiated as we transition to PY5.
- Provision of strategic maternal health technical support to the **Survive and Thrive Global Development Alliance** partners (especially the three professional associations: American Congress of Obstetricians and Gynecologists [ACOG], American Academy of Pediatrics [AAP] and American College of Nurses and Midwives [ACNM]) and the GDA itself through participation in technical discussions to shape the GDA's priority technical interventions and in an orientation of the Director's Joint Consultative Committee and National Professional Associations hosted by the East, Central and Southern Africa Headquarters (ECSA HQ), Regional Center for Quality Health Care (RCQHC) and MCHIP in Arusha, Tanzania, in August 2012. MCHIP also served as the interim secretariat for the GDA by coordinating partner communication, travel logistics for a three-country trip to Tanzania, Mozambique and Malawi in August 2012, and arranging all GDA steering committee, technical and programmatic planning meetings.

Skilled Attendance at Birth

(Note: All work under this section contributes to the PPH, Eclampsia and Newborn Pathways.)

- MCHIP supported efforts to better understand and promote **Respectful Maternity Care (RMC)**:
 - MCHIP participated in the quarterly meeting of the RMC Advisory Council hosted by White Ribbon Alliance (WRA) on December 19, Feb 21 and May 10, and presented a Brown Bag Lunch on respectful care at birth and contributed to the technical review of advocacy materials on respectful care at birth. Final versions of advocacy materials were linked to pre-service education (PSE), PPH, and PE/E toolkits on the Knowledge for Health (K4H) website.
 - The Model Maternity Initiative (MMI) (field-funded) that promotes RMC through MCHIP Mozambique was chosen as one of 50 finalists for the Women Deliver best projects for Maternal Mortality in the world. MCHIP supported the Mozambique team to prepare materials to be presented in an event that was held at the American Embassy in Mozambique on March 27. In July, MCHIP and USAID visited Mozambique and reviewed current activities related to the promotion of RMC and provided guidance for the incorporation and expansion of key interventions.
 - MCHIP assisted in the development of the following materials, which are currently under revision to support countries' effort to incorporate activities related to RMC in their programs/projects:
 - a) RMC program review form;
 - b) Experience/story of RMC activities implemented in Mozambique;
 - c) Three PowerPoints about RMC practices implementation.

- The Mozambique experience in implementing MMI and RMC was shared with representatives from 22 countries during the Jhpiego Quality Improvement/SBM-R® meeting held in Mozambique on September 26–28, 2012.
- MCHIP supported improved **Pre-Service Education** in India and Ghana and through the PSE toolkit (core and field-funded):
 - MCHIP supported a training of trainers (TOT) for strengthening of the **Pre-Service Education** for Nursing and Midwifery Cadre in India in November 2011.
 - MCHIP supported planning for implementation of a two-year workplan focused on improving midwifery pre-service education in Ghana. TA was provided on pre-service training with development of two manuals, the Reference Manual for Simulation Laboratories in Midwifery Education Programs and the Reference Manual for Preceptorship in Midwifery Education. These were developed in partnership with MCHIP-Ghana and ACNM. TA for mMentoring (mobile mentoring for tutors) was provided in development of SMS messages and questions. Support and mentoring of new field staff as trainers was provided during a BEmONC skills standardization for midwifery tutors.
 - Online orientation materials for the **PSE toolkit** were translated to French and Spanish and posted to the K4H website and an online orientation was also conducted for Francophone countries, with approximately 20 participants. Postcards and CD-ROMs were created for the PSE toolkit and disseminated at the 2012 Asia Regional meeting. The online PSE toolkit received over 8,000 visits in Year 4 (2,584 visits in Q1, 2,186 visits in Q2, 2,145 visits in Q3 and 1,595 visits in Q4)².
- **The Maternal Recall Indicator Validation Study** in Mozambique was completed and an article submitted to *PLoS Medicine* for publication. The primary objective of the study was to validate women’s self-report of selected elements of maternal and newborn care during the intrapartum and immediate postpartum periods. The Maternal and Newborn Indicator Validation study is linked to the maternal and newborn quality of care health facility survey conducted in Mozambique in PY 11, in that the direct observations recorded during labor, delivery and the early postpartum periods for the QoC will serve as the gold standard against which women’s responses during a face-to-face interview will be compared. Study findings have important implications for measurement of maternal and newborn health service utilization, service content and behavioral indicators through population-based surveys.
- As part of its global work to improve indicators for monitoring the quality and content of maternal care services, MCHIP has reviewed the current status on **monitoring of quality of maternal health services** across multiple countries in sub-Saharan Africa and South Asia. MCHIP has developed a concept note and initiated country-level discussions on piloting incorporation of quality/content indicators in routine monitoring in several countries.
 - A pilot MNH surveillance activity was initiated in Kenya in four hospitals. The MNH indicators have been harmonized, when feasible, with the Helping Babies Breathe (HBB) indicators and the maternal indicators that MCHIP is working on with WHO. Phase I of the Kenya pilot activity is focused on standardizing MNH evidence-based practices (via on-site training) and strengthening existing MNH data collection efforts and data use. Data on C-section, uterotonic in the third stage of labor, partograph, maternal complications and newborn resuscitation are being collected and synthesized. Improvement of data management is one of the key objectives in the MNH road map in Kenya; however, this is

² The percentage of new visits increased in Q2 (from 72.6% new visitors in Q1 to 93% new visitors in Q2) and then evened out to 75.94% new visitors in Q3 and 77.20% new visitors in Q4. Top 10 countries visiting the site this year were: USA, Philippines, UK, India, Nigeria, Kenya, Uganda, Canada, Ethiopia and Ghana.

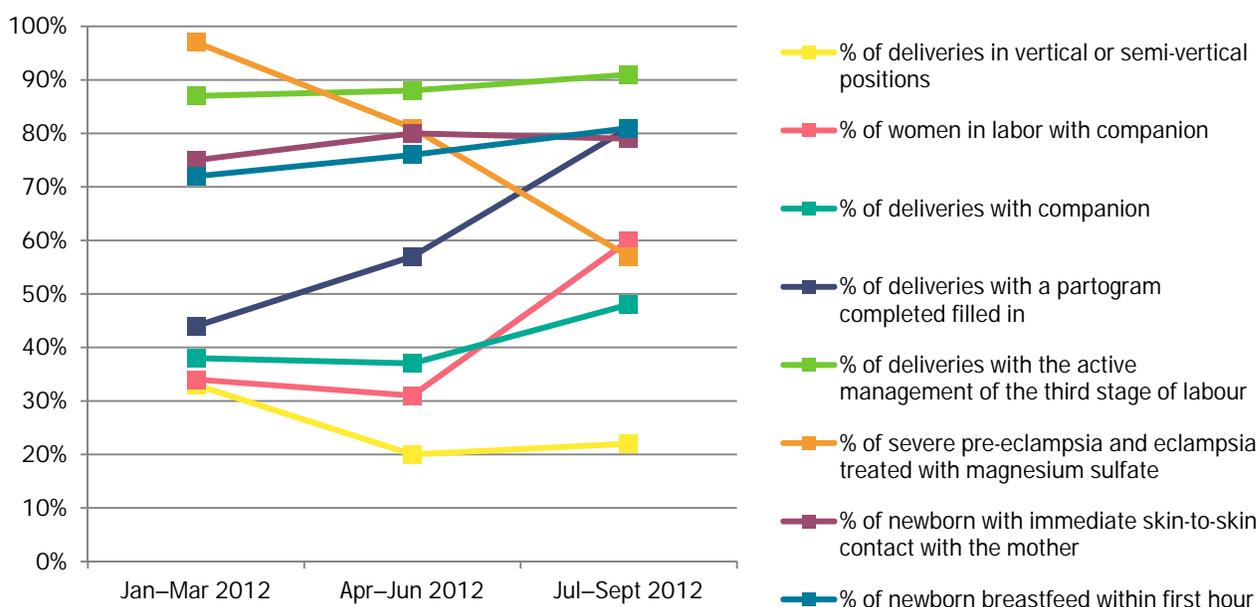
still inadequately addressed in most facilities. Baseline assessments in the four hospitals confirmed poor data collection practices, incomplete documentation in the sector tools, poor utilization of critical tools (e.g., partograph), and deficient competencies in the skills being tracked. Interventions instituted included skills strengthening sessions involving the core competencies being tracked; re-orientation on use of registers, partograph and summary tools; supportive supervision and mentorship; and data use workshops. To date, there has been revitalization of Maternal, Perinatal Death Review, increased use of partograph, improvement in documentation of key indicators and utilization of data at facility level for decision-making. Initial results have also been used at national level to inform planning and implementation of high-impact interventions (e.g., during MNH Rapid Results Initiative campaigns).

- MCHIP completed the field test draft of a Clinical Observer Learning Resource Package (LRP) for training clinicians to observe and score clinical services as part of a quality of care assessment and the package will be tested in Tanzania in Program Year 5. MNH clinical skills to feature in training videos of flawed and correct performances were selected. Using primarily the QoC tools as checklists, selected portions of newborn resuscitation, ANC/PMTCT counseling, postnatal family planning counseling, and AMTSL, including immediate essential newborn care, and counseling for cervical cancer prevention were filmed demonstrating perfect and flawed performance using Johns Hopkins University facilities and will be field tested during the Tanzania field test in year 5.
- Six of the seven countries that have implemented the maternal and newborn QoC survey have conducted national dissemination events to date, including with their respective Ministries of Health. In addition, three countries (Madagascar, Rwanda and Tanzania) have submitted abstracts to international conferences. In the six countries, findings were used in the following ways:
 - In **Ethiopia**, the team was able to secure commitment from the Federal Ministry of Health (FMOH) to expand utilization of magnesium sulfate (MgSO₄), especially in private facilities.
 - In **Kenya**, the outcome of the national dissemination workshop was consensus among participants, including the Ministry of Health (MOH), that the various participants could initiate changes in their regions without waiting for national-level validation, as long as the personnel are properly trained and the activity does not contradict any policies. More concretely, in one west coast province, participants moved ahead with trainings on the use of the partograph. As a result of the workshop's group work, all teams developed regional action plans adapted to their specific needs. It is important to note that all individual action plans called for further dissemination of study results to be done at all levels.
 - In **Madagascar**, following the national dissemination workshop, key stakeholders—including the MOH, international nongovernmental organizations (NGOs), professional associations, UN agencies and the national drug warehouse—developed an action plan to address the gaps in the quality of care identified in the study. Through this workshop, MCHIP was able to raise awareness about HBB, and one of the resulting recommendations was to adopt HBB nationally. Study findings also influenced PSE curriculum revision activities planned for PY5 as well as ongoing MCHIP MNH trainings, which now include more emphasis on the use of the partograph, as well as prevention, recognition and treatment of PPH and PE/E.
 - In **Mozambique**, study results were discussed with the national directorate of public health of the MOH, and were informally discussed with the provincial health authorities. Results on the newborn care piece of the assessment were included in a

national stakeholders meeting—attended by the MOH, WHO, UNFPA and USAID—on newborn resuscitation and advocacy for adoption of HBB as the national protocol.

- In **Rwanda**, study results were disseminated at different levels, first at a MCH Technical Working Group and later at a national stakeholder meeting in which the MCHIP team shared findings with all partners, including UN agencies and other implementing NGOs. The MOH took ownership of the findings and began revising its own policies and drug procurement lists to address gaps and also began identifying appropriate NGOs and projects that could intervene to address gaps. Additionally, the MCHIP team used findings to advocate for strengthening the newborn care and HBB components of the basic emergency obstetric and newborn care (BEmONC) training package and also to influence the development of the national neonatal guidelines. Some other noteworthy results of the QoC study and its dissemination include the government's inclusion of key drugs and equipment on national lists, such as supplies for HBB, calcium supplementation and MgSO₄. In fact, the MOH has not only understood the importance of access to MgSO₄ but has also committed to ensuring that providers are properly trained on its use.
- The **Tanzania** program conducted a MNH forum with stakeholders in September 2011 in which the QoC study findings were discussed and the report shared with various partners. In addition, the team submitted abstracts to Global Health Council and other regional conferences. They are considering future dissemination in various publications and at other regional and global conferences, such as the January 2013 Maternal Health Task Force meeting in Arusha. One key outcome of these efforts to publicize QoC study findings is that partners like Venture Strategies Innovations (VSI) and John Snow, Inc. (JSI) are more closely reviewing the issue of misoprostol supply and, in fact, JSI is now actively tracking maternal health drugs such as misoprostol.
- In **India**, MCHIP strengthened Auxiliary Nurse Midwife Training Centers (ANMTCs) in Jharkhand and Uttarakhand. MCHIP supports site strengthening at seven ANMTCs and trained 11 faculty members from seven ANMTCs in Jharkhand. MCHIP continues to support the strengthening of educational and clinical standards at ANMTCs in three focus districts. All but one of the districts have achieved at least 80% of both the clinical and educational standards. In Uttarakhand, MCHIP continued to support implementation of educational and clinical standards at district ANMTCs, training for 10 ANM tutors, conducting a Clinical Skills Standardization Workshops and postpartum family planning/infection prevention (PPFP/IP) trainings, and procuring supplies for skills labs and libraries in three additional ANMTCs. The focus districts showed a general improvement in achieving the pre-service education standards.
- In **Mozambique**, 49 facilities implementing the MMI sent completed data for the period January to September 2012, and all demonstrated improvements in the quality of delivery care services. Figure 2 (on the following page) shows the trends for key indicators for this period. With the exception of indicators related to the percentage of severe pre-eclampsia and eclampsia treated with magnesium sulfate and the percentage of deliveries in vertical and semi-vertical positions, all other indicators show a positive trend.

Figure 2. Trends in Selected Quality of Care Indicators at Model Maternities in Mozambique: January to September 2012



- In Indonesia**, MCHIP supported scale-up of MNH interventions to new districts. MCHIP held a “Mini University” to share effective programmatic strategies and lessons learned with other districts in the country that had not received MCHIP support. Following the Mini University, all 42 participating districts selected MNH interventions for replication—34 of which participated in the training of facilitators for at least one program intervention, and 20 of which requested and received technical assistance from the MCHIP districts to implement at least one of the program packages. The participating districts selected the MNH interventions they intend to implement (e.g., SBM-R, maternal and perinatal audits) using the following criteria: 1) district need; 2) availability of human resources; and 3) availability of financial resources. The districts also felt that if the program was deemed necessary, funds could be requested for the implementation of the program in the district planning and budget cycle. During the past quarter, MCHIP focused primarily on replication assistance in these districts. MCHIP has developed the following resources, to be shared with the MoH during the closeout meetings, to support replication:

 - Detailed program and cost guidelines
 - Detailed guideline to develop an integrated MNH program
 - Facilitators and champions for replication of integrated MNCH programs at the provincial, district and village levels

Prevention and Treatment of Postpartum Hemorrhage

- MCHIP began documenting all the countries where **misoprostol** has been distributed at the community level, examining method of distribution and coverage level in order to evaluate and compare coverage based on mode of distribution for replication in other countries. The article on this work was submitted for publication in Q4.
- The MCHIP maternal, monitoring and evaluation (M&E) and newborn teams supported the **Zimbabwe** QoC study, which has been integrated with a larger national health facility assessment led by the MOH. MCHIP core funds supported the data collector training workshop, development of the mobile phone data collection tool applications, and data

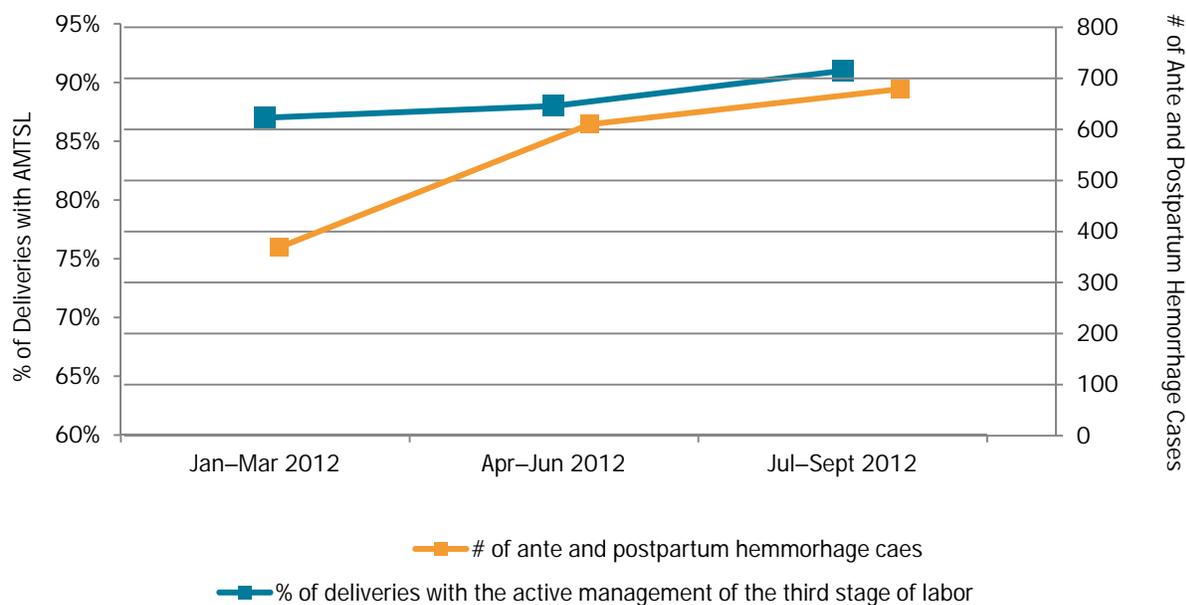
management, cleaning and analysis after the fieldwork was completed. MCHIP also conducted emergency obstetric care training in Zimbabwe.

- MCHIP worked together with WHO, USAID and other colleagues to review available evidence and update the **global recommendations on prevention and management of PPH**. The meeting addressed major issues related to the prevention of the leading cause of maternal mortality, both for women who give birth in facilities and for those who deliver at home. WHO released the updated PPH guidelines at the end of Q4; MCHIP will liaise with them to produce a two-page briefer.
- CORE Group promoted and diffused the “Prevention and Management of Postpartum Hemorrhage and Pre- Eclampsia/Eclampsia: National Programs in Selected USAID Program-Supported Countries” status report from 37 countries, including hosting related session at the CORE Group Fall Meeting in October 2011.
- PPH Prevention in Five Countries: South Sudan, Liberia, Madagascar, Rwanda and Guinea (field-funded):
 - MCHIP provided technical assistance to a PPH prevention program stakeholder meeting in South Sudan where the pilot program implementation plan was revised and finalized. The study was approved by the Johns Hopkins Bloomberg School of Public Health Institutional Review Board (JHSPH IRB) in July. The first two training of trainers were conducted in June. Further training of home health promoters was conducted in July and August and misoprostol distribution began. The MCHIP M&E Advisor to South Sudan conducted a follow-up visit in September to ensure proper data collection. In addition, MCHIP provided Médecins Sans Frontières (MSF) with a concept paper to assist them in starting up community-based distribution of misoprostol in South Sudan—contributing to expansion and scale-up of the PPH prevention program.
 - In Rwanda, the pilot program was designed and the study protocol was developed and approved by the JHSPH IRB and Rwanda IRBs. Training of study data collectors was conducted over the summer and study data collection has been initiated.
 - To continue the expansion of programs for PPH prevention through distribution of misoprostol, the study application for the PPH study in Liberia was approved in July 2012. Regional M&E Advisor Gbenga Ishola traveled to Liberia September 12, 2012 to provide TA related to reviewing the M&E tools and training local staff. The Madagascar PPH prevention study was approved by the JHU IRB in June 2012. Country Support Manager Steve Hodgins traveled to Madagascar September 19 to provide TA for PPH prevention program implementation. In addition, implementing partner Mary Stopes International (MSI) shipped the misoprostol in early September and in-country staff recruited two dedicated program staff in Quarter 4.
 - Planning for a PPH pilot program was initiated in Guinea.
- **PPH and PE/E Multi-Country Analysis:** The analysis was completed with responses from 37 countries. In addition to the questionnaire, MCHIP conducted an analysis of service delivery guidelines related to prevention of PPH and essential medicines lists (EMLs) for oxytocin and misoprostol. The report was finalized and disseminated electronically to all participating countries, partners and relevant working groups and is available online and in hard copy. Preliminary results were presented at the 2012 Asia Regional Meeting in Dhaka, Bangladesh (May 3–6, 2012). Report results will assist in developing appropriate interventions in the core and field workplans for PY5, and were shared with global partners and presented at the FIGO Conference in October 2012 in Rome, Italy, and the American Public Health Association Conference and the Fall CORE Group meeting. The report will also provide much needed data on maternal health supplies, which will aid in addressing

some of the recommendations from the United Nations Commission on Life-Saving Commodities for Women and Children.

- **Life-Saving Commodities for Women and Children:** As part of the ongoing dialogue related to the UN Commission on Life-Saving Commodities for Women and Children, and especially elevating the role of maternal health drugs in relation to UN Commission recommendations, MCHIP submitted a list of possible activities to USAID to consider while developing the workplan for addressing the recommendations, and discussed areas where MCHIP could take the lead. MCHIP participated in the first meeting held by USAID to develop the workplan related to the UN recommendations in relation to oxytocin and MgSO₄.
- **Oxytocin Potency Testing:** Zimbabwe continues to move forward on the testing of oxytocin potency—the sample will include testing along the supply chain. The study protocols and data collection tools were finalized in Year 4 and a half-day training for the sample/data collectors will be conducted during Quarter 1 in Year 5. Data collection for the oxytocin study is scheduled to begin in Quarter 2 of Year 5 (and will take approximately two weeks once started). MCHIP will not conduct the study in other countries due to lack of interest from country-level stakeholders at this point. However, MCHIP will focus on advocacy and development of simple tools to improve storage conditions of oxytocin in PY5.
- In **Mozambique**, across 49 Model Maternities over the past year, the percentage of deliveries with AMTSL increased while the number of antepartum and postpartum hemorrhage cases decreased (see Figure 3 below). The current information system summary form does not separate antepartum hemorrhage cases from postpartum hemorrhage cases. (field funds)

Figure 3. Trends for the Percentage of Deliveries with AMTSL and the Number of Postpartum Hemorrhages



Pre-Eclampsia/Eclampsia

- MCHIP completed a technical briefer on the 2011 WHO PE/E guidelines in collaboration with WHO, and it is now posted on both WHO and MCHIP websites. MCHIP has also agreed with WHO to initiate translation in French, Spanish and Portuguese to make it accessible to other regions.

- MCHIP prepared a map of both ongoing and completed PE/E programs implemented by MCHIP/Jhpiego and PRE-EMPT. This was shared at the Asia Regional Meeting to promote dialogue with NGO programs that are engaged in the PE/E effort, and to understand program expansion capacity.
- PE/E Task Forces: MCHIP facilitated advanced discussions on technical issues around PE/E and PPH work through continued support to task forces. Materials were prepared and disseminated through the 2012 MCHIP Asia Regional Meeting on PPH and PE/E in May. In addition, coordinating lunch meetings were held during this event where membership was reviewed and deliverables and support needed from MCHIP were discussed. MCHIP continues to support the activities of the PE/E task forces as follows:
 - Standards, Training and Quality Assurance Task Force: Met in Dhaka, Bangladesh, and working on updated list of deliverables related to standards, training and quality assurance for PE/E.
- Drugs and Devices Task Force:
 - Compiling information for a list of registered products in MCHIP countries (e.g., manufacturers, names, presentation) for labetalol, MgSO₄, misoprostol 25 mcg and oxytocin (in coordination with Systems for Improved Access to Pharmaceuticals Program at Management for Science Health [MSH]). MCHIP initially expected to contribute to this effort under a second-round multi-country analysis; however, plans for the second-round MCA have been discontinued and MCHIP is not managing the process.
 - Conducting a literature review on the incidence of MgSO₄ toxicity to assist development of a risk profile. The MgSO₄ toxicity paper was completed and submitted to USAID in Quarter 4 of Year 4.
 - Exploring synergy with the Reproductive Health Supplies Coalition and other reproductive and maternal health supply groups (e.g., Caucus on New and Underused Reproductive Health Technologies).
 - Working with MCHIP to develop job aid for dilution of MgSO₄.
- **MgSO₄ Job Aids:** Continued work on expansion of use of MgSO₄ job aids for PE/E management through development of MgSO₄ animation. A draft of the MgSO₄ animation was shared at the Asia Regional Meeting, and feedback was collected. ZMQ Software Solutions is now preparing a revised version.
- CORE Group promoted and diffused “Prevention and Management of Postpartum Hemorrhage and Pre- Eclampsia/Eclampsia: National Programs in Selected USAID Program-Supported Countries” status report, including hosting a related session at the CORE Group Fall Meeting.

Program Learning for Maternal Health

Multi-country analysis and scale-up maps of PPH and PE/E (Data source: Multi-country analysis on PPH and PE/E; MCHIP theme: scale)

MCHIP conducted a survey of 37 countries to assess national programs for the prevention and management of PPH and PE/E. In addition to the questionnaire, MCHIP conducted an analysis of service delivery guidelines related to prevention of PPH and EMLs for oxytocin and misoprostol. The report also provided much-needed data on maternal health supplies, which will aid in addressing some of the recommendations from the United Nations Commission on Life-Saving Commodities for Women and Children. The report was finalized and disseminated electronically to all participating countries, partners and relevant working groups and is available online and in hard copy. Preliminary results were presented at the 2012 Asia Regional

Meeting in Dhaka, Bangladesh (May 3–6, 2012). Report results were shared with global partners and presented at the FIGO Conference in October 2012 in Rome, Italy, and the American Public Health Association Conference and the Fall CORE Group meeting in PY5.

Prevention of PPH at the community level using community-based distribution of misoprostol (Data source: Review of all completed PPH misoprostol programs up to 2012; PPH studies in South Sudan, Liberia, Rwanda, Madagascar, Guinea and monitoring in Mozambique; MCHIP theme: community)

In PY4, MCHIP started up the pilot intervention phase of community-based distribution of misoprostol in South Sudan, Rwanda and Madagascar. In PY5, programs in Liberia and Guinea will begin and results from the five programs will be used to influence WHO policy on community-based distribution of misoprostol for prevention of PPH. Dissemination will be conducted at the national level and at international conferences such as the Maternal Health Task Force meeting in Arusha, Tanzania, in January 2013.

Understanding and improving uterotonic potency in Zimbabwe (Data source: Oxytocin Potency Study in Zimbabwe; MCHIP theme: quality)

In Year 4, MCHIP worked with the Zimbabwe field team to develop the process for testing of oxytocin along the supply chain. The study will be carried out in Q1 of PY5 and results will be disseminated nationally and be used to inform the PY5 activity related to improving the process of storage of oxytocin.

The Monitoring and Evaluation team, together with the Maternal Health and Newborn Health Teams, is examining the theme of measurement of coverage and quality of maternal and newborn health interventions. Several activities done in Year 4 explored the feasibility and validity of several different way to measure the quality of antenatal care (ANC) and labor and delivery services:

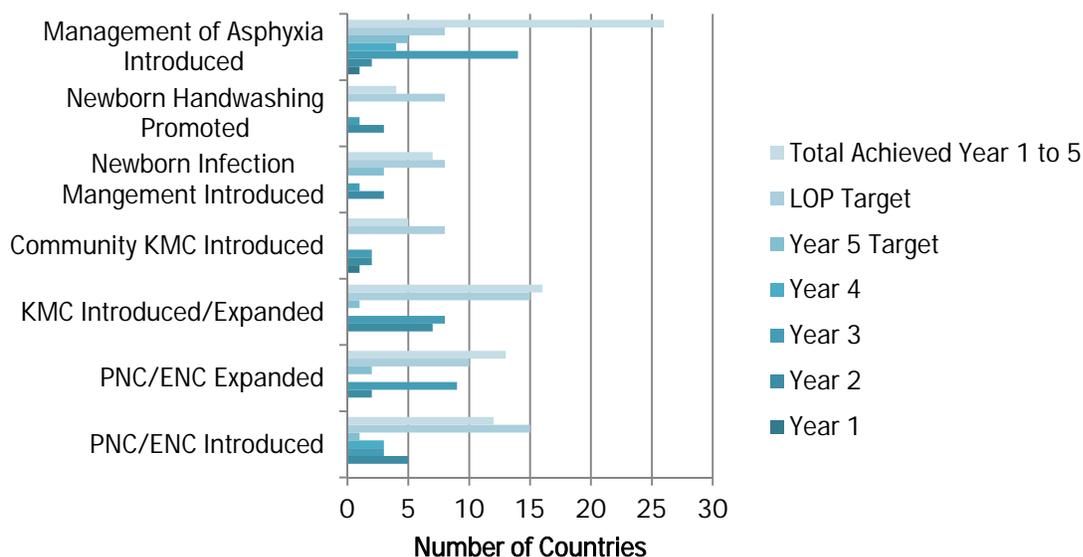
- Quality of Care (QoC) observational studies.
- Analysis of the indicators in the QoC studies to devise a smaller set of facility-based indicators that can reliably track progress for quality of service delivery. This work will be completed in Year 5 with the production of recommendations for this smaller set of MNH indicators.
- Ongoing work with WHO on indicators that can reliably track content as well as contact for MNH services
- Kenya MNH surveillance activity.
- A maternal recall validation study for MNH indicators in Mozambique. The study was completed in Year 4 and will be published in *PLoS One* in Year 5.

NEWBORN HEALTH

MCHIP's newborn health strategy focuses on the introduction and expansion of evidence-based newborn interventions that address the three main causes of newborn mortality: birth asphyxia, preterm births and newborn infection. In Year 4, MCHIP continued to support the strengthening and integration of evidence-based interventions with existing MOH and pre-service institution systems and programs, and document learning around the scale-up and sustainability of newborn health interventions. Key achievements in Year 4 included publication and dissemination of the Kangaroo Mother Care (KMC) Implementation Guide, two multi-country assessments of KMC and PNC home visits for newborn survival, a situation analysis of newborn health in Liberia, technical assistance to the initiation of the new Survive and Thrive GDA, technical assistance to

the Born Too Soon preterm care teams on antenatal corticosteroids and KMC, and MCHIP's continued leadership of the LAC Neonatal Alliance. In addition, in Year 4 MCHIP completed its core-funded program in Azerbaijan, which produced training films and complementary materials and job aids on clinical exam of the healthy newborn and newborn resuscitation; these materials have been introduced into the country's national medical education curriculum. In Year 4, MCHIP has continued to provide leadership on chlorhexidine for cord-stump care, as a core participant in the global technical working group, providing input on a range of issues including crafting programmatic guidance and input to countries interested in moving forward with piloting and introduction. Progress for high-impact newborn health interventions is presented in Figure 4 on the below. See Annex B for results supported by the Africa Bureau and Annex C for results supported by the LAC Bureau.

Figure 4. Progress for High-Impact Newborn Health Interventions



Global Leadership

- Technical assistance to the new *Survive and Thrive* GDA** MCHIP participated in *Survive and Thrive* secretariat meetings and in country visits to Tanzania and Malawi. The visits were used to explain the mission and purpose of the GDA, understand the regional and MoH national strategy for improving MNC survival, and understand the strengths of major stakeholders in implementing/supporting MNCH interventions at scale. Through these visits, Malawi identified preterm care as a priority intervention for the country and made a commitment to become a champion country for preterm care, including KMC and the use of antenatal corticosteroids in preterm labor to facilitate maturation of the baby's lungs. An agreement was also reached to strengthen the national midwifery and medical associations, and provide opportunities to engage young health scholars in international development work.

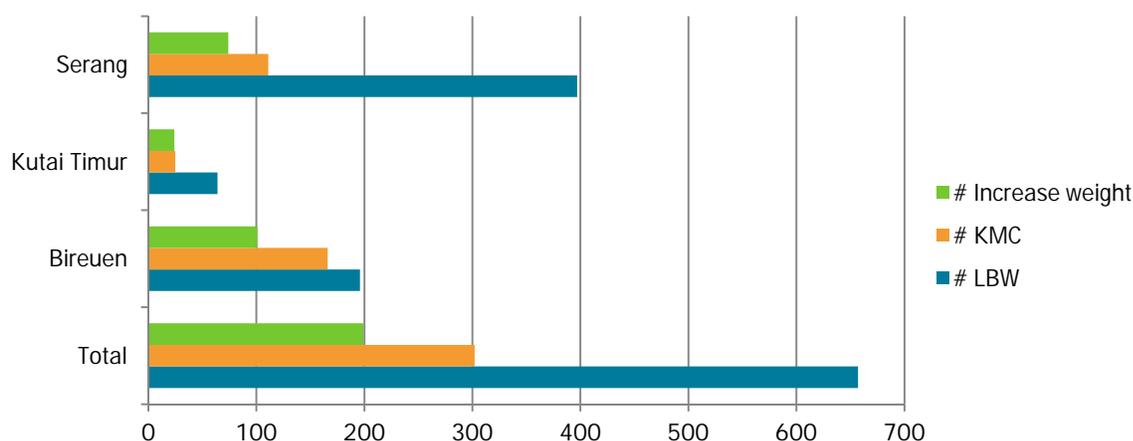
Kangaroo Mother Care and Low Birth Weight and Preterm Newborns

- MCHIP's multi-country review of KMC in Malawi, Mali, Rwanda and Uganda was co-funded by Save the Children's Saving Newborn Lives (SNL) program and used a model developed and tested by the South African Medical Research Council (MRC) Unit for Maternal and Infant Health Care. Facilities were assessed using a standard questionnaire and checklist, which has been applied in South Africa and adapted for use in Malawi, Ghana, Nigeria and Indonesia. The scoring methodology is based on three phases: pre-implementation, implementation and institutionalization. A multi-country brief and detailed individual reports for each country are under preparation, and will be finalized and presented at the International KMC Conference in November 2012. Recommendations from the review will be used to inform improvements in MCHIP-supported KMC programs as well as help to answer MCHIP's program learning question about how to successfully introduce and sustainably scale up KMC at the country level.
- MCHIP provided technical assistance to the *Born Too Soon* preterm care teams on antenatal corticosteroids and KMC through the analysis of available versus required tools necessary to support rollout of these priority interventions. MCHIP also participated in defining critical paths needed to facilitate uptake of priority interventions within the context of existing reproductive, maternal, newborn and child care packages. In Year 4, MCHIP has supported Malawi and Liberia as commitment and champion countries; a **commitment** country is ready to have a high-level government official publicly state that their country will prioritize care for preterm births (Liberia), while a **champion** country is one that is providing preterm birth services (KMC and/or antenatal corticosteroids) at scale and has centers of excellence that could serve as learning centers for other countries (Malawi).
- MCHIP's *KMC Implementation Guide* was published in Year 4 and disseminated in print and electronic form, including at the May regional meeting in Dhaka. Several countries at that meeting, including Pakistan, expressed interest in taking up KMC. MCHIP will follow up and propose using the anticipated associate awards to introduce KMC. Given the renewed attention to KMC as a result of the *Born Too Soon* report, MCHIP's guide is very well-timed and will continue to be proactively shared with countries through various forums.



Newborn in KMC position in Rwanda

Figure 5. Total KMC Implementation in Three Districts of Indonesia: January–September 2012



- MCHIP has expanded facility-based KMC in three MCHIP target hospitals in the three supported districts in **Indonesia**. *Perinasia* (Indonesian Perinatologist Association), which had been leading the effort of establishing facility-based KMC in Indonesia, is providing technical assistance to MCHIP for KMC expansion. The data from the three districts from January through September show a steady number of low birth weight cases that have received KMC at the hospital. Serang Hospital had a disruption in KMC because of the move to a new facility, but the services are now restored.

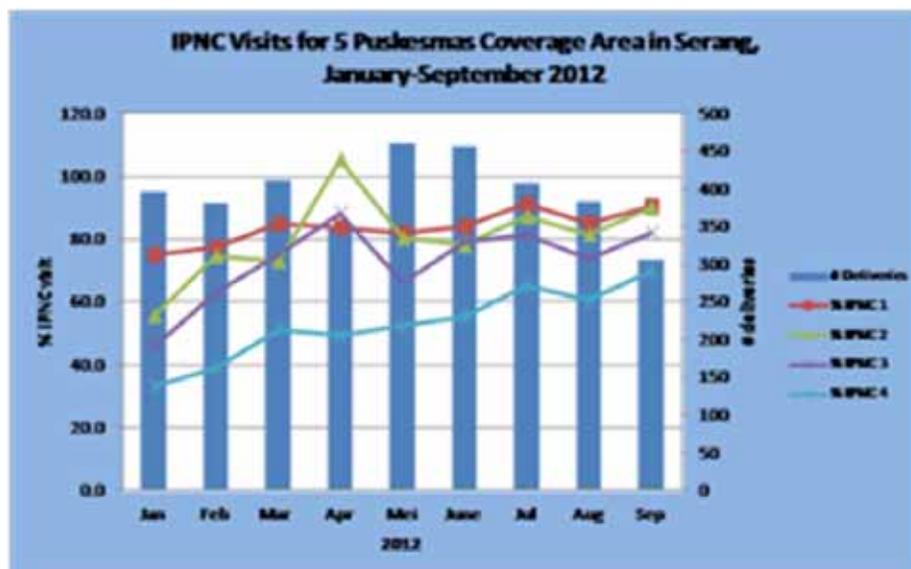
Newborn Sepsis Management

- MCHIP continues to co-host and participate in the **newborn sepsis management technical working group** (TWG), which is presently focused on the development of a Newborn Sepsis Management Implementation Guide. The full draft of the guide has been completed and has been circulated for review among the working group. The guide provides information for program managers and policymakers on the key essential steps for introducing community-based newborn sepsis management into their programs, with a goal of appropriate expansion within the country.
- **Analysis of Liberia newborn health situation and readiness to scale up newborn health interventions.** In Year 4, MCHIP undertook a newborn situation analysis (SITAN) and conducted a review of Liberia's readiness to implement and scale up newborn health interventions. The latter was done using a list of benchmarks developed and tested in 15 countries by Save the Children's SNL program as well as MCHIP's scale-up mapping tool. MCHIP supported the Liberian MoHSW to convene a stakeholder meeting in September 2012 to review the draft SITAN, examine the benchmarks, and complete a scale-up map on newborn sepsis management. Key outcomes of the meeting included consensus to present findings from the benchmark review, mapping and SITAN at the MoHSW's annual program review meeting with county health teams in October 2012. This would allow for better review of strengths and weaknesses, identification of possible solutions and discussion of how to improve county-level planning for newborn health. In Year 5, MCHIP will use core funds to publish the final SITAN report and provide targeted technical assistance to Liberia for newborn sepsis management (identified as particularly weak in the SITAN and through the mapping exercise) and to support Liberia as a commitment country for preterm care.

Postnatal Care

- MCHIP in **Indonesia** has developed an integrated postnatal care (IPNC) model to that is being scaled up at the national level. The current PNC schedule for skilled care differs for the mother and the newborn, and few postnatal visits are happening at all. The period during which mothers and newborns are most at risk, 24 to 48 hours after birth, is often missed, as this early visit is not integrated with community health services. In the MCHIP districts, the midwives were trained and supervised to provide integrated postpartum visits for mothers and newborns at 6–48 hours, 3–7 days, 8–28 days, and 36–42 days. Data from all three districts show that the IPNC visits are now happening. Data from Serang show that the majority of births from January to September received IPNC, although prior to MCHIP few postnatal visits were happening. In addition, at the national level, MCHIP adapted the global IPNC guidelines to the Indonesia context and created job aids for midwives. (field funded).

Figure 6. IPNC Trend in Serang, January to September 2012



- MCHIP’s multi-country review of PNC home visits, co-funded by Save the Children’s SNL program, examined the status of PNC implementation in five countries (Malawi, Nigeria, Rwanda, Bangladesh and Nepal). This review was accomplished through document and data review, country visits (except in the case of Nigeria, for which phone interviews were conducted) and interviews with central MoH staff and stakeholders. Documents, surveys and monitoring data related to PNC home visits were reviewed in each country, in addition to interviews with MOH staff involved with planning and implementation of the maternal, newborn and child health program, as well as other local stakeholders and international development partners. Field visits to districts implementing home PNC program activities were conducted. MOH staff involved with implementation at the lower levels, including district and sub-district managers, supervisors, facility and community-based health workers were interviewed—as well as community volunteers, community members and mothers of young children. Findings have been synthesized as short country summaries, organized into three areas: 1) policy and strategy adoption; 2) community health worker selection and training; and 3) program implementation and coverage. The findings have been shared with each country, but not formally presented or disseminated. MCHIP will be following up concerning any changes made as a result of the recommendations. Preliminary results were also shared at the WHO PNC meeting in Geneva in February 2012, to which MCHIP also provided significant technical assistance. Based on MCHIP and SNL’s draft report and the results of a PNC survey administered to 53 countries, the following recommendations were made at the Geneva meeting and are now being acted upon. MCHIP will be reviewing and contributing to both documents.

 - Provision of guidance by WHO on an optimal intervention package for mother and baby. This guidance will guide the update of their current community-based training material, which has limited material on the mother.
 - Development of a practical guide for the implementation of PNC home visitation. The guide was a need expressed by the more than 70 participants who attended the Geneva meeting.

Newborn Resuscitation

- To date, the newborn team has supported HBB/resuscitation programming in 23 countries, both at pre-service and in-service levels.
- MCHIP conducted the first round of data collection for the Malawi HBB performance evaluation. Targeting 90 facilities (45 intervention and 45 control facilities) from 27 districts, MCHIP collected data through observations of deliveries, clinical simulations using the NeoNatalie anatomic model, document reviews, health facility audits and key informant interviews. When completed, this evaluation will contribute to improvements in HBB approaches to training, implementation and scale-up at the service delivery level, both in Malawi and in settings where birth asphyxia is a major cause of neonatal mortality. Data cleaning and analysis are under way.
- MCHIP reviewed and revised the French version of HBB training materials (December 2011) and polled MCHIP country offices regarding their interest in purchasing these materials to determine whether Laerdal's minimum print requirement (1,000 copies) could be reached. The required minimum was obtained, and this information was shared with Laerdal.
- MCHIP continued its funding of AAP in FY12 to support completion of the HBB video, and to provide AAP TA and quality assurance support to MCHIP countries implementing HBB. AAP members provided TA on HBB in Zambia and Mozambique. In Zambia, they provided guidance on the integration of HBB into BEmONC training materials, and in Mozambique they participated in a dialogue with the MOH to adopt and integrate HBB into their in-service and pre-service training materials.
- MCHIP supported Ghana HBB pre-service activities. Over 625 final year nursing and midwifery students have been trained in HBB.
- In **Malawi**, MCHIP worked to institutionalize HBB training by establishing HBB in Malawi's 13 pre-service institutions implementing ENC. While MCHIP, SSDI-Services and other projects are rolling out HBB at the service delivery level, this activity will ensure future providers are equipped with the knowledge and skills to use HBB when deployed to health facilities. MCHIP assessed each training institution to determine if a skills laboratory exists and what equipment/supplies are available and needed. MCHIP also assessed training needs in ENC/HBB among faculty members and students and the number and type of students undergoing ENC/HBB course. Based on findings, MCHIP supported training of 24 lecturers and tutors and provided necessary supplies and materials.
- In **Egypt**, MCHIP developed training materials and curricula for improved MNCH/FP/Nutrition services provided by private doctors and community health workers (CHWs). The materials were adapted and updated from the existing national government curriculum. Training on key MNH services for service providers in all governorates continued throughout September. Focus areas included neonatal health care, including HBB and KMC, emphasizing care of pre-term or low birth weight babies, and PFP.
- In response to a USAID/Health, Infectious Diseases and Nutrition (HIDN) directive, MCHIP developed and produced two competency-based training packages in Azerbaijan to complement recently revised newborn clinical practice guidelines. A technical working group, including various MoH staff, was involved throughout to ensure harmonization with national protocols and eventual inclusion in the national curriculum. One package focused on newborn resuscitation and included a live-action instructional video and a training handbook. The second training package—on clinical assessment of

Comment from USAID/Azerbaijan regarding the MCHIP:

I would like to say thanks a lot to you all for your support. The project went wonderfully! This is great example when big long-term results can be achieved using small amounts of money. Congratulations to you all!

the healthy newborn—also included a live action instructional video, facilitator’s guide, updated checklists for skills development, clinical scenario package, presentations and job aids. MCHIP procured and distributed 60 NeoNatalie newborn clinical simulators to five medical institutions to allow for the demonstration, practice and testing of resuscitation skills. MCHIP trained 24 physicians (neonatologists, pediatricians and ob/gyns) from five institutions to competency as trainers, six of whom were selected as master trainers. These individuals then trained 68 physicians from facilities across Azerbaijan using both packages. Finally, the MoH approved the use of all materials and Azerbaijan Medical University formally approved the integration of the training packages into the national pre-service medical education curriculum.

- CORE Group, in partnership with MCHIP, ACNM and SNL, continued to promote and disseminate “Helping Babies Breathe (HBB) Implementation Guide” and “Taking Care of a Baby at Home After Birth: What Families Need to Do,” (nearly 500 copies) in English, Kiswahili and Kalenjin. Through a small grant to University Research Co. (URC), the flipbook was translated into French and adapted to the Benin context. The flipbook is now part of the Government of Benin’s newborn health package. With URC, CORE Group produced a case study on the adaptation process and will feature the process at the CORE Fall 2012 meeting. CORE Group participated in the HBB GDA partners’ meetings and the Newborn Indicators Working Group and was a member of the LAC Newborn Alliance. CORE Group facilitated Suzanne Stalls’ (ACNM) participation in the Asia Regional Meeting in Dhaka and her presentation during the “Orientation on Programming the HBB Initiative for Newborn Resuscitation” session.

Handwashing for Newborn Survival

- Formative Research was completed in Indonesia and was presented in a national forum in Jakarta on Global Handwashing Day—October 15, 2011. The findings were incorporated into the behavior change communication (BCC) materials that were developed with Unilever specifically for Indonesia. These materials are being introduced by MCHIP in PY5. They have also been shared with other USAID-funded programs, notably the EMAS bilateral.
- In Bangladesh, formative research by icddr,b was completed. The findings will be presented in a stakeholder’s meeting in PY5 in Dhaka. The findings will be used to adapt materials and strategies to the situation in the MaMoni impact areas.

Program Learning for Newborn Health

In Year 4, MCHIP used core funds to advance learning related to the implementation of PNC home visits and KMC, test the use of scale-up readiness benchmarks and scale-up maps, analyze the newborn health situation in Liberia and more. Two specific accomplishments are listed below, with other program learning activities/achievement descriptions included in the Major Accomplishments elsewhere in this report.

What is required to introduce and sustainably scale up facility-based KMC services in a country? (Data source: KMC multi-country review; MCHIP themes: Scale-up, quality, integration)

MCHIP’s Year 4 multi-country review of KMC in Malawi, Mali, Rwanda and Uganda was co-funded by Save the Children’s SNL program and used a model developed and tested by the South African Medical Research Council (MRC) Unit for Maternal and Infant Health Care. Facilities were assessed using a standard questionnaire and checklist, which has been applied in South Africa and adapted for use in Malawi, Ghana, Nigeria and Indonesia. The scoring methodology is based on three phases: pre-implementation, implementation and institutionalization. A multi-country brief and detailed individual reports for each country were drafted late in Year 4, and will be finalized and presented at the International KMC Conference

in November 2012. Recommendations from the review will be used to inform improvements in MCHIP-supported KMC programs as well as help to answer MCHIP's program learning question about how to successfully introduce and sustainably scale up KMC at the country level.

How can countries track and assess progress in scale-up of newborn interventions? (Data source: Zambia, Liberia, Cambodia using readiness assessments to scale up newborn interventions; MCHIP themes: Scale-up)

MCHIP and Save the Children's SNL program tested SNL's scale-up readiness benchmarks while also applying MCHIP's scale-up mapping tool in Liberia. Planned travel to Zambia for the same purpose was postponed by the MoH until Q1 of Year 5, when SNL will also visit Cambodia to apply both tools. MCHIP will use the Liberia experience to revise guidance to country teams on the use of scale-up maps for planning and tracking purposes. Experiences from Zambia and Cambodia will be combined with Liberia's in a multi-country brief on the uses of both the benchmarks and scale-up maps.

MCHIP's multi-country review of PNC home visits (Data source: Desk review and country visits [Malawi, Nigeria, Rwanda, Bangladesh and Nepal]; MCHIP theme: Community)

Can Health Extension Workers in Ethiopia effectively provide newborn care services including community KMC and performance of essential newborn care and resuscitation?

Is it feasible to initiate and continue KMC at home with the support of community-based workers?

MCHIP is conducting an operations research (OR) study to assess whether mothers who are counseled during the antenatal period in Ethiopia by community health workers (Health Extension Workers or HEWs) will be able to initiate skin-to-skin and early breastfeeding at home for their newborns—irrespective of the birth weight. During this period, institutional review board (IRB) approval was obtained, questionnaires were finalized, interviewers were trained and fieldwork for the baseline household survey was completed. Analysis and report preparation are under way. The training materials for CHWs, including job aids and information, education and communication (IEC) materials for pregnant women and their families, were also finalized. Training of trainers and CHWs was conducted. Findings from this study will contribute significantly to the knowledge of whether or not it is feasible to initiate and continue prolonged skin-to-skin contact and breastfeeding at home. Findings will also provide information on whether universal promotion of prolonged skin-to-skin contact and early and exclusive breastfeeding for all newborn infants is an effective model for reaching small babies.

What factors facilitate scale-up of the management of newborn asphyxia through the Helping Babies Breathe approach? What results can be achieved at scale in 13 districts in Malawi with respect to health system performance, provider competence, quality of care and newborn outcomes?

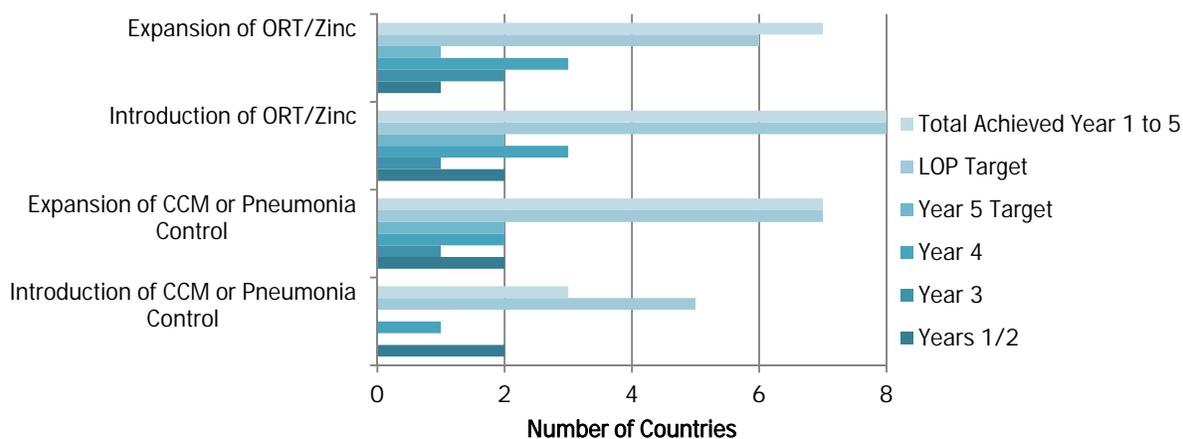
In Malawi, the scale-up of HBB provides an opportunity to understand program performance at a national scale. The MCHIP-led performance evaluation of the HBB program will examine issues of health system performance, provider competence, quality of care and newborn outcomes. It is proposed that a manuscript summarizing findings from the study be prepared and submitted in PY6 should an extension be approved. (Please see additional discussion of HBB-related background and activities in the Newborn Health section of the workplan.)

CHILD HEALTH

During FY12, MCHIP contributed toward the achievement of greater impact at scale for child health programs at global, regional and country levels. Working collaboratively with global and country-level partners, MCHIP strengthened the expansion of iCCM in two countries (Rwanda and Mali), introduced the iCCM program in Guinea and advocated for its introduction in Kenya. In addition, MCHIP supported the use of oral rehydration salts (ORS)/zinc in diarrheal disease case management in these four countries. With the goal of highlighting cross-cutting lessons learned, MCHIP drafted a synthesis report of the programmatic and policy implications of the findings from iCCM program reviews in the Democratic Republic of Congo (DRC), Senegal and Malawi. This synthesis report will be disseminated in Year 5 to contribute to ongoing iCCM program development and improvement.

MCHIP continued to serve as Secretariat of the global CCM Task Force (TF), which collaborated catalytically to develop supportive materials to guide country-level partners in designing, implementing and monitoring CCM programs. In addition, MCHIP defined the work of the TF through the development and refinement of the Terms of Reference and TF workplan. During the program year, MCHIP refined the CCM Central website to ensure greater usability and is in the process of translating sections of the website into French. As a result, global and country partners as well as MOHs have greater ability to access a centralized source for examples of promising practices and tools to implement and scale-up iCCM programs. Progress for high-impact child health interventions is presented in Figure 7 below. See Annex B for results supported by the Africa Bureau and Annex C for results supported by the LAC Bureau.

Figure 7. Progress for High-Impact Child Health Interventions



Community Case Management

- MCHIP served as Secretariat of the CCM TF, providing an example of what partnerships can achieve through collaboration. Part of this process entailed redefining the subgroups, the Terms of Reference and the TF and specific subgroup workplans. These tools will guide the future of the TF, ensuring that value is added through the partnership.
- MCHIP worked collaboratively with global partners (WHO and UNICEF) and country-level partners (including USAID Missions, MOHs, CORE Group, USAID implementing agencies and other bilateral donors at the country level) to assist CCM introduction or expansion in four countries. In Rwanda and Mali, MCHIP provided technical assistance to strengthen iCCM expansion efforts, and in Guinea, MCHIP supported the introduction of iCCM. In Rwanda, Mali and Guinea, MCHIP's technical assistance contributed to enhanced collaboration and coordination between the MOHs and other CCM implementing agencies in each country. In Kenya, the process of advocating for the introduction of iCCM has involved several stages. In addition to active involvement in various meetings over the year to

discuss CCM in Kenya, MCHIP also facilitated two workshops that contributed to the development of the CCM Implementation Guide. The first workshop focused on drafting the Implementation Guide itself, which involved outlining the implementation steps that the Kenyan Ministries and partners were interested in rolling out over the coming years. The second workshop focused on drafting an M&E plan to support the Implementation Guideline. For both workshops, MCHIP had in-country and DC-based staff providing TA. Under the Implementation Guide, several different implementing partners, including MCHIP, will begin CCM research in pilot sites.

- MCHIP refined, restructured and populated the CCMCentral.com website, which serves as a portal for countries implementing iCCM to access meeting reports, links to current initiatives and events, and implementation tools for iCCM scale-up. Currently being translated into French, the website will provide in-country partners with key updates on child health and with the tools needed to develop, strengthen and scale up iCCM programs.
- The Operations Research subgroup of the CCM TF, supported by MCHIP, contributed to the development of 15 papers on iCCM in the Journal Supplement of the *American Journal of Tropical Medicine and Hygiene* (AJTMH). When published in Q1 of the next program year, the articles will provide program implementers working on CCM with important research and policy findings.
- MCHIP supported the finalization of CCM indicators, working closely with the Monitoring and Evaluation subgroup of the CCM TF. It is anticipated that during the next program year, an indicators workshop/regional meeting will be held to disseminate these indicators to countries and advocate for their use. This technical support will enable countries to strengthen their use and reporting on CCM indicators.
- MCHIP developed a synthesis report of the cross-cutting findings and lessons learned from iCCM programs at scale in the DRC, Senegal and Malawi. The synthesis report analyzes the lessons learned from each of these countries and puts forward key recommendations on how CCM programs can integrate these lessons into current and future programming. MCHIP continued to disseminate findings from the iCCM documentation through a presentation to USAID Washington technical officers in December 2011 and a Webinar coordinated by the CORE Group in January 2012. A total of 47 CORE Group members actively participated to discuss respective experiences from three countries and lessons aimed at helping introduce and scale up iCCM in other countries.
- CORE Group co-hosted a CCM webinar series, which included the “Scaling-up iCCM in DRC, Senegal and Malawi” and the “Why Does Diarrhea Matter: Preventing a Million Deaths and Lessons from Countries” presentations. CORE Group continued to participate in the Global CCM Task Force and to serve as the Co-focal Person for the Roll Back Malaria (RBM) CMWG “Expanding Access to Treatment” Workstream. CORE Group continued strategic diffusion and promotion of *CCM Essentials Guide* and Graphic, and CCMCentral.com. Five hundred copies of the French version were printed and several hundred copies were disseminated at the CORE Group Spring Meeting, to partners and international meetings. A second revised edition was completed, and includes the addition of www.CCMCentral.com as a resource, the addition of the updated *Sick Child Form* and reference to the adaptation of CCM for emergencies for future directions. At the Spring Meeting, CORE Group also facilitated a CCM session entitled, “Using and Improving Indicators for CCM of Sick Children,” which highlighted the global iCCM benchmarks and indicators.

Diarrhea Disease Prevention and Control

- MCHIP has actively and substantially contributed to global momentum to increase visibility of the importance of child health programming. Specifically, MCHIP brought key stakeholders together to discuss available and potential forums for influencing diarrhea

control efforts and how to work collaboratively to ensure global leadership. In Year 4, MCHIP supported and contributed to the growing momentum that led up to the Child Survival Call to Action, the Declaration on Scaling Up Treatment of Diarrhea and Pneumonia and the establishment of the UN Commission on Commodities for Women's and Children's Health. Some examples of how MCHIP contributed to global momentum around diarrheal disease include:

- MCHIP attended the Diarrhea and Pneumonia Working Group meetings and the JSI Maternal, Newborn and Child Health Center Technical Meeting, and participated in the diarrhea panel presentation at the World Federation of Public Health Associations 13th Congress.
- MCHIP contributed as a panel presenter and moderator to the “Why Does Diarrhea Matter” webinar series, hosted by MCHIP program partner the CORE Group, which brought together global and country-level stakeholders to raise awareness of the global diarrheal disease burden, to discuss how to address low coverage of effective diarrheal disease interventions and to share lessons learned surrounding promising practices at country level.

Program Learning for Child Health

As a global leader in iCCM, MCHIP focused its program learning efforts on this technical area, but also supported efforts in diarrhea control through the development and implementation of several reviews and special studies. These reviews and studies have been and will continue to be disseminated to CORE member countries, USAID and WHO and the wider global community through briefings, monographs and peer-reviewed publications, including:

Assessment of Training and Supervision Tools for Malaria Case Management (Data source: Desk review and key informant interviews in PMI countries; MCHIP theme: Community)

In Year 4, MCHIP initiated an assessment in President's Malaria Initiative (PMI) countries to identify major bottlenecks to scaling up WHO diagnostic testing and treatment guidelines for malaria within the context of Integrated Management of Childhood Illness (IMCI). Mainly focused at the clinical level, the review assesses how IMCI training and supervision tools currently used at country level address updated guidance encouraging diagnostic testing of all suspected malaria cases and treatment of only those with a positive test. It also examines guidance for pre-referral treatment for the severely ill and recommendations for definitive management of severe malaria. This assessment will be finalized during PY5 and disseminated through a presentation to USAID and key stakeholders.

Tanzania Assessment of CCM Services for Childhood Illness at Government Dispensaries and the Private Accredited Drug Dispensing Outlets (Data source: Field assessment of SHOPS program in three regions of TZ; MCHIP Learning Themes: Community, integration)

MCHIP worked with Strengthening Health Outcomes through the Private Sector (SHOPS) and Population Services International (PSI) to provide technical assistance to carry out an assessment of how the private sector has been utilized to improve coverage of child health services through community-based mechanisms. The assessment provides guidance for USAID and other program partners as they design future child health programs. The findings were preliminarily disseminated in PY4 with USAID. Full dissemination is planned for PY5 and will include a presentation to USAID.

Multi-Country Review of ORS (oral rehydration salts)/Zinc Scale-up (Data source: Desk review and key informant interviews in 4 countries--Malawi, Zambia, Mali, and Senegal; MCHIP theme: Scale-up)

This qualitative study utilized interviews with key informants from MOHs, NGOs and academic institutions to identify enabling factors and obstacles to scale-up of ORS and zinc in both low- and high-performing countries, and highlights potential solutions to overcome obstacles. Dissemination through a peer-reviewed journal is planned for PY5 to assist CCM program implementers and policymakers.

Study on Prevention of Diarrheal Disease in Children in Urban Slums using Aquatabs for Water Disinfection (Data source: Special study in Orissa, India; MCHIP theme: Community)

MCHIP supported PSI to complete a double blind randomized control, the Aquatabs Research Study in Orissa, India, which found no evidence that the intervention was effective. These findings were disseminated through MCHIP's partner PSI.

In PY5, MCHIP will focus its program learning efforts exclusively on iCCM. It will build on PY4 work to deepen understanding about the best ways to scale up and institutionalize iCCM competencies, both through the MCHIP assistance to the CCM Task Force and to countries to help them monitor their progress through adoption and institutionalization of the new standardized CCM indicators.

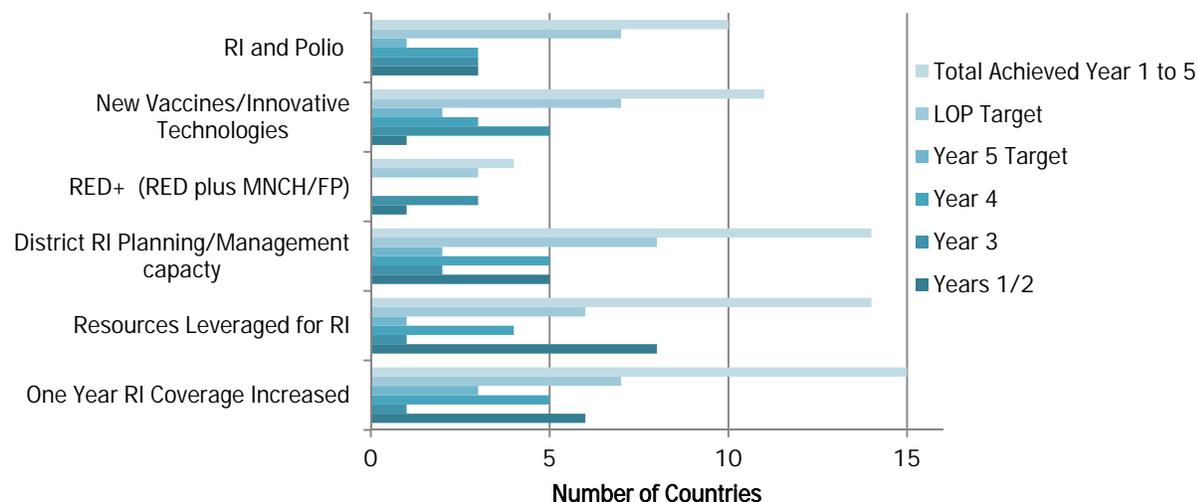
IMMUNIZATION OVERVIEW

MCHIP continues to work to strengthen routine immunization systems at the global, regional and country levels. At the same time, MCHIP is ensuring linkages with new and underutilized vaccine introduction, vaccine-preventable disease eradication and elimination initiatives, accelerated disease control, and other health programs (e.g., family planning and child survival). In PY4, among the nine MCHIP countries implementing immunization activities this program year, seven countries (DRC, India, Kenya, Malawi, Rwanda, Timor-Leste, Zimbabwe) received technical assistance to introduce new, lifesaving vaccines, while five countries (Malawi, Rwanda, Senegal, Tanzania, Zimbabwe) continue to receive technical assistance to plan and prepare for upcoming new vaccine introductions.

In collaboration with numerous partners (e.g., GAVI Alliance, USAID, U.S. Centers for Disease Control and Prevention [CDC], WHO, UNICEF, USAID bilaterals, and others), MCHIP immunization also plays a key technical role to serve as a liaison between global, regional and country levels. This role is taking on greater visibility through the Global Vaccine Action Plan (for which regional and country input was incorporated), which was approved by the World Health Assembly in May 2012; new vaccine introductions planned in over 30 countries in the coming years; and existing partnerships (e.g., the Measles Rubella Initiative and with the Polio Eradication Initiative).

MCHIP's immunization technical assistance in countries (many co-funded with field support) increased significantly in PY4, continuing activities in DRC, India, Kyrgyzstan, Kenya, Tajikistan, Rwanda, Zimbabwe and Timor-Leste. In addition, MCHIP started new programs in Malawi, Senegal, Tanzania, Uganda and Ukraine. MCHIP also provided support to other countries (e.g., with polio funding for Pakistan and Nigeria; for integration of immunization with other health priorities in Liberia and Kenya; and with future technical assistance to South Sudan, Yemen and Pakistan). Progress for high-impact immunization interventions is presented in Figure 8 on the following page. See Annex B for results supported by the Africa Bureau and Annex C for results supported by the LAC Bureau.

Figure 8. Progress for High-Impact Immunization Interventions



- Global Leadership Immunization in Practice training module:** Based on a WHO request and MCHIP’s experience with engaging communities, MCHIP has started drafting a module for the widely used and updated version of WHO’s Immunization in Practice training course that will address partnering with communities. The course is used throughout the world by MOHs, WHO and partners to train facility and district-level staff on immunization.
- WHO/AFRO MLM Training (and finalization of two modules: New Vaccine and Communication, and Community Involvement):** At the request of WHO/AFRO, MCHIP co-facilitated the testing of an updated series of immunization Mid-Level Managers (MLM) Modules for over 65 participants from 19 Francophone countries in Abidjan from August 20–September 1, 2012. As a result, some needed revisions in the content were identified and will be incorporated by WHO. MCHIP contributed as a co-author to these modules, which will be finalized by WHO/AFRO and distributed for use throughout the region in 2013.
- WHO/EURO “Tailoring Immunization Programs (TIPS) Toolkit”:** In partnership with JSI (subcontracted from WHO/EURO), MCHIP contributed to the drafting of a sampling framework and monitoring and evaluation chapter as well as the editing of other chapters in the first draft of the Toolkit. The TIP Toolkit will assist countries to develop appropriate communication and community linkages toward improving immunization coverage. The draft version of the Toolkit was presented to the MOH and partners in Bulgaria in September 2012. It will be further field-tested in Bulgaria and other countries to help MOHs improve immunization support and coverage within marginalized communities.
- Revision of the comprehensive Multi-Year Plan (cMYP) guidelines and costing tool:** MCHIP staff contributed to a TWG at WHO/HQ that developed the first stage of recommendations for the revision of the cMYP guidelines and costing tool, anticipated to be completed and shared by the second quarter of 2013. The cMYP is a requirement for countries applying to GAVI for support.
- Global NUVI Implementation Annual Meeting:** MCHIP presented at the 2012 New and Underutilized Vaccines Introduction (NUVI) meeting organized by WHO/HQ to address key issues related to the introduction of new and under-utilized vaccines, and to review progress in NUVI implementation. MCHIP presented on its support to NUVI and other immunization services at global, regional and country levels and on MCHIP’s plan for the next 12 months. MCHIP also led sessions on the “effects of vaccine presentations on coverage (example: 5 dose measles vaccine)” and “integrated communication approach for

new vaccine introduction” (including Tanzania as a country example). In addition, MCHIP contributed to a cold chain and logistics working group consultation.

- **Rotavirus Communication Working Group:** As a member of the rotavirus communication advisory group, MCHIP provided technical input to the Rotavirus Fact Sheets. These fact sheets provide guidance to countries on the WHO Strategic Advisory Group of Experts (SAGE) recommendations on rotavirus vaccine introduction. The group has also developed a “Key Messages on Rotavirus Vaccine for EPI Managers” reference document to accompany these Fact Sheets for country adaptation and use. This document was also distributed at the National Stakeholders meeting held by the MOH/Tanzania in September 2012 (in which MCHIP participated).
- **WHO Eastern and Southern Africa GAVI Working Group Meeting in Maputo, Mozambique:** MCHIP facilitated sessions at this meeting, organized by UNICEF/East and Southern Africa Regional Office and the WHO/AFRO. This meeting provided a forum to discuss technical updates, progress and planning for multi-agency support to the countries in the region. Topics addressed related to priority actions to raise immunization coverage (e.g., RED); integration of immunization policy and function; use of NUVI to strengthen routine services; and broadening of community participation and ownership. Country schedules for planned introduction and support needs, status of Post-Introduction Evaluations, and the status of country applications and preparations for new vaccines introduction were also discussed.
- **Immunization Practices Advisory Committee (IPAC):** As a member of IPAC, MCHIP provided technical advice to the Director of WHO’s Immunization Program. Topics included special challenges that rotavirus vaccine introduction presents, contributing to IPAC’s recommendations concerning training approaches and required content; efforts by environmental groups that would remove the only available preservative from multi-dose vaccine vials, despite its safety; design of field-testing of visual cues for placement on each multi-dose vial to signal when it must be discarded after opening; revision of the WHO process for pre-qualifying vaccines; and many more topics.
- **Global Vaccine Action Plan (GVAP) contributions:**
 - MCHIP staff co-led the multi-agency “Strengthening Immunization Systems Performance and Monitoring” within the “Delivery Working Group” and provided input into the Decade of Vaccines (DoV) draft action plan. MCHIP also led sessions at the DoV Collaboration Consultation Meeting in Namibia, which followed the Annual Conference on Immunization in Africa.
 - MCHIP staff advocated for the retention of the DTP1 to DTP3 indicator in the GVAP. The justification piece presented by MCHIP resulted in the re-opening of a global discussion on the preferred indicator to be used by all countries throughout the decade to monitor dropout.
- **Institute of Medicine (IOM) Committee:** As a member of an IOM Committee on Identifying and Prioritizing New Preventive Vaccines for Development, MCHIP staff provided a global perspective on the attributes of future vaccines that would best meet the needs of vaccination programs in developing countries. Input was given into the development of a computer model to assist stakeholder decisions regarding design and introduction of vaccine products.
- **Cold Chain and Logistics Technical Working Group:** MCHIP’s contribution to this TWG resulted in the revision of Effective Vaccine Management (EVM) tools and of the cold chain and logistics guidance during the cold chain and logistics (CCL) meeting in New York. Additionally, MCHIP contributed to drafting and reviewing the 30-day temperature recording (DTR) guidelines and to discussions on direct solar refrigerators for use of storing vaccines.

- **Vaccine Presentation and Packaging Advisory Group:** MCHIP serves on the Vaccine Presentation and Packaging Advisory Group, which is a unique body receiving input from public agencies and vaccine manufacturers to identify attributes for new vaccines intended for use in developing countries. MCHIP participated in monthly conference calls, providing technical input.
- **Primary Vaccine Container Roundtable:** MCHIP staff co-led a “Roundtable on Consideration for Primary Vaccine Container Selection in Developing Countries – Defining the Evidence and Framework for Decision Making.” This global meeting convened a group of experts from countries, agencies, academia and the private sector to: present and respond to available evidence and a preliminary framework for primary container decision-making; identify the most relevant data gaps inhibiting evidence-based decision-making; understand diverse needs of stakeholders involved in container decisions; and identify opportunities for improved data and decision-making to affect product development, programs and policy.
- **UNICEF Collaboration:** The MCHIP/HQ immunization team met with the UNICEF/HQ immunization team in New York to update them on immunization activities and discuss collaboration. MCHIP presented on its current work in routine immunization strengthening and new vaccines introduction at global, regional and country levels. MCHIP held follow-up meetings with several UNICEF staff on joint activities, including: global and country-level rotavirus and new vaccine communication (in preparation for a session at the global NUVI meeting); polio and routine immunization communication strengthening and country support for it; in addition to technical and logistics collaboration with WHO, Clinton Health Access Initiative, MOHs and others at country level.
- **Measles Elimination Initiative:**
 - MCHIP provided detailed technical feedback to the GAVI Alliance guidelines for support to supplementary immunization activities (SIAs) in priority countries. MCHIP/HQ and field staff also assisted with in-country support for SIAs and linkages with routine immunization strengthening in DRC, Kenya and Zimbabwe.
 - MCHIP contributed as technical experts (funded by WHO) at the multi-agency Global Measles and Rubella Management meeting hosted by WHO/HQ. MCHIP provided technical input to global measles priorities as well as shared experiences and lessons learned from country support (e.g., India, Tanzania, DRC and Kenya) to feed into global measles and rubella strategies.
 - MCHIP advocated for measles and measles-rubella vaccines in 5-dose vials to be offered by UNICEF Supply Division. MCHIP advised UNICEF on a survey to ascertain country interest. As a result, UNICEF estimated that up to 40% of country demand for the routine program would be in 5-dose vials. As a result, UNICEF Supply Division decided to include a measles vaccine 5-dose presentation in its next international tender.

Routine Immunization and New Vaccines

- MCHIP collaborated with USAID, MOHs, WHO and other partners to provide TA for the introduction and post-introduction of safe and lifesaving vaccines in nine GAVI-eligible countries: DRC, India, Kenya, Malawi, Rwanda, Senegal, Tanzania, Timor-Leste and Zimbabwe, while assisting six countries in preparatory activities to introduce vaccines in PY5 (Kenya, Malawi, Rwanda, Senegal, Tanzania and Zimbabwe).

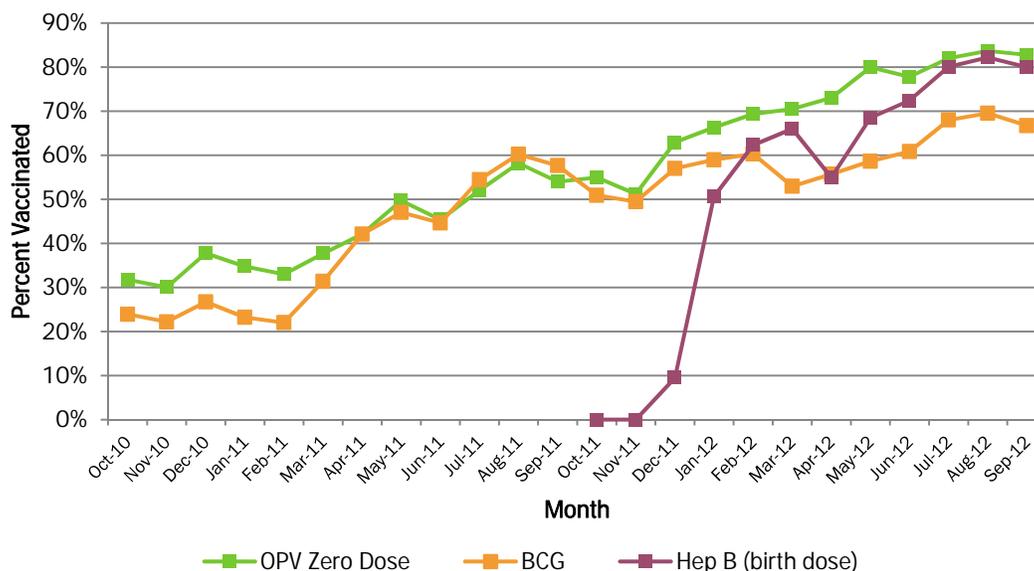
Table 1. Progress toward New Vaccine Introduction

| Country | PNEUMOCOCCAL VACCINE | ROTAVIRUS VACCINE | Other | |
|---------|----------------------|--|---|---|
| 1 | DRC | Met GAVI conditions, continuing phased introduction of PCV13 in 2012 | N/A | |
| 2 | India | N/A | Phased rollout of pentavalent vaccine in USAID focus states in 2012 | |
| 3 | Kenya | Monitor coverage and quality and conducted post-introduction evaluation (PIE) in 2012 | Support introduction in 2013 | |
| 4 | Malawi | <ul style="list-style-type: none"> ▪ Introduced in November 2011 ▪ Supported PIE in June 2012 | <ul style="list-style-type: none"> ▪ Introduction in October 2012 ▪ PIE in 2013 | Assist with measles 2nd dose GAVI proposal development and prepare for introduction in 2013 |
| 5 | Rwanda | N/A | <ul style="list-style-type: none"> ▪ Introduced in May 2012 ▪ Support PIE in 2013 | Assisted with measles 2nd dose and HPV GAVI proposal development and introduction preparation in 2013 |
| 6 | Senegal | Support introduction in 2013 | Assist with rotavirus vaccine GAVI proposal development in 2013 | <ul style="list-style-type: none"> ▪ Support introduction of MenA in November 2012 and PIE in 2013 ▪ Assist with measles 2nd dose GAVI proposal development in 2013 |
| 7 | Tanzania | Support introduction in Jan 2013 | Support introduction in Jan 2013 | N/A |
| 8 | Timor-Leste | N/A | N/A | <ul style="list-style-type: none"> ▪ Coordinated with partners to support introduction of pentavalent vaccine in Oct 2012 ▪ PIE in 2013 |
| 9 | Zimbabwe | <ul style="list-style-type: none"> ▪ Supported introduction in June 2012 ▪ Support PIE in 2013 | Satisfy GAVI conditions and support introduction preparations (introduction planned) for 2014 | N/A |

- MCHIP continues country-level TA to improve data quality, quarterly supportive supervision and effective implementation of all five Reach Every District (RED) components. The purpose of this assistance is to ensure the sustainability of a strong routine immunization platform that will also contribute to maximizing the investment to integrate new vaccines into the EPI. In Tanzania, Senegal, Zimbabwe and Malawi, MCHIP has supported the functionality and partner participation and collaboration in the EPI Technical Inter-agency Coordination Committees (ICC) to keep routine immunization strengthening on the agenda, while ensuring sufficient partner collaboration in new vaccine introduction planning.
- CORE Group continued to promote increased NGO involvement in immunization including expanding the Immunization Interest Group listserv, which disseminates MCHIP-related materials and resources, to 86 members. With polio-specific funding, CORE Group hired Elaine Murphy to develop a guide, *Social Mobilization: Lessons from the CORE Group Polio Project in Angola, Ethiopia and India*, based in part on interviews with MCHIP immunization staff. The guide includes recommendations for reaching inaccessible populations with routine immunization and other health services.
- In India, MCHIP piloted the “Tracking Every Newborn (TEN)” initiative in 22 sub-centers of Uttar Pradesh and Jharkhand. TEN provides input to the GOI’s Mother and Child Tracking

System to more effectively track children to improve immunization coverage. MCHIP also introduced the “My Village, My Home” tool in 45 centers in Uttar Pradesh and Jharkhand. Health workers use this tool to monitor immunization “left outs” and “drop outs.” Additionally, MCHIP’s initiative to institutionalize neonatal vaccinations in the focus districts effectively supported immunization and ensured continuous vaccine tracking (see Figure 9). Finally, MCHIP assisted districts as they rationalized facility microplans. This process identified 1,437 left-out areas and ensured immunization service for 400,000 people (approx. 12,000 newborns).

Figure 9. Progress in Newborn Vaccination in Three Focus Districts of UP



Polio Eradication

MCHIP provides support to polio activities in four countries (DRC, India, Kenya and Zimbabwe) and works to strengthen polio eradication communication at global and country levels with its sub-contractor, The Communications Initiative (CI). This work has included technical input to WHO, UNICEF and focus-country strategies as well as the following:

- **Polio communication field implementation:** MCHIP provided input on polio communication and experiences/recommendations in field implementation (including linkages with routine immunization) to the Independent Monitoring Board for the Global Polio Eradication Initiative as well as with the Bill & Melinda Gates Foundation, UNICEF, WHO, the Polio Communication Advisory Group, other partners at global level, in the AFRO region, and with MOHs in priority countries.
- **National-Level Communication Reviews:** CI participated in national-level communication reviews in India, Pakistan and Nigeria, providing expert consultants, preparing consolidated reports and, in Nigeria and Pakistan, convening quarterly follow-up conference calls to track progress against recommendations.
- **Pakistan Technical Advisory Group:** CI contributed in identifying achievements and gaps in polio communication, providing recommendations.
- **Feedback provided on global documents** to USAID, on the Global Polio Emergency Plan and the financial case for global immunization in the context of the Decades of Vaccines; and to UNICEF, on the quarterly communication update presented to the polio eradication Independent Monitoring Board.

- **Papers and research proposals submitted:** A CORE polio paper was submitted to the *Journal of Health Communication* for review; a Qualitative Comparative Analysis proposal (with CORE and UNICEF in India) was submitted to the polio research committee.
- **Engaging civil society organizations:** CORE Group participated in and promoted increased NGO involvement in immunization that included creating an Immunization Interest Group listserv, working with the CORE Group Polio Project and helping to diffuse lessons learned through promotional material and video development.
- **Surveillance reviews:** MCHIP staff and consultants participated as external technical experts in multi-agency acute flaccid paralysis and vaccine-preventable disease surveillance reviews in three countries (Ethiopia, Uganda and Tanzania), as well as in the Horn of Africa technical advisory group.
- **Country support** was provided for SIAs in DRC, Kenya and Zimbabwe and with improving newborn tracking and increasing OPV0 (and routine OPV) coverage in focus districts in Kenya and India (MCHIP) and Nigeria (with TSHIP [Targeted States High Impact Project] bilateral). These approaches are being adapted for other countries.

Program Learning for Immunization

The MCHIP immunization team has focused its PY4 program learning on disseminating lessons learned from country-level experience in new vaccine introduction, routine immunization strengthening, accelerated disease control and efforts on polio eradication. In PY4, MCHIP disseminated program learning through published articles in peer-reviewed professional journals (four accepted, two awaiting acceptance) and presenting at a number of meetings and conferences. With an increased focus on new vaccine introduction, MCHIP's program learning illustrates the importance of a strong routine immunization system to maximize investments toward bringing new vaccines to scale, while targeting hard to reach populations to close the equity gap.

A literature review on understanding the impact of new vaccine introduction on immunization programs and health systems (Data source: Literature review of published literature)

As new, lifesaving vaccines are introduced into national immunization programs and delivered at scale, there is significant opportunity to reduce child morbidity and mortality due to vaccine-preventable diseases. At WHO's request, MCHIP sought to understand how the introduction of new vaccines impacts national immunization programs and broader health systems. To this end, MCHIP carried out a comprehensive review of published literature, with key findings organized in terms of the main components and sub-components of WHO's health systems framework. Findings have been accepted to be published in the journal *Vaccine*.

- Terri Hyde....Mike Favin. "Impact of New Vaccine Introduction on the Immunization and Health Systems: a Review of the Published Literature" (Accepted May 2012 to *Vaccine*)

Analysis of how equity can be achieved in the "Decade of Vaccines" (Data source: Literature review; MCHIP and other experience. MCHIP theme: Equity)

Save the Children Fund (SCF)/UK, WHO, UNICEF and MCHIP collaborated on this submission as a follow-up to the monograph published by SCF/UK earlier in 2012 on "Finding the Final Fifth: Inequalities in Immunization." This is a review of published and unpublished literature emphasizing "how" inequalities can be addressed to immunize the final fifth.

- Lara Brearley, Jos Vandelaer, Rudi Eggers, Robert Steinglass. "Applying an Equity Lens in the Decade of Vaccines" (submitted to *Vaccine* August 2012)

Development of a strategic planning approach for using measles and rubella campaigns to help strengthen routine immunization and surveillance. (Data source: WHO-supported field work in two countries plus previous studies by London School of Hygiene and Tropical Medicine)

MCHIP contributed to the completion of work supported by WHO to develop a systematic, feasible approach to taking advantage of potential opportunities presented by measles supplementary activities (SIAs) to strengthen the management of routine immunization. Products from this work include a planning module to be disseminated by WHO and a journal article, submitted for publication in a supplement to the journal *Vaccine* on the “Decade of Vaccines Collaboration.”

- *Rebecca Fields, Alya Dabbagh, Manish Jain, Karan Singh Sagar.* “Moving Forward with Strengthening Routine Immunization Delivery as Part of Measles and Rubella Elimination Activities.” (submitted to *Vaccine* August 2012)

Review of understanding why children are not vaccinated (Data source: Grey literature review; MCHIP theme: Equity)

A review of grey literature was conducted to gain a better understanding of the demographic, health system or family characteristics that put children at risk for being unimmunized; and the more immediate, direct causes to children being either partially immunized or not immunized at all. The review was at the request of WHO and has been disseminated to partners and decision-makers.

- *Michael Favin, Robert Steinglass, Rebecca Fields, Monika Sawhney, Kaushik Banerjee.* “Why Children Aren’t Vaccinated: A Review of the Grey Literature”. *International Health* (“an official journal of the Royal Society of Tropical Medicine & Hygiene”). Accepted March 2012.

Literature review of understanding integrated delivery of health services during outreach visits through an immunization perspective (Data source: literature review of articles and grey literature documents)

MCHIP conducted a literature review to explore integrated service delivery during immunization outreach and risks associated with service integration. This research was initiated as previous research focused on integration at fixed sites or during campaigns. While the policy climate is favorable to service integration as a strategy for increasing the equity and efficiency of important health interventions, it may also present some risk to immunization programs, requiring well-planned and well-implemented steps. This article was published in the *Journal of Infectious Diseases*.

- *Tasnim Partapuri, Robert Steinglass, Jenny Sequeira.* “Integrated Delivery of Health Services During Outreach Visits: A Literature Review of Program Experience through a Routine Immunization Lens.” *Journal of Infectious Diseases*, March 2012: 205 (Suppl 1).

Identifying research needs on routine immunization—do we know what we don’t know? (Data source: Panel of external experts)

CDC assembled a panel of external experts to review and identify areas of research required to strengthen routine service delivery in developing countries. They concluded that there are research needs in: identifying ways to increase coverage with existing vaccines and introduce new vaccines; integrating other services with immunization; and financing immunization programs. The panel placed importance on identifying operational research for programmatic needs, with a focus on scaling up best practices. This article was published in the journal *Vaccine*.

- Clements CJ, Watkins M, de Quadros C, Biellik R, Hadler J, McFarland D, *Steinglass R*, Luman E, Hennessey K, Dietz V. “Researching Routine Immunization - Do We Know What We Don't Know?” *Vaccine* 2011 Nov 3; 29(47): 8477–82.

Progress toward polio eradication through lessons learned and information dissemination

CI contracted and edited two research papers for submission to peer-reviewed journals, capturing lessons from CORE India's polio program and exploring the importance of culture and the social determinants of health for the polio program. To reach its audience of more than 14,000 subscribers to its global electronic Immunization, Vaccines and Polio site, CI also expanded and revised its web-based resource platform through the following activities: adding over 100 new knowledge summaries, reorganizing the site structure and content to focus more on the needs of practitioners, redesigning the quarterly newsletter and establishing a social networking space.

MCHIP also discussed and disseminated program learning findings at the following key meetings:

- ***Global NUVI Implementation Annual Meeting:*** MCHIP presented at the 2012 New and Underutilized Vaccines Introduction meeting organized by WHO/HQ to address key issues related to the introduction of new and under-utilized vaccines, and to review progress in NUVI implementation. MCHIP presented on its support to NUVI and other immunization services at global, regional and country levels and on MCHIP’s plan for the next 12 months. MCHIP also led sessions on the “effects of vaccine presentations on coverage (example: 5-dose measles vaccine)” and “integrated communication approach for new vaccine introduction” (including Tanzania as a country example). MCHIP also contributed to a cold chain and logistics working group consultation.
- ***11th Annual Meeting of the Measles Rubella Initiative presentation, September 2012, Washington, D.C.:*** MCHIP hosted a session at the 11th annual measles rubella initiative meeting titled: *Using measles SIAs to Strengthen Routine Immunization*. The session discussed identifying opportunities and practical ways in which countries can use supplemental immunization activities focused on controlling or eliminating measles to also strengthen routine immunization and surveillance system performance for the mutual advantage of both efforts.
- ***MCHIP Global Immunization Program Learning Meeting:*** MCHIP hosted a global Immunization Program Learning Meeting that convened MCHIP immunization headquarters and selected regional and country field staff in Addis Ababa, Ethiopia. Many of the challenges facing countries were similar. Some have overcome obstacles in creative ways that are highly relevant to other countries. Such issues include: how to reach the last child for better equity; how to involve the community for routine immunization; what it takes to use disease-specific mass campaigns deliberately to strengthen routine immunization; how to introduce a new vaccine deliberately to have a positive effect on the immunization system; etc. Sharing lessons across countries was highly motivating to staff—who each have a mission and developmental challenge to strengthen routine immunization in their own countries in the face of overwhelming partner focus on other aspects of the immunization enterprise (polio eradication, measles elimination, diseases surveillance, etc.). This meeting provided an opportunity for learning among country programs by sharing experiences and lessons learned (particularly related to NUVI) that will be included in project documentation and technical dissemination to USAID and partners (e.g., WHO, UNICEF, GAVI, others).
- ***World Federation of Public Health Associations (WFPHA) conference:*** MCHIP technical staff presented as a panel (with the JSI/ARISE project) to approximately 70 participants from around the world on “Reaching the unreached: New challenges and promising approaches in equitably immunizing the world's children.” This included three presentations on: Routine immunization strengthening and new vaccines—links with global pneumonia and diarrheal disease prevention and the MDGs; Improving coverage in under-

reached populations using RED and new vaccine introduction in Kenya; and Addressing equity and reaching the underserved and unreached in India.

MALARIA

MCHIP has contributed toward accelerating malaria prevention and case management by maintaining a focus on ensuring that quality, lifesaving services are delivered through a platform of MNCH care. MCHIP's leadership in malaria spans the global, regional and country levels, through providing programmatic and technical guidance, developing evidenced-based tools, sharing best practices and lessons learned, and promoting their dissemination and application at the country level for improved program results. MCHIP's areas of focus include: 1) malaria in pregnancy (MIP); 2) integrated-community case management (iCCM); and 3) malaria prevention and case management that are comprehensively addressed at the community level through the Malaria Communities Program (MCP).

In PY4, MCHIP participated in a number of global meetings to support efforts to advance MIP programming under RBM as well as strengthen the partnership between malaria control and reproductive health. MCHIP disseminated findings and recommendations from its three MIP case studies in Zambia, Senegal and Malawi, with reproductive health and malaria control stakeholders in the three countries, emphasizing considerations for moving their MIP programs to the next level. MCHIP also contributed to the achievement of greater impact at-scale for child health programs at the global, regional and country levels. Working collaboratively with global partners and country-level partners, MCHIP strengthened the expansion of iCCM in two countries (Rwanda and Mali), introduced the CCM program in Guinea and advocated for its introduction in Kenya. MCHIP disseminated widely the findings and lessons learned from the CCM documentation in Senegal, DRC and Malawi, to the three countries, as well as to USAID, the CCM Task Force and CORE Group members. MCHIP continued to serve as Secretariat of the global CCM TF, which collaborated extensively with global stakeholders to develop supportive materials to scale up child health programs. MCHIP continued to build the capacity of MCP grantees by supporting the development of annual workplans, supervision tools, sustainability plans and final evaluation scopes of work.

Malaria in Pregnancy

- MCHIP completed the **MIP case studies** for Senegal and Malawi, adding to the case study finalized for Zambia during the last program year. MCHIP synthesized the key findings and recommendations across the three case studies in one succinct MIP analysis brief, to use as a companion piece for dissemination to countries at multiple forums, including the Southern Africa RBM Network (SARN), East Africa RBM Network (EARN) and through the RBM MIP working group. MCHIP also submitted an article on the best practices, challenges and lessons learned from these case studies to the journal *Malaria* to expand program learning even further at both global and country levels. The case studies were presented to key stakeholders in each of the three countries: Senegal (October 24, 2011); Malawi (June 7 and July 18, 2012); and Zambia (July 16, 2012). The purpose of these presentations was to encourage discussions about findings, recommendations and prioritized areas of focus for scaling up MIP in the countries. As a result, Senegal plans to accelerate free distribution of insecticide-treated nets (ITNs) during ANC and integrate reproductive health and malaria programs through development of a joint coordination committee. Zambia has begun formation of a focused ANC working group, with representation from the, reproductive health unit, national malaria control program and other relevant partners, to finalize and move forward and action plan for MIP priorities. The analysis brief is particularly useful for wider dissemination to other countries that can apply the lessons learned and recommendations to scale up their own country MIP programs. All of the completed documents are available online at www.mchip.net/Documentation_and_Dissemination.

- MCHIP participated in the **Global Fund technical consultation meeting in Nairobi, Kenya** (December 13–16, 2011). The purpose of MCHIP's involvement was to support countries in developing transitional plans for MIP programming. In response to cancellation of Round 11 funding, eligible countries were given instruction about the transitional funding mechanism and about how to analyze gaps to prioritize essential interventions. MCHIP provided guidance to countries on performing a gap analysis; including focusing resources on key program systems for supporting intermittent preventive treatment during pregnancy (IPTp), long-lasting insecticide-treated nets and case management. This guidance will be particularly useful for countries that need to reallocate scarce resources so that priority malaria activities can be implemented and scaled up for maximum impact.
- MCHIP supported the RBM Secretariat function throughout the year to advocate for MIP to key stakeholders including the RBM Board. MCHIP collaborated with the Secretariat to organize and minute the **RBM MIP working group** meeting in Kigali, Rwanda, on April 18–20; MCHIP also provided technical leadership and participation in the meeting. This resulted in the development of MIP updates for eight countries (Kenya, Mozambique, Ghana, Guinea, Rwanda, Tanzania, Uganda and Zambia). These updates will be used to drive country-level discussions with key stakeholders and engender efforts to accelerate MIP programming. The meeting also resulted in key recommendations and solutions to support MIP scale-up. The meeting minutes are available online at http://www.rbm.who.int/partnership/wg/wg_pregnancy/docs/MPWG_14Meeting_Minutes-e.pdf.
- MCHIP coordinated with fellow members of the CORE Group's MIP working group to organize a panel of presenters on the topic of "Malaria in Pregnancy: Strengthening Health Systems to Improve Outcomes for MIP" during the **CORE Group Spring Meeting** in May 2012. While not included in MCHIP's workplan, this activity presented an opportunity to advance the technical dialogue and contribute to program learning among the CORE Group's multiple member organizations and partners from around the globe that work in community-focused public health, with a specific emphasis on women of reproductive age and children. MCHIP continued to serve as a technical resource and lead for MIP-related CORE Group Malaria Working Group activities and links to global forums.
- MCHIP participated in the **Malaria in Pregnancy: Bringing the Maternal Health and Malaria Communities Together** meeting in Istanbul, Turkey, June 26–28, 2012, organized by the Maternal Health Task Force. Realizing that MIP is at a crossroads and strides must be made to sustain gains, the meeting convened 40 experts in malaria and/or maternal and newborn health. They shared lessons learned from sub-Saharan African countries, forged collaborations and innovations, and determined next steps to improve the partnership of the malaria, maternal, newborn and child health communities. The meeting identified obstacles to increased coverage of MIP interventions and concluded with a list of 20 next steps for addressing the most pressing barriers, organized by priority actions at four levels—community, district and facility, country and global. Meeting minutes will be made available through the Maternal Health Task Force.
- WHO supported MCHIP's Malaria Team Leader to participate in the **WHO MIP evidence review group (ERG)** meeting on IPTp with sulfadoxine-pyrimethamine (SP), in Geneva, Switzerland, July 9–11, 2012. In light of preliminary data from observational studies showing a reduced effectiveness of IPTp with SP and growing concern over the decreasing effectiveness of a two-dose regimen, the ERG convened malaria experts, observers and ERG members to develop recommendations on IPTp with SP for consideration by the Malaria Policy Advisory Committee (MPAC). MPAC will adopt or reject ERG recommendations as early as October 2012. While not supported through PMI, MCHIP's participation in the ERG has significant implications for future guidance to countries on the use of IPT with SP.

- In **Rwanda**, a “Study to Determine the Current Prevalence of Malaria Detectable among Pregnant Mother Registering for ANC in Six Districts in Rwanda” was conducted. Data have been collected, and rapid diagnostic testing (RDT) and microscopies done at selected health centers to detect malaria among pregnant women coming for their first ANC. Microscopy control has been done by the national reference laboratory, and samples have been sent to a Johns Hopkins University (JHU) laboratory for polymerase chain reaction examination. Data entry and data analysis are ongoing. Writing of the study report is now in process. (field support)
- In **Burkina Faso**, malaria training was scaled up to 44 districts. A total of 1,553 providers were trained on the Integrated Malaria Training Package. In collaboration with the National Malaria Control Program (NMCP) and district management teams, at least one provider from each health facility per district in 44 districts was trained. Over the 3 years of the project, training on updated malaria protocols has reached 2,648 providers across all districts. A Transfer-of-Learning Module for cascade orientation by trained providers was developed and added to the Integrated Malaria Training Package. An additional 4,867 providers were reached by cascade orientation as reported in 41 of 44 districts. (field funds)

Integrated Community Case Management

- MCHIP served as **secretariat of the CCM Task Force**, providing an example of what partnerships can achieve through collaboration. Part of this process entailed redefining the subgroups, the Terms of Reference of the TF and specific subgroup workplans. These tools will guide the future of the TF, ensuring that value is added through the partnership.
- The Operations Research subgroup of the CCM TF, supported by MCHIP, contributed to the development of 15 papers on CCM in the journal supplement of the *American Journal of Tropical Medicine and Hygiene* (AJTMH). The articles will provide program implementers working on CCM with important research and policy findings when published in Q1 of PY5.
- MCHIP, in collaboration with the Monitoring and Evaluation subgroup of the CCM TF, supported the finalization of the CCM benchmarks and indicators. It is anticipated that during the next program year, an indicators workshop/regional meeting will be held to disseminate these indicators to countries and advocate for their use.
- MCHIP worked collaboratively with global partners (WHO and UNICEF) and country-level partners (USAID Missions, MOHs, CORE Group, USAID implementing agencies and other bilateral donors at the country level) to assist **CCM introduction or expansion in four countries**. In Rwanda and Mali, MCHIP provided technical assistance to strengthen iCCM expansion efforts, and in Guinea, MCHIP supported the introduction of iCCM. In Kenya, MCHIP advocated for the introduction of iCCM, which contributed to the development of a draft national CCM implementation guide with program activities scheduled to begin in 2013. In Rwanda, Mali and Guinea, MCHIP’s technical assistance contributed to enhanced collaboration and coordination between the MOHs and other CCM implementing agencies in each country.
- MCHIP refined, restructured and populated the **CCMCentral.com** website, which serves as a portal for countries implementing iCCM to access meeting reports, links to current initiatives and events, and implementation tools for iCCM scale-up. Currently being translated into French, the website will provide in-country partners with key updates in child health and with the tools needed to develop, strengthen and scale up iCCM programs.
- CORE Group, in addition to the CCM-related activities included under Child Health, attended the 6th RBM CMWG Meeting in Geneva, Switzerland, in June. As the Co-focal Person for the *Access to Treatment Workstream*, CORE Group presented on Workstream activities, led planning sessions and continued to advocate for iCCM at related global

malaria forums. In addition to the promotion of *CCM Essentials Guide* and CCMCentral.com, several partnerships and collaborative activities were identified and a direct request was received from the DRC MOH for French versions of the Guide.

For more results on MCHIP's CCM activities, refer to the Child Health section of this report.

Malaria Communities Program

- Reviewed and provided feedback on annual workplans to 15 grantees, annual reports to 18 grantees, a total of 15 quarterly reports to seven grantees and final reports to five grantees.
- Developed Technical Assistance plans for six grantees, and provided on-site assistance to three grantees: Christian Social Services Commission Tanzania, HealthPartners Uganda and Medical Teams International Uganda.
- Reviewed and provided feedback on supervision tools, M&E plans, sustainability plans, sermon guides and Final Evaluation SOWs for 13 grantees.
- Reviewed and provided feedback on the protocol for an RDT pilot for one grantee, HealthRight Kenya.
- Developed five guidance documents for grantees focused on: Seeking Additional External Financing; Planning and Implementing a Final Evaluation; Developing Abstracts; Closing-Out MCP Projects; and FY12 Final Report Guidance.
- Hosted two webinars: 1) Planning and Implementing a Final Evaluation; and 2) Community-Based Financing Schemes, highlighting implementation of these strategies as part of MCP projects by HealthPartners Uganda and Lutheran World Relief Mali.
- Assisted seven grantees to develop posters and talking points for the MCP Event in October 2012 in Washington, D.C., in conjunction with the CORE Group Fall Meeting.

Program Learning for Malaria

In Year 4, MCHIP was able to answer key program learning questions in malaria through its MIP and iCCM case studies completed in four countries and assessment of CCM tools in PMI countries.

MIP case studies on program successes, challenges and lessons learned in Zambia, Senegal and Malawi (Data source: Desk review and key informant interviews in the three countries; MCHIP learning themes: Scale-up, integration, quality, community, measurement)

The purpose was to learn from selected PMI countries performing comparatively well on key MIP indicators (use of IPTp and ITNs) what is working well and what can be done better. The framework for analysis focused on eight areas of MIP programming: integration (among malaria control, reproductive health and HIV), policy, commodities, quality assurance, capacity-building, community awareness and involvement, monitoring and evaluation, and financing. The case studies provide lessons learned and recommendations to help countries scale up MIP programs as well as a framework for additional countries to apply to strengthen their future MIP programs. In Year 4, the case studies were shared with PMI and stakeholders in each of the three countries through dissemination meetings. The case studies and a summary brief have also been shared more broadly with partners through mechanisms such as RBM and the CORE Group.

Assessment of Training and Supervision Tools for Malaria Case Management (Data source: Desk review and key informant interviews in PMI countries; MCHIP theme: Community. See under Child Health in Program Learning Matrix)

In Year 4, MCHIP initiated an assessment in PMI countries to identify major bottlenecks to scaling up WHO diagnostic testing and treatment guidelines for malaria within the context of IMCI. Mainly focused at the clinical level, the review assesses how IMCI training and supervision tools currently used at country level address updated guidance encouraging diagnostic testing of all suspected malaria cases and treatment of only those with a positive test. It also examines guidance for pre-referral treatment for the severely ill and recommendations for definitive management of severe malaria.

MCHIP iCCM Synthesis Report (Data source: Desk review of iCCM reports in Senegal, DRC and Malawi; MCHIP theme: Community)

In PY4, MCHIP developed a synthesis report on the cross-cutting findings and lessons learned from CCM programs at scale in the DRC, Senegal and Malawi. The synthesis report analyzes the lessons learned from each of these countries and puts forward key recommendations on how CCM programs can integrate these lessons into current and future programming. MCHIP presented findings from the CCM reports to USAID Washington technical officers in December 2011 and at a Webinar coordinated by the CORE Group in January 2012. A total of 47 CORE Group members participated in the Webinar, where respective experiences from three countries and lessons aimed at helping introduce and scale up CCM in other countries were discussed.

In Year 5, MCHIP will further expand its program learning focus on understanding the mechanisms to scale up MIP and iCCM. For MIP, MCHIP will examine the need for harmonization of MIP guidelines at the country level, consistent with the latest WHO guidance, and review country-level M&E indicators and reporting to inform guidance on an ideal M&E system. MCHIP will continue assistance to the CCM Task Force and to countries to help them monitor their progress through adoption and institutionalization of the new standardized CCM indicators. Through MCP, MCHIP is conducting four themed case studies to show how MCP grantees' community-based approaches have contributed to national and global malaria control efforts, and showcase MCP contributions to the PMI and Global Health Initiative strategies.

FAMILY PLANNING

MCHIP's Family Planning (FP) Team focuses on the health benefits of FP for mothers and children. FP integration within MNCH services is a key strategy for reducing maternal, infant and child mortality and morbidity through the prevention of unintended pregnancies and the promotion of healthy pregnancy spacing. Over the past 4 years, MCHIP-FP has successfully incorporated the following key components to more effectively meet the FP needs of women within MNCH services through the promotion of PFP during the extended postpartum period:

- MCHIP assures proactive counseling to inform women of both the pregnancy risks and ways to safely avoid unintended pregnancies.
- MCHIP systematically offers information and services with the emphasis on integration of FP with other MNCH services for pregnant and postpartum women through a continuum of care.
- MCHIP considers contraceptive methods based on the timing of the postpartum period and women's breastfeeding status.
- MCHIP implements strategies for effective integration of FP with other MNCH services.

- MCHIP advances PPFPP at the global level through strong advocacy and technical leadership through annual technical consultations and ongoing working meetings.

Over the past year, MCHIP-FP has led advocacy efforts for promotion of PPFPP as a best practice in the global arena. In collaboration with USAID and WHO/Department of Reproductive Health and Research, the MCHIP-FP team created “The Statement for Collective Action for Postpartum Family Planning.” This document has been endorsed by 18 key international organizations and is currently being disseminated worldwide. MCHIP-FP has also advanced integrated programming within a variety of technical areas, such as immunization, maternal health, nutrition and MNCH community programs. In addition, MCHIP has provided technical leadership in the area of postpartum IUDs (PPIUCD) by co-chairing a technical working group, providing TA to a myriad of countries through quality technical assistance.

Global Leadership

- WHO and MCHIP have created **The Statement of Collective Action for PPFPP**, which has been officially endorsed by several international organizations including FIGO, International Council of Nurses, UNFPA, AusAID, WRA and the RHR Division of WHO. The Web launch of the statement went live in July 2012, and allows other organizations and individuals to endorse the document. Work continues on the development of a Program Strategies document based on the Statement. Input was garnered during an MCHIP-sponsored technical consultation in Washington, D.C., on July 18, 2012. The contributions from this meeting helped further develop the document, as well as guide the agenda for a global meeting, which was held in September in Geneva.

- Key stakeholders from health ministries, international NGOs and donor organizations from more than 20 countries met at WHO Headquarters for a “**WHO/UNFPA and Stakeholders’ Technical Consultation on Programme Considerations for Postpartum Family Planning.**” This very participatory consultation provided direction on the content and development of the document, including a suggestion that the document be produced as a set of “strategies” for PPFPP rather than as “considerations” only. Not only did the consultation provide valuable feedback on the draft, but it generated ownership and enthusiasm among participants. MCHIP is currently revising the document to incorporate feedback from consultation participants. The revised draft will be reviewed by MCHIP as well as by USAID and WHO and consultation participants. It is hoped that the document will be finalized by the end of 2012 and will be launched at the Women Deliver conference in 2013.



Saswati Das, MCHIP/India demonstrates PPIUCD insertion technique at the MCHIP PPIUCD Auxiliary Event

- MCHIP had a large and active presence during the second **International Conference on Family Planning: Research and Best Practices** between November 29 and December 2, 2011, in Dakar, Senegal. Before the conference, MCHIP FP staff contributed to conference planning, organization and abstract review through participation on the international steering committee. MCHIP also significantly contributed during pre-conference meetings on postabortion care and contraceptive technology updates. During the conference, MCHIP staff moderated three panels, delivered six individual presentations, two posters and two IBP interactive sessions, and hosted two auxiliary events and four roundtable lunchtime discussions on FP topics—reflecting country programs from Bangladesh, Guinea, Kenya, India, Liberia and Nigeria. MCHIP materials were displayed at Jhpiego’s booth and disseminated widely. An MCHIP evening session

on: “MNCH and FP Integration: A Community Marketplace for Practitioners and Programmers” highlighting experience from the field in different areas of MNCH integration was held, with approximately 75 people attending. MCHIP also organized an auxiliary session on PPIUCD at the International Family Planning Conference in Dakar, with presentations from PSI (Zambia and El Salvador), FHI 360 (Rwanda in collaboration with MCHIP) and MCHIP (Guinea and India) on PPFPP/PPIUCD programs. A total of 34 participants from 10 countries were present. Programmatic experience in initiation and rollout of PPFPP/PPIUCD programs was shared, challenges in follow-up were discussed, and participants had an opportunity to practice insertions on models from two demonstration stations (one English and one French) during the session.

Postpartum Family Planning

- **Health Fertility Survey Results in Bangladesh:**

- Data collection for the 30-month postpartum survey as part of the **Healthy Fertility Survey** in Bangladesh was completed, with 188 women (92.6%) of the cohort successfully interviewed. The 30-month postpartum results revealed that project activities were associated with a 26% increase in contraceptive uptake in the intervention arm from baseline (18%) to 30 months postpartum (43.9%). The probability of becoming pregnant by 30 months was 44.8% in the control arm, compared to 36.5% in the intervention arm ($p < 0.001$). The probability of a subsequent birth after the delivery index child within 30 months was significantly low in the intervention area (25% in the intervention arm and 30% in the control arm, $p < 0.001$).
- There were 790 study participants for the 36-month postpartum survey interviewed; 36-month postpartum interviews will be completed for the cohort in the upcoming quarter (October–December).
- A return to fertility assessment was conducted between July and September of 2012 to examine views of women, husbands and mothers/mother-in-laws in the study sites regarding postpartum return to fertility. Data collection was completed using qualitative methods that included in-depth interviews with 40 women who had delivered in the past year, four focus group discussions with mothers and mothers-in-law, four with partners, four with female CHWs and community mobilizers, and one with male community mobilizers and project officers. The final report will be published in the upcoming program year.
- MCHIP is a co-leader in the **PPIUCD Working Group**, whose vision is to position the IUD for post-obstetric women as a first-line option and a viable and accessible family planning method. The goals of the working group are: 1) provide a forum for interested members in the communities of practice such as PPFPP, long-acting and permanent methods, long-acting reversible contraception and others to share results and lessons learned in PPIUCD programs and studies; and 2) support the development of strategies and tools and create a repository of technical and programmatic evidence necessary to position the PPIUCD as a key component in the method mix within family planning and maternal health programs.
- During the working group meeting on June 6, 2012, 23 participants from 10 organizations met and agreed to work on expanding the PPIUCD tab on the postpartum toolkit. The IUD and postabortion care toolkits will also include links to the PPIUCD tab on the PPFPP

Comments from USAID/India about MCHIP:
I felt good today when in a review meeting, Anuradha Gupta was extensively praising the good work done by Jhpiego under the MCHIP project on Nursing and PPIUCD work. So, Kudos to your leadership and to your teams at Delhi and the states who are doing lot of work which has been acknowledged by GOI. Even when many DPs were present, she singled out this praise and showed lot of confidence in the work. Thanks for noting the support of USAID for this work.

Please pass on my best compliments to your team.

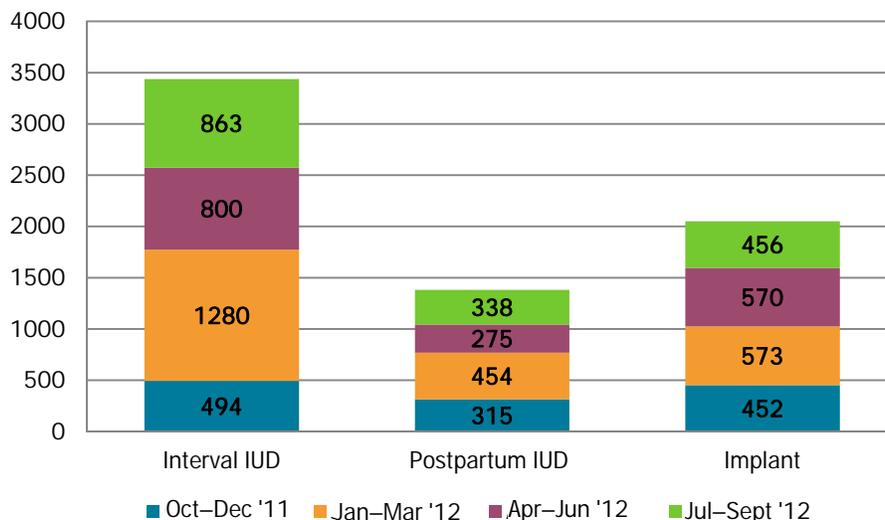
Toolkit. Subgroups have been working on collecting relevant information for the PPIUCD tab. The PPIUCD bibliography was updated and shared among working group members and now includes several studies on IUD provision during postabortion care.

- MCHIP has taken advantage of regional meetings to present its work to the maternal/newborn health communities. For example, demonstration of PPIUCDs during the Dhaka maternal health conference organized by the MCHIP Maternal Health Team created an interest in PPIUCDs from USAID Missions from the Philippines and Yemen. MCHIP went to the Philippines for an initial assessment of PPF/PPIUCD and MNH in the Philippines. At the same time, the USAID Mission requested that the team conduct a first batch of training for PPF/PPIUCD in Manila.
- MCHIP has developed a draft called, “Guidance for Postpartum Intrauterine Contraceptive Device Services: Programmatic Experience from Multiple Countries,” reaching out to PSI, FHI 360, and MCHIP countries providing PPIUCD services. It is currently under USAID review.
- In **Rwanda**, MCHIP supported the MoH in scaling up community-based distribution of family planning methods in four districts (Nyanza, Huye, Burera and Gakenke) and trained CHWs in the districts of Burera and Gakenke on four FP methods. This included training of CHWs, sensitization meetings of local authorities and procurement of basic supplies for the CHWs providing services. CBP/FP (Community-Based Provision/Family Planning) was officially launched on August 12, 2011 in Nyanza District to be implemented in all districts of the country. In addition, In collaboration with the MoH, the 2012–2016 desk FP policy and strategy were developed and signed by the Minister of Health. (field support)
- In **India**, MCHIP supported government PPF/PPIUCD scale-up activities - In Uttar Pradesh, MCHIP supported the development of the 2012–2013 state Program Implementation Plan (PIP). The PIP now supports PPF/PPIUCD scale-up, including training 85 providers and hiring 290 Family Welfare Assistants. In Jharkhand, the 2012–2013 budget includes funds to train 84 providers, hire 27 FP counselors, print materials, keep records, and share experiences in 24 districts and 3 medical colleges. (field support)

Long-Acting and Permanent Methods

- In Guinea, there are now 18 facilities offering PPIUD services, 87 providing interval IUD, 36 facilities offering implants, and eight facilities offering tubal ligation in the MCHIP project areas. A total of 154 providers were trained in long-acting and permanent methods, 28 on PPIUD, 53 on interval IUD, 60 on implants and 13 on tubal ligation. Instrument kits were provided to each of the new sites. To promote the utilization of these new services, radio spots in local languages were organized for broadcast in the prefectures involved. In addition to the uptake shown in Figure 10, 182 women elected to have a tubal ligation for permanent contraception. (field funds)

Figure 10. Uptake of Long-Acting Family Planning Methods by Quarter, FY2012 in Guinea



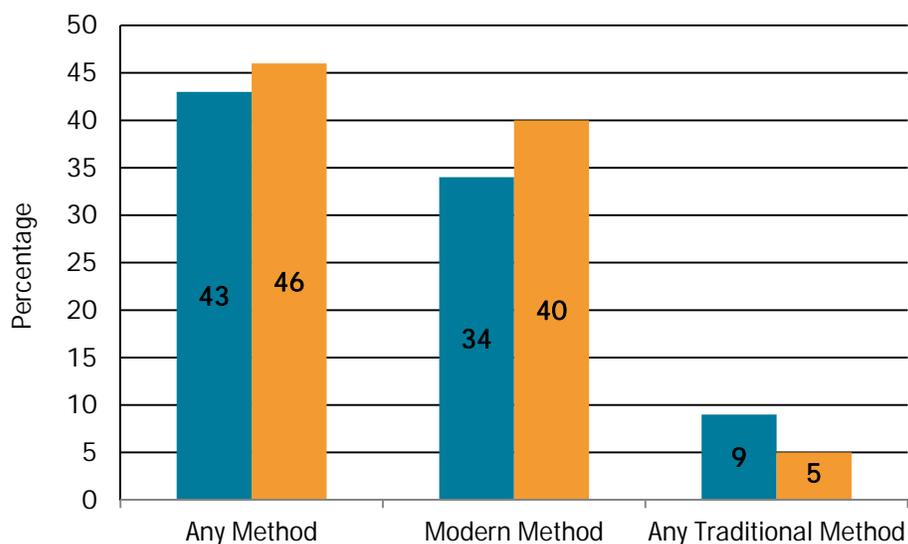
Integration with Other RH/MNCH Services

- Beginning in 2011, MCHIP began a demonstration project to assess the feasibility and implications of integrating FP and immunization in a total of 10 facilities in Bong and Lofa counties in **Liberia**. During this program year, an EPI/FP training guide was developed and IEC/BCC materials (job aid, poster and brochure) to support integration were finalized. Trainings were conducted for 22 County Supervisors, Officers In-Charge from project clinic facilities and District Health Officers as well as vaccinators and family planning providers in Bong and Lofa, and supportive supervision was provided. The training covered the rationale for integration, background on PPF and immunization priorities and key messages, service delivery considerations for integration, use of M&E tool, and use of IEC materials. There were 3,328 individuals counseled during immunization visits and 1,634 new FP clients. In July/August 2012, MCHIP conducted refresher trainings for service providers along with a mid-process assessment. The process assessment revealed a number of challenges including commodity stock-outs, client privacy, staff shortages and attrition, long wait times and gaps in PPF counseling by FP providers. Through discussions with service providers and key stakeholders, several adjustments to the approach were proposed. (field funded).
- MCHIP has incorporated **Postpartum Systematic Screening (PPSS)** in selected blocks in MCHIP-supported districts in **Jharkhand, India**, at the community level to increase opportunities for FP counseling, encourage early adoption of PPF among women with young children and screen for all relevant services. During this reporting period, MCHIP received IRB approval for the Postpartum Systematic Screening Study in India, identified sites for both intervention and control groups, and trained data collectors. MCHIP India rolled out the study at the selected blocks in Jharkhand. Following the protocol and study procedures, documents related to data collection were finalized and the PPSS screening tool was revised, based on comments from pre-testing in February 2012. Training for ANMs (auxiliary nurse midwives) and Sahiyas (the CHW equivalent) was carried out in the intervention areas in early March. MCHIP plans to conduct monthly supportive supervision visits to the intervention areas. Following routine monthly supportive supervision visits and completion of the midterm assessment in May/June 2012, MCHIP completed the endline data collection in September 2012. Data analysis is under way.
- CORE Group contributed to the collaborative MIYCN-FP (mother, infant and young child nutrition-family planning) Toolkit completion and launch and disseminated the GSM-funded *“Better Together –Linking Family Planning and Community Health for Health Equity and*

Impact” paper and *Social and Behavior Change for Family Planning: How to Develop Behavior Change Strategies for Integrating Family Planning into Maternal and Child Health Programs*. CORE Group assisted in identifying examples of simplified pregnancy screening tools for CHWs and FP evidence-based referral tools that have been used effectively at the field level. CORE Group continues to participate in and promote FP integration activities including collaborating with the MIYCN-FP Working Group and IBP Consortium.

- In Mozambique, from January to September 2012, MCHIP assisted the MOH to more than quadruple the number of health facilities offering integrated cervical cancer prevention (CECAP)/FP services from 17 to 75. MCHIP assisted the MOH to train and supervise personnel as well as install and/or maintain equipment in all of these facilities and donated cryotherapy equipment to nine of them. During this time, over 6,000 women were screened for cervical cancer and there were over 50,000 new family planning acceptors.
- The MaMoni Associate Award supported family planning in Sylhet district through providing training to government (Female Welfare Assistants or FWAs) and NGO CHWs. CHWs provided additional support to FWAs in 138 larger units (more than 800 couples) and took over as FWAs in 70 vacant units. As FWAs were recruited, CHWs were withdrawn in phases. As CHWs were phased out, MaMoni introduced depot holders in the community to ensure that pills and condoms were available from rural retail outlets and community volunteers were referring clients for LAPM. Overall, this effort was supported by extensive community mobilization activities and a *community MicroPlanning* process. Figure 11 shows the results from two population-based surveys (2010 and 2012) conducted under MaMoni by icddr,b. The survey results show a contraceptive prevalence rate increase for modern methods by 18% in 17 months of effective intervention, with more than 35% increases observed in each of the lowest two socioeconomic status quintiles. Activities under MaMoni in Sylhet are now winding down and being transferred over to the government.

Figure 11. Percentage Distribution of Currently Married Women Age 15–49 by Contraceptive Method Currently Used, Sylhet 2010–2012



Program Learning for Family Planning

The FP team has identified several key program learning priorities in the area of FP/MNCH integration. This past year, the MCHIP FP team has continued to implement pilot projects in which postpartum family planning is integrated with nutrition (Kenya), immunization (Liberia, India, Mozambique), a MNH community program (Bangladesh, Mali), and maternal health (scale-up of PFP including PPIUCD programs in Guinea, Kenya, Rwanda, India and others).

In addition, MCHIP-FP aims to identify essential components for successful MNCH/FP integration by using knowledge generated from both ACCESS-FP and MCHIP. Key PY4 program learning activities and results included:

Advocacy of Unmet Need of Postpartum Family Planning through Re-analysis of DHS Data (Data source: DHS; MCHIP theme: Integration, Equity)

Since MCHIP's inception, a total of 10 descriptive country profiles for the extended postpartum period up to 24 months after delivery have been produced, all of which are for Population and Reproductive Health (PRH) priority countries. These profiles demonstrate missed opportunities for integration of family planning by making use of existing DHS data for women 2 years postpartum. All profiles were posted on the PFP Toolkit on K4H and shared with in-country stakeholders as important advocacy materials to inform programming decisions related to postpartum family planning.

Technical Leadership in MNCH/FP Integration (Data source: program-specific information, literature review; MCHIP theme: Integration)

At the global level, MCHIP has been active in documenting and exchanging program experiences and lessons learned around use of PFP as an opportunity to strengthen linkages with MNCH/FP integration. One key forum where MCHIP-FP provides global technical leadership is through hosting the PFP Community of Practice (CoP). As of September 2012, the CoP includes 1,089 members from 80 countries. In the past year, MCHIP facilitated three online discussion forums (postpartum use of progestin-only contraceptive methods, postpartum tubal ligation, and return to fertility and pregnancy risk after delivery). MCHIP also co-leads the Maternal, Infant and Young Child Nutrition and Family Planning (MIYCN-FP) and FP/Immunization Integration Working Groups to document and exchange emerging experience and research in these areas. Notable products from the two working groups are the MIYCN-FP Toolkit (<http://www.k4health.org/toolkits/miycn-fp>), which contains materials for advocacy, training, client counseling and program implementation, as well as learning from country experiences, and the High Impact Practices (HIP) for Family Planning Brief on FP/Immunization Integration (to be finalized). Furthermore, MCHIP continues to maintain the PFP Toolkit and updates annotated bibliographies in PFP, MIYCN-FP, PPIUCD, and FP/Immunization. The latest quarterly statistics show that the PFP Toolkit has increased its visibility and traffic substantially. MCHIP will continue to use these channels for disseminating results and lessons learned for global and country level activities.

Model Development in Integrated Service Delivery in Liberia (Data source: Ongoing monitoring data through supportive supervision; MCHIP theme: Integration, Quality)

Beginning in 2011, MCHIP began a demonstration project to assess the feasibility and implications of integrating FP and immunization in a total of 10 facilities in Bong and Lofa counties. By June 2012, 543 women accepted referral to family planning from the immunization station, and of these, almost 80% (77%, 423 out of 543) of them accepted a family planning method (including the lactational amenorrhea method) on the same day. Products prepared to-date include: EPI/FP baseline assessment report, EPI/FP supportive supervision tools, EPI/FP training tools, process assessment report and monthly supportive supervision reports. MCHIP plans to provide ongoing supportive supervision and propose a national scale-up strategy in the upcoming year.

Model development in FP/MIYCN Integrated Service Delivery, Bondo, Kenya

In early 2011, MCHIP initiated an activity linking MIYCN and FP in Bondo District, in partnership with the Ministry of Public Health and Sanitation and other local stakeholders. This model uses a community/facility approach involving integrated health promotion and service delivery. Products prepared to date include: MIYCN/FP advocacy materials, MIYCN/FP baseline assessment report, message and materials development workshop report, preliminary

monitoring report and MIYCN/FP training materials. MCHIP plans to provide ongoing supportive supervision and expand its coverage area to an additional five facilities and four community units in the upcoming year.

In-service Capacity Strengthening and Scale-up of PPIUCD in India (Data source: PPIUCD follow-up study; MCHIP theme: Scale-up, Integration, Quality)

Since 2007, ACCESS-FP (now MCHIP) has been supporting the Indian Ministry of Health and Family Welfare and the Government of India (GoI) to introduce an alternative training approach. Follow-up results revealed an expulsion rate of 2% and infection rate of 1%. In addition to sharing results with global and in-country level stakeholders, MCHIP looks forward to preparing at least one publication through an identified peer-reviewed journal.

Postpartum IUCD (PPIUCD) Findings in Paraguay (Data source: Secondary data analysis; MCHIP theme: Integration, Quality)

In September 2012, the abstract “Postpartum Use of the Copper T 380A Intrauterine Device. The 10-Year Experience at Hospital Nacional, Asunción, Paraguay” was accepted for publication in *Contraception*. The article is based on a retrospective case series of more than 3,000 postpartum IUD insertions. Findings from this study indicate that the expulsion rate for PPIUDs at 1.4% is much lower than reported in previously published literature (10–15%). A plausible explanation for this is an improved clinical technique, and the same technique has been currently introduced in supported countries of Afghanistan, Ethiopia, Guinea, India, Mali, Mozambique, Pakistan, Philippines and Rwanda. The Paraguay findings were also presented at the Association of Reproductive Health Professional (ARHP) conference in New Orleans in September 2012. This presentation elicited notable interest among domestic audience members—a good example of how international experience can guide domestic service providers.

Healthy Fertility Study (HFS) in Bangladesh (Data source: HFS study data; MCHIP theme: Integration, quality, community)

Since 2007, MCHIP (previously ACCESS-FP), Johns Hopkins University Bloomberg School of Public Health, Shimantik, the Center for Data Processing and Analysis and the Government of Bangladesh, have been conducting an OR study to examine the impact of FP integration on a community-based MNH program. Findings are presented under the Family Planning Major Accomplishments section. Furthermore, a return to fertility assessment was conducted between July and September of 2012 to examine perceptions of women, husbands, mothers/mother-in-laws, community health workers and study staff in the study sites regarding postpartum return to fertility. The final assessment report will be published in the upcoming program year and several publications are under way:

- Two articles were submitted in September 2012 to peer-reviewed journals for publication consideration: “The Effect of Family Planning Integration with a Maternal and Newborn Health Program on Improving Postpartum Contraceptive Use: Results from a Quasi-Experimental Trial in Rural Bangladesh” was submitted to *The Lancet* and “Operations Research to Address Unmet Need for Contraception in the Postpartum Period in Sylhet District, Bangladesh” was submitted to *The European Journal of Contraception and Reproductive Health Care*.
- A HFS BCC and Community Mobilization Brief and a Program Managers’ Guide to Community-Based FP and MNH Integration were developed.
- A brief on the MaMoni application and scale up of the HFS model is being drafted and will be finalized.
- Seven manuscripts will be produced by Johns Hopkins University Bloomberg School of Public Health.

In Year Five, MCHIP will complete OR and special studies in Bangladesh, Kenya, India, Liberia, Mali, Mozambique and Nigeria, and results will contribute to the larger program learning agenda in area of MNCH/FP integration. MCHIP is also considering looking at how to assist country health planners to develop scale-up plans for taking integration experiences developed at a district or sub-district level to wider scale. We also plan to host a regional conference in Africa with champions and potential champions of PPIUCD services, with intent to facilitate scale-up.

HIV/AIDS

In FY12, MCHIP has globally supported and provided technical assistance to a variety of HIV activities. MCHIP remains a global leader in the scale-up and implementation of voluntary medical male circumcision (VMMC) programs supporting many countries in their successful implementation. In addition, MCHIP contributes to the global VMMC guidance by participating in key meetings and developing international guidance documents. In Kenya and Ethiopia, MCHIP has worked closely with the in-country teams to develop innovative approaches to the prevention of mother-to-child transmission of HIV (PMTCT) to work toward MDGs. MCHIP has also provided technical assistance and support to an injection safety and post-exposure prophylaxis program in Malawi and continues to work on a comprehensive evaluation of an innovative USAID program, Centership model. This innovative program is characterized by strengthening HIV and health information and referral links within the community as well as between the community and public and private facilities (as appropriate) in Namibia. MCHIP is also working on examining program-level data from voluntary counseling and testing (VCT) and provider-initiated testing and counseling (PITC) programs to understand the outcomes of the two methodologies. In FY12, MCHIP has identified specific program learning priorities and is building the knowledge base and best practices in these areas. MCHIP has worked hard to disseminate some of these findings in FY12, and will continue to gain knowledge and employ and disseminate program learning findings in FY13.

Global Leadership

- In FY12, MCHIP has continued to support **Voluntary Medical Male Circumcision (VMMC)** scale-up while ensuring implementation from the ground up. VMMC programs are performing well, guidance documents have been developed and VMMC services are truly country-owned with services integrated with the existing systems. In FY12, MCHIP has been successful in providing high-level technical assistance to a variety of country programs. Core-funded technical assistance has been essential in translating research finding to program implementation at the ground level. MCHIP's technical assistance has allowed country programs to scale up rapidly while continuing to provide high-quality services, which is evidenced by the ever-increasing numbers of procedures and maintenance of low rates of adverse events. Other MCHIP VMMC activities include the development of key international VMMC guidance documents, including essential reference and training documents. These materials provide new and current programs guidance as they initiate and reach scale-up of VMMC services. The *PEPFAR VMMC Site Operational Guide* has been developed to provide the necessary guidance for President's Emergency Plan for AIDS Relief (PEPFAR) partners to plan and implement VMMC programs within the context of PEPFAR funding. The *VMMC Models for Optimizing Volume and Efficiency (MOVE) video* will be a global resource for individual male circumcision (MC)



Photo credit @ Lisa Russell – Governess Films

Emmanuel Njeuhmeli, USAID, Hally Mahler, MCHIP, President Mkapa, Former President of Tanzania, and Kelly Curran, MCHIP, at the VMMC Satellite, AIDS 2012.

providers, implementers and programs working in VMMC.

- MCHIP continues to advocate and educate in the global arena on the benefits of male circumcision and the urgent need to scale up services in order to have the greatest public health impact. MCHIP supported the well-attended and well-reviewed satellite event, *Call to Action for VMMC for HIV Prevention*, - at the International AIDS Conference in Washington, D.C. The satellite hosted an impressive panel including former African Presidents, traditional leaders and Members of Parliament. The panel discussed the successes and challenges to VMMC implementation and scale-up in East and Southern Africa and touched on numerous topics regarding VMMC, including en's perspective and the economics of VMMC, finally concluding with President Mkapa's call to action to his fellow African leaders.
- As a follow-on to this call to action, MCHIP also coordinated and supported a WHO/PEPFAR joint meeting in South Africa this September. This regional technical workshop focused on accelerating scale-up of VMMC in east and southern Africa. The workshop convened Ministry of Health, Ministry of Defense and implementing partner representatives from the following 14 priority countries: Botswana, Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, South Africa, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe. Country representatives shared experiences from the 14 countries and shared the progress they have made toward reaching the goals of catch-up VMMC for adults. Participants also examined the longer-term goal of establishing sustainable programs through early infant male circumcision. This workshop also provided a forum for multi-sectorial engagement and collaboration across organizations. The approximate 160 participants who attended this workshop now form a core group of leaders and advocates who are prepared to stimulate community involvement on the ground and catalyze the critical mass that is essential for the successful scale-up of comprehensive HIV prevention programs for VMMC service delivery. These leaders and advocates include regional multilateral staff from UNAIDS and regional WHO offices; the World Bank, the Global Fund to fight HIV, TB and Malaria; international NGOs; U.S. Government (USG) Implementing Agencies including the USAID, the U.S. Department of Defense (DoD), CDC, and the U.S. Office of the Global AIDS Coordinator (OGAC).



Photo credit @ Lisa Russell – Governess Films

Panelists Chief Mumena, Traditional Leader, Kenneth Kaunda, former president of Zambia, and Speciosa Wandira, former Vice President of Uganda at the MCHIP-supported VMMC Satellite, AIDS 2012.

Injection Safety

- The Malawi ***Injection Safety*** (IS) program trained and oriented providers and support staff on injection safety/PEP standards. Although MCHIP's funding is limited to provide training or providers on IS/PEP, in collaboration with the MOH and SSDI project, the project is advocating for interventions to fill the gap around resources for temporary medical waste and sharps collection at point of use and final disposal. Also, reporting and management of post-exposure prophylaxis is strengthened as per the recommendations in the national guidelines.

Counseling and Testing

- MCHIP is currently performing a desk review examining Zimbabwe's program-level data, comparing stand-alone, client-initiated VCT programs to PITC. The aims of this review are to assess outcomes between the two HIV testing and counseling modalities, with a focus on referring to VMMC and care and treatment, characterizing VCT clients, and documenting and describing approaches to integration. In addition, the study will look at where losses occur in the continuum of engagement in HIV prevention and care, to further strengthen

referral systems. To date, MCHIP has developed a research protocol that has been submitted to IRB.

- USAID/W designed an activity around the creation of information hubs called “*Centershops*” in Namibia. USAID intended Centershops to provide community health volunteer services to the community on maternal, child health and HIV/AIDS interventions, as well as to collect community-based information and promote key health messages. Two very disparate communities in Namibia were selected by USAID for testing this model. MCHIP was asked to evaluate and prepare a case study comparing the successes and lessons learned in both communities and conducted baseline and midline data collection. The program has been extended for an additional year and endline data collection will happen in PY5.

Prevention of Mother-to-Child Transmission

Through its field offices, MCHIP also implemented innovative program interventions to improve access and utilization of integrated **PMTCT** services. In Kenya, where the government rapidly expanded PMTCT services to more than 4,000 sites, gaps in access, retention, quality and coverage remained intractable. USAID/MCHIP piloted an adaptation of immunization’s Reaching Every District (RED) approach. The RED approach was implemented in Bondo district from October 2010 to June 2012. CHWs conducted home visits each month; and health care providers conducted outreach services to hard-to-reach areas. These interventions improved the coverage and utilization and retention to care.

- The proportion of those who completed four focused ANC visits (proxy indicator of early ANC attendance) improved from 25% to 41% ($p < 0.001$); and delivery with a skilled attendant increased from 23% to 47% ($p < 0.001$) between 2010 and 2012.
- The proportion of HIV-infected mothers decreased slightly from 21% to 18% ($p = 0.002$) and the proportion of HIV Exposed Infants (HEIs) tested at 6 weeks improved from 27% to 78% ($p < 0.001$).³
- Data on HEIs tested and the proportion who were HIV-positive for 2010 was not available; however, between January and June 2012, only 35/765 (5%) of HEIs were identified as HIV-positive through polymerase chain reaction testing.

This PMTCT experience from Kenya was shared as an encouraging initiative to integrating PMTCT with MNCH and engaging community health workers in the process, in a conference held in Kenya focusing on integration.

Voluntary Medical Male Circumcision

- MCHIP supported the highly visible VMMC Advocacy Satellite Meeting at AIDS, 2012, Washington, D.C., which was covered in numerous press articles and had African leaders advocate for the scale-up of VMMC in the priority countries.
- High-level technical assistance was provided to Tanzania, Lesotho, Mozambique and Malawi using a combination of core and field funding mechanisms.
- In October 2011, in partnership with the MOH, MCHIP implemented the first high-volume VMMC outreach campaign at four sites in Mulanje district of Malawi. A total of 4,516 men registered to receive VMMC during Malawi’s first outreach campaign, which took place during a 4-week period. As a result of these efforts, 4,348 men were circumcised. HIV testing uptake was high, with 4,237 (97.4%) clients accepting testing. Of these, 2.1% ($n = 88$) clients tested HIV-positive. The adverse events rate was lower than 1% and over 60% of clients returned for their first follow-up visit at 48 hours. (field funded)

³ DHIS 2012

- Program Year 4 saw the development and production of the *PEPFAR VMMC Site Operational Guide*, which is focused on implementation activities at the site-service level—providing the steps needed to implement programs at scale. The guide will be hosted on the WHO MC Clearinghouse website and disseminated in hard copy and CD-ROM to the 14 priority countries.
- The *VMMC Models for Optimizing Volume and Efficiency (MOVE) video* was also produced this year. The video will be a global resource for individual MC providers, implementers and programs working in VMMC.
- MCHIP/Jhpiego staff played a part in five out of nine free-access and peer-reviewed articles published in a special supplement to *PLoS* on VMMC.
- MCHIP technical staff attended various meetings in a series that examine the future possibilities of VMMC devices in service provision. MCHIP continues to work with the PEPFAR TWG to begin strategizing and planning for the approval of one or more VMMC device(s) and the implementation repercussions of using devices to improve the scale-up of VMMC in the 14 priority countries.
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Photo Credit @ Laura Gustafson, MCHIP

WHO/PEPFAR joint consultative meeting to scale up VMMC, September 2012, South Africa

Tuberculosis

- MCHIP received a small amount of TB core funds, which were used to test the integration of TB with MNCH services in high TB incidence settings, with particular emphasis on intensified case finding (ICF). The pilot initiative of TB integration into focused antenatal care (FANC) began in six facilities in Karonga District, Malawi. Four orientation sessions to the initiative were held between 17 and 22 September and included 124 participants: clinicians, lab personal, counselors and Health Surveillance Assistants. A FANC/TB suspect register was developed by the MOH and partners and will be used in the pilot sites.
- Advocacy continues through dissemination of the ANC tape measure and FANC tool. TB Care II developed a 'FANC+ job aid, which provides information specifically for women living with HIV, highlighting the importance of screening for symptoms of TB, collecting sputum if symptomatic and ensuring prompt treatment. These are being distributed with the tape measure. The routine FANC job aid has "screen for TB" included. Operational

guidance on adaptation, distribution and monitoring use is distributed to any countries requesting copies of the FANC tools. MCHIP and bilateral country programs in Malawi, Liberia, Ghana, Angola and Nigeria have received shipments. Many countries are using the tools in pre-service education for nurses and midwives, expanding the number of individuals reached (students and educators/preceptors).

- With its TB funding, CORE Group continued global advocacy with STOP TB and hosted a booth that showcased community-based TB approaches at the International Union Against TB and Lung Disease Conference. The TB Working Group was expanded and created a new very active Pediatric TB Task force focused on highlighting the need for better policy, tools and funding to support pediatric TB programs. In support of the World TB Day 2012 spotlight on Pediatric TB, CORE Group's Tuberculosis Working Group presented three webinars from world leaders in the fight against pediatric TB (*Pediatric TB: The Basics; Childhood TB: An MSF Perspective; TB Treatment: Successes and Challenges from India*). CORE Group staff collaborated with WHO to develop a *Community-based TB Primer*, and to discuss a possible new activity to create a TB curriculum module for frontline health workers. USAID provided comments on the TB Primer, which will be finalized in early FY13. The TB WG advocated for the inclusion of pediatric TB into the IMCI algorithm.

Program Learning for HIV/AIDS

What are the differences in outcomes between client-initiated voluntary and provider-initiated testing and counseling programs? What are the current needs for VCT? (Data source: Desk review of Zimbabwe VCT program; MCHIP theme: Other)

MCHIP is currently performing a desk review examining Zimbabwe's program-level data comparing stand-alone, client-initiated VCT programs to PITC. The aims of this review are to assess outcomes between the two HIV testing and counseling modalities, with a focus on referral to VMMC and care and treatment, characterizing VCT clients, and documenting and describing approaches to integration. In addition, the study will look at where losses occur in the continuum of engagement in HIV prevention and care, to further strengthen referral systems. To date, MCHIP has developed a research protocol that has been submitted to IRB.

Is the Centership model an effective way to deliver integrated HIV interventions? (Data source: Namibia case study—program data and key informant interviews; MCHIP themes: Community, measurement)

USAID/W designed an activity around the creation of information hubs called “**Centerships**” in Namibia. USAID intended Centerships to provide community health volunteer services to the community on maternal and child health and HIV/AIDS interventions as well as to collect community-based information and promote key health messages. The Centership activity contributes to community systems strengthening efforts, and reinforces the USG emphasis on locally driven, locally owned programs. Two very disparate communities in Namibia were selected by USAID for testing this model. MSH was given funding to initiate and provide support to implementation of the Centership model in both communities. MCHIP was asked to evaluate and prepare a case study comparing the successes and lessons learned in both communities. During FY 2012, MCHIP staff made two site visits to the Centership Project sites (Rosh Pinah and Onderombapa) in Namibia to conduct baseline key informant interviews and collect data for a case study evaluation report. A second visit in July 2012 was originally planned and conducted as an endline assessment but was changed to a midline assessment when the USAID Mission in Namibia provided some funding to extend and modify the activity for 1 more year.

USAID/Namibia has provided a small amount of additional funding to MSH to extend the Centership Project until June 2013. The rationale for the extension period is to provide sufficient time for the community-based health information system and health promotion activities and the community-owned micro-business aspect to be consolidated. This will be Phase 2 of the project and the implementation design for each site has changed based on local circumstances.

USAID/Namibia has requested that ICF International extend the period of performance through June/July 2013 in order to conduct a final evaluation of the Centership projects in Onderombapa and Rosh Pinah/Tutungeni, and complete the analysis and case study report. During this period, the data collected during the midline assessment interviews will be coded and analyzed and a preliminary report drafted. ICF International will also provide input as needed to support the community-based health information system and approaches being tested.

Can access and utilization of integrated PMTCT services be improved through the use of the RED approach? (Data source: Program data from MCHIP pilot in Bondo District, Kenya; MCHIP theme: Integration)

Through Kenya field funding but with TA from MCHIP HQ, MCHIP also implemented innovative program interventions to improve access and utilization of integrated **PMTCT** services. In Kenya, where the government rapidly expanded PMTCT services to more than 4,000 sites, gaps in access, retention, quality and coverage remained intractable. Over 90% of pregnant women attend first ANC late and 56% deliver at home, limiting opportunities to provide effective PMTCT services. To address these challenges, USAID/MCHIP piloted an adaptation of immunization's Reaching Every District (RED) approach. The RED approach was implemented in Bondo district from October 2010 to June 2012. CHWs were recruited and trained in PMTCT/MNCH using the MOH curricula; numbers of pregnant women were estimated in target communities; CHWs conducted home visits each month; and health care providers conducted outreach services to hard-to-reach areas and held community dialogue and action days. Health workers' competencies were reinforced through training and supportive supervision. These interventions improved the coverage and utilization and retention to care.

What factors facilitate rapid and effective scale-up of VMMC for HIV prevention? (Data source: Review of program data from 14 countries; MCHIP theme: Scale-up)

VMMC is a relatively new biomedical intervention, yet the need to scale up quickly and effectively is urgent to make the greatest public health impact. In addition, the pool of research and best implementation practices continues to grow. VMMC country programs continue to need the guidance and support to ensure the most recent research and best practices are integrated into both new and existing programs. This year, MCHIP has focused on developing key guidance documents that will allow programs to have easy reference manuals so they are able to implement the best quality programs. MCHIP/Jhpiego staff contributed to five out of nine free-access and peer-reviewed journal articles published by *PLoS* on various subject matter related to VMMC.

The learning priorities in FY12 focused on strengthening program effectiveness and maintaining efficiency at scale by putting research into practice and disseminating best practices through technical assistance and document development. To this end, MCHIP has compiled generic guidance and best practices into a comprehensive document—an operations guide for VMMC—which guides service providers, program managers and decision-makers to successfully implement VMMC at scale. The use of the draft guide has helped MCHIP programs to have a standardized approach toward implementation at scale and also an opportunity to document performances in timely way (please see the success stories section). As country programs are more successful in providing VMMC to younger men, there is a need to emphasize services to reach older men (> 25 years) to meet the immediate risk reduction needs of men at “higher risk” of acquiring HIV. MCHIP field programs conducted a number of best practices reviews and formative assessments in order to address the challenges of capturing “older” clients—such as dedicated clinic days, adult only clinics, services after work hours and the like. To date, the intervention has not resulted in improved utilization of services by “older” men. Therefore, MCHIP will continue to explore, through further formative assessments, innovative service delivery models such as “near house circumcision,” model male clinics to attract older men with additional sexual and reproductive health needs, and couple services.

URBAN HEALTH

MCHIP has invested core funds to better understand and address urban challenges in Ethiopia and Kenya. The Government of Ethiopia (GOE) has taken leadership in establishing its nationwide Urban Health Extension Program (UHEP). MCHIP support is designed to link Ethiopia's key UHEP champions to the global urban health community of practice and create opportunities for them to share and learn from their own and the implementation experiences of other developing countries. In Kenya, MCHIP is working side by side with the Bill & Melinda Gates Foundation-funded Tupange project on a pilot PPH intervention that includes both a clinical quality and a community BCC component. The start-up of this activity has been delayed because of the need to finalize the national emergency obstetric and newborn care (EmONC) training package and also to obtain the necessary IRB approval.

Ethiopia

- **International Conference on Urban Health (ICUH), Belo Horizonte, Brazil (November 2011).** MCHIP supported the participation of two urban health champions from Ethiopia at the annual conference of the Society for Urban Health. The participants gave three poster presentations; learned about tested urban health approaches; and visited a health facility supported by Brazil's Family Health Program—the program upon which Ethiopia's UHEP was originally modeled.
- **Urban health study tour to India (February 2012).** MCHIP also worked with USAID/India and its Health for the Urban Poor (HUP) project to organize a 12-day exchange visit for 15 urban health leaders from the Federal Ministry of Health (FMOH), its Regional Health Bureaus (RHB), USAID/Ethiopia and USAID/Ethiopia's PEPFAR-funded UHEP technical assistance project. During the visit, participants traveled to five large cities—Mumbai, New Delhi, Pune, Bhubaneswar and Agra—where they learned how health issues are being addressed in India's highly diverse urban and peri-urban areas. The participants were able to share their experiences, tools, achievements and challenges in working with low-income urban populations. Participants returned equipped with new ideas for adaptation to the Ethiopian context (e.g., how to foster inter-sectoral collaboration, development of public/private partnerships including the CSR model, the use of e-infrastructure to streamline systems; web-based data management, telemedicine, mHealth etc.) and the foundation was laid for a continuing bilateral partnership between the two country teams and their USAID Missions.
- **Secondary 2011 EDHS analysis of urban data.** Following the study tour to India, the need to gain a better understanding of the factors affecting utilization of MNCH services in urban settings became evident. There are many assumptions regarding the barriers to utilization, but little data to validate them. Utilization patterns and barriers may also vary from one region to another. MCHIP conducted a secondary analysis of urban MNCH data from the 2011 EDHS to specifically tease out information pertaining to maternal, newborn and child health problems and health-seeking behaviors of Ethiopia's urban poor. The analysis is almost complete and a detailed report will be available early in PY5.
- **Qualitative formative assessment.** In addition to the secondary analysis of the 2011 EDHS urban data, MCHIP conducted a qualitative formative assessment in Hawassa, the specific urban area selected for MCHIP's intervention. The purpose was to assess health facility MNCH readiness and determine the principal barriers (social, cultural, economic, geographic, etc.) to the utilization of facility-based MNCH services by socioeconomically disadvantaged urban populations. The entire process, including developing tools, obtaining regional support and ethical clearance, recruiting and training data collectors, conducting the assessment, and analyzing findings, took place from March to August 2012. Key findings were disseminated in September to 130 officials, experts, health managers, health professionals, UHE –professionals, community representatives of the Hawassa city health department, the Regional Health Bureau, City Health Department, health centers,

hospitals, the media, , civil society organizations, NGOs, and community and municipality leaders. Strategies to increase the coverage of selected MNCH interventions were discussed, and concrete actions, such as working with urban health extension workers to foster greater awareness within the community, developing a local media campaign, and providing “communication” training to service providers to improve rapport building skills, were incorporated into Hawassa city’s health department annual workplan.

- The secondary EDHS analysis and qualitative assessment in Hawassa have provided a far better understanding of the target audience, the underlying attitudes, knowledge gaps and cultural practices that affect MNCH service utilization. This will lead to the design of targeted approaches to increase utilization and coverage. In fact, the findings from the qualitative assessment conducted in Hawassa have drawn such interest that the UHEP and MCHIP/Ethiopia teams have proposed to replicate some of these activities in up to two additional cities in PY5.

Kenya

- PPH/FP urban slums intervention study: Obstetric hemorrhage is the most common cause of maternal mortality in Kenya, contributing to 35% of maternal deaths (KDHS 2001/9). As a contribution to the national MNH research agenda and in order to strengthen the evidence base for postpartum hemorrhage prevention and management, MCHIP supported initial preparations for an interventional study in three Nairobi slum areas reporting very high maternal mortality ratios. The proposals, consent forms and data collection materials and training tools were completed. The study was awarded an exemption status from Johns Hopkins Bloomberg School of Public Health but local IRB approval is awaited. Clearance has been obtained, however, from the DRH and the DMOHs of participating institutions and buy-in obtained from the DRH MER TWG.

NUTRITION

WHO estimates that 42% of pregnant women (56 million) are anemic worldwide, with 62% of maternal anemia in the Africa and Southeast Asia regions. Maternal anemia is associated with 20% of maternal deaths, and the risk of dying in children under 5 years of age is reduced by 34% when their mothers take iron-folic acid supplements. Because of this, increasing the coverage of interventions that reduce anemia, including helminth and malaria control, is an important activity for MCHIP to help countries in achieving MDGs 4 and 5. Anemia is one of the most prevalent health problems in developing countries, and iron deficiency, anemia’s main cause, is the most prevalent nutrition deficiency in both developed and developing countries. The USAID HIDN’s Division of Nutrition has prioritized anemia prevention and control through USAID-funded global projects including OMNI, MOST, A2Z, SPRING and MotherCare.

As reported in *The Lancet* Maternal and Child Undernutrition series, iron deficiency anemia is the cause of 20% of maternal deaths due to obstetric complications. And, as documented by Stolfus (2004), annually 591,000 perinatal deaths and 115,000 maternal deaths can be attributed globally to iron-deficiency anemia. Therefore, Using Roll Back Malaria and maternal health funding, the ACCESS Program addressed anemia by improving malaria control in pregnancy and FANC. MCHIP, as USAID’s flagship project on maternal and child health, receives nutrition core funding for maternal anemia-related activities. In Years 1–3, this funding has been used to disseminate information about and advocate for maternal anemia prevention and control. In Year 4, MCHIP nutrition funding has been used for both global and in-country advocacy to promote an integrated package to address the major causes of maternal anemia, which include inadequate dietary intake of iron and other micronutrients and parasitic infections (i.e., helminths and malaria). Funding has also been used to provide technical expertise on anemia to MCHIP countries to improve anemia program implementation. While there is an emphasis at MCHIP on

maternal health through FANC, this integrated approach to prevent and control anemia cuts across other public sectors such as agriculture, education, and water and sanitation, along with the private sector and civil society.

The MCHIP extensive platform is an effective way to integrate cross-cutting areas such as nutrition into maternal and child health. Small amounts of core nutrition funding have been successfully leveraged by MCHIP to advocate for better programming in the area of anemia prevention and control with USAID and international partners, and in MCHIP countries. These Global Leadership and in-country activities occurred only because core nutrition funding allowed MCHIP to have a Nutrition Team with expertise in maternal anemia prevention and control.

Maternal Anemia

- The MCHIP Nutrition Team contributed significantly to organizing and implementing the meeting on May 3, 2012, in Dhaka, Bangladesh, entitled, “Guidance on Implementing Effective Programs to Prevent Pre-Eclampsia and Anemia to Improve Maternal and Newborn Outcomes.” The meeting was attended by 115 people from 16 countries, and contributions from partners representing the Gates-funded Alive and Thrive project, the Canadian International Development Authority (CIDA)-funded Micronutrient Initiative and USAID’s SPRING project made the meeting a success.
- MCHIP developed an anemia prevention and control website, which is housed through the K4Health project. This website includes information on the causes and consequences of anemia, practical program evidence, and resources to improve anemia prevention and control implementation using an integrated package of interventions. USAID requested that MCHIP expand the website to include information on anemia prevention and control programs for children as well as women.
- MCHIP took the lead, with partners the CORE GROUP and SPRING, in spearheading a Multi-Sector Anemia Prevention and Control Task Force, which was approved by USAID. MCHIP and partners the CORE Group, FANTA-3 and SPRING will act as the Secretariat for the Anemia Task Force.
- MCHIP gave technical assistance to the CORE Group in organizing a session (“Many Actors, One Goal: Tackling Anemia in Mothers and Children—A Mali Case Study”) for its spring meeting. This session was presented by URC to show a more integrated approach to addressing anemia. MCHIP worked with the CORE Group to identify the session.
- MCHIP completed a paper based on a “deep dive” of the literature related to nutrition’s role in obstetric complications. This paper will be submitted to a maternal health or nutrition journal in Program Year 5 to influence and revitalize international dialogue and increase programming on the subject.
- MCHIP provided technical assistance, using field and core funding, to the Division of Nutrition in Kenya to hold a stakeholders’ meeting on maternal anemia prevention and control. This meeting resulted in a workplan to improve existing anemia control programs in the country. MCHIP will support specific activities in this national work plan in Year 5.
- MCHIP provided technical assistance, using field funding, to the Ministry of Agriculture in Rwanda to include nutrition messages, including on iron-folic acid supplementation for women and improving dietary intake of iron, in its kitchen garden training in three MCHIP districts. It was the first time the Ministry of Agriculture had included messages and training on the consumption of foods to improve health and nutrition.
- CORE Group in collaboration with MCHIP organized an anemia session at the CORE Group Spring Meeting entitled “*Many Actors, One Goal: Tackling Anemia in Mothers and Children—A Mali Case Study.*” CORE Group also hosted a meeting with MCHIP and

SPRING representatives to define roles and next steps for the Multi-Sector Anemia Prevention and Control Task Force and submitted a related proposal to USAID. The proposal directly led to becoming a part of the secretariat along with MCHIP, FANTA-3 and SPRING, which will help support the now USAID-led Anemia Task Force. CORE Group also helped compile related anemia resources and information to be incorporated into a new toolkit on K4H and supported the coordination of interested partners to catalyze and invigorate integrated program responses to reducing maternal and child anemia.

Infant and Young Child Feeding

- MCHIP provided technical assistance, using field funding, to the Nutrition Department of the Ministry of Health and Child Welfare in Zimbabwe to conduct formative research on infant and young child feeding, which included information on feeding practices related to iron-rich foods.
- MCHIP gave technical assistance, using field funding, to the Egypt MCHIP SMART project to include iron-folic acid supplementation in its antenatal care program activities and to include an analysis of iron-rich foods in children in the design of a study on the causes of stunting in children.
- MCHIP developed a nutrition Brown Bag Lunch series to share new nutrition research and best practices in program implementation with USAID implementing partners and others in the Washington, D.C. area, as well internationally through *Illuminate*. The first presentation of the series, “Integrating Child Development and Nutrition Interventions among Infants in Rural India: Lessons from the Field” by Dr. Maureen Black, took place at the end of Year 4. The session was attended by 20 people at the MCHIP offices and by another 20–30 people through *Illuminate*.
- The Alive and Thrive project supported MaMoni in introducing the Infant and Young Child Feeding (IYCF) package in Habiganj district of Bangladesh. MaMoni Module-2 training began in June 2012, and has incorporated IYCF components for all outreach workers, service providers and supervisors. IYCF will also be gradually incorporated within *Community MicroPlanning* and community mobilization activities. All FWAs, health assistants and their supervisors have been trained in IYCF. MaMoni has developed a joint workplan with FANTA III to strengthen three components:
 - Postpartum IFA supplementation
 - Community identification and case management of moderately and severe acute malnutrition
 - Strengthening of Essential Nutrition Action interventions

This intervention will initially focus on Madhabpur upazila, and may be scaled up in the remaining seven, if found effective. The Directorate General of Family Planning, Institute of Public Health Nutrition (IPHN)/National Nutrition Services (NNS) and Director General of Health Services will support this activity. NNS has already provided directives in this matter. (field funds)

Cross Sectoral

- CORE Group organized several nutrition-related sessions at the CORE Group Spring Meeting and continued to disseminate the *Essential Nutrition Actions* and the *Nutrition Program Design Assistant (NPDA)*. CORE Group collaborated with the TOPS Food Security & Nutrition Network to promote more effective dialogue and collaboration between the agriculture, nutrition and health sectors. CORE Group coordinated a technical advisory group meeting for implementers with NPDA tool experience to identify needed revisions and

adaptations to improve and better promote the resource. Through advocacy efforts, NPDA is now listed as a key resource for the Child Survival and Health Grants Program (CSHGP) and Title II. CORE Group continued to serve as a member of the Civil Society Taskforce of the Scaling Up Nutrition initiative, provided input into the transitional governance structure, and contributed to the advocacy activities of Thousand Days.

GLOBAL LEADERSHIP FOR NUTRITION

MCHIP took the lead in organizing and implementing a meeting on May 3, 2012, in Dhaka, Bangladesh, entitled, “Guidance on Implementing Effective Programs to Prevent Pre-Eclampsia and Anemia to Improve Maternal and Newborn Outcomes,” which was attended by 115 people from 16 countries. Presentations focused on evidence for the consequences of maternal anemia and calcium deficiency in mothers and newborns, the global experience in implementing effective maternal anemia control programs, and how this experience can inform the design and introduction of calcium supplementation programs to prevent pre-eclampsia. A survey will be distributed to countries to collect feedback on the meeting and elucidate what additional information countries need to accelerate anemia prevention and control. In addition, this information will be used to follow up with countries in filling out their scale-up maps. This meeting stimulated discussions with USAID Yemen, which resulted in field-level maternal anemia control funding for MCHIP.

During planning for the nutrition meeting in Dhaka, the team decided information-sharing was a key component to understanding the context, and essential elements of program design and implementation for anemia prevention and control. A knowledge-sharing platform shared with country-level and US-based partners would also foster dialogue. MCHIP developed an anemia prevention and control website, which is housed through the K4Health project. This website includes information on the causes and consequences of anemia, practical program evidence, and resources to improve anemia prevention and control implementation using an integrated package of interventions. USAID requested that MCHIP expand the website to include information on anemia prevention and control programs for children as well as women. MCHIP plans to have the website reviewed by experts from the technical areas of nutrition, malaria and helminths as well as with CORE Group partners before it “goes live.” A dissemination and monitoring plan to ensure that the website reaches and is useful to program managers and implementers in developing countries will be devised.

MCHIP took the lead, with partners the CORE GROUP and SPRING, in spearheading a Multi-Sector Anemia Prevention and Control Task Force, which was approved by USAID. MCHIP and partners the CORE Group, FANTA-3 and SPRING will act as the Secretariat for the Anemia Task Force. This Task Force will include health technical areas within USAID and its implementing partners and facilitate sharing on anemia prevention and control with the aim of expanding programming in this area. The Secretariat held its first meeting at the end of Year 4, and developed a list of agencies which could be a part of the Task Force.

Program Learning for Nutrition

What is the role of nutrition in obstetric complications? (Data source: Literature review; MCHIP theme: Other)

MCHIP completed a paper based on a review of the literature related to nutrition’s role in obstetric complications. This paper will be submitted to a maternal health or nutrition journal in Year 5 to influence and revitalize international dialogue and increase programming on the subject. It will also be used to leverage additional funding to integrate nutrition into the MCHIP Platform.

PVO/NGO AND CORE GROUP SUPPORT OVERVIEW

MCHIP's vision is to maximize the contributions and potential of the PVO and NGO grantees in the scale-up of and learning from proven interventions. MCHIP assisted the CSHGP to further its objectives through strategic analysis and dissemination of CSHGP portfolio data, and targeted technical support to the active portfolio of CSHGP grantees and support to existing CSHGP management systems that are utilized to guide, organize, collect and diffuse portfolio-level data. Program Year 4 was marked by an emphasis on program learning and strengthening support to grantees through revised program guidance and stronger links to MCHIP technical teams. In addition to the Program Learning Activities and Major Accomplishments reported in the Program Learning section of this report, the PVO/NGO Support Team continued supporting the CORE Group and organized sessions for its biannual meetings. The PVO/NGO Support Team also formed stronger linkages with MCHIP Technical Teams, contributing to NGO project development during Detailed Implementation Plan reviews, and learned about NGO project contributions to global agendas through rapid portfolio analyses and Brown Bag Lunches.

Technical Support to CSHGP Grantees

- Supported the successful launch of six new CSHGP Innovation Projects in Ghana, Guatemala, Malawi, Rwanda, Sierra Leone and Timor Leste. Specific support included regular technical check-ins with grantees over the first 6 months of their programs; input into baseline assessment strategies and tools and monitoring and evaluation plans; and review and recommendation for approval of OR protocols and Detailed Implementation Plans.

Management Support to CSHGP Team

- A historical review of CSHGP structure and contributions was created in a comprehensive PowerPoint presentation for senior USAID leadership.
- Management supported the CSHGP Team in its overhaul of CSHGP Program Guidelines to reflect new USAID priorities and recommendations for stronger reporting made by Program Learning Advisors.



FCHV counsels a mother during a home visit (CARE/Nepal)

Global Learning

- The CSHGP Learning Agenda advanced in three strategic areas: retrospective investigations in the CSHGP portfolio in the areas of MNH, CCM and Operations Research were completed by global experts (Program Learning Advisors) in these fields. This learning strengthened elements of CSHGP grantee support, including reporting guidance.
- CSHGP contributions to global learning in breastfeeding promotion, malaria control and prevention, family planning integration and HIV/AIDS integration were documented and shared globally.
- Program Learning Activities included initiation of the development of four articles for publication, in order to systematically analyze and share the results of selected projects.
- A compendium of equity programming tools was created with input from global experts to strengthen and support project efforts to understand and address equity issues.

Program Learning for CSHGP

MCHIP engaged in several Program Learning Activities in PY4 to maximize learning from PVO/NGO work for itself and the PVO/NGO community, and to inform global agendas. This learning spans several technical areas including CCM, MNH, OR, breastfeeding, malaria, HIV/AIDS and equity. All of these Program Learning Activities seek to answer the question: “What has been learned from community-based CSHGP projects in this technical area and what does that learning contribute to global agendas?” All of these activities contribute to MCHIP’s community theme because they describe community-based projects. Other MCHIP themes are noted in parentheses as appropriate. The activities described below helped to inform PY5 Program Learning questions around strengthening project implementation and reporting. Several activities (e.g., peer-reviewed publications) will continue into PY5 and new learning from two completed OR projects is expected. For a detailed description of results from specific activities, please contact info@mchipngo.net.

CSHGP Learning Agendas

- MCHIP advanced the learning agendas on MNH, CCM and Equity through the development of strategic products (i.e., papers and presentations) in each area. (Data source: review of qualitative and quantitative data in grantee reports; MCHIP themes: quality, scale, equity) These investigations into the CSHGP portfolio yielded rich information about PVO/NGO contributions to these areas of global health and prompted several recommendations from the authors about how to strengthen program planning, monitoring and reporting. Key results will be disseminated in a summary report and at three sessions at the CORE Fall Meeting. Headlines from the authors include:
 - **Maternal and Newborn Health** (*Marge Koblinsky*). There is far too much effort for far too little gain in knowledge in the present portfolio of MNH projects. Learning is hard to access for outsiders. Present learning efforts learn across projects (e.g., CCM), but the focus on OR and M&E open doors for project-specific learning that would be so useful for others. To join the international dialogue, increase the time/effort for analyzing, interpreting and writing up efforts in the last project year. Following a standard journal approach, a 20–25 page paper summarizing project purpose, intervention package, adequacy of implementation and outcomes should be a goal of every project.
 - **CCM** (*David Marsh*). Reviewing documentation of 22 CCM projects through a vetted CCM evaluation framework demonstrated grantees’ good *approaches* to increase access to, quality of, demand for, and enabled environments for using curative interventions for sick children—and good *results*. But reviewing long, dense project documents to answer a broad question—“What did we learn?”—was time-consuming, and the information yield was often low. On the other hand, reviewing documents to answer a narrow question—“What CCM indicators were used?”—was efficient. Even more, surveying informants to draft structured “fill-in-the-blanks” case summaries or to map national CCM benchmarks, with NGO attribution, was efficient and informative. CSHGP grantees likely save thousands of lives through CCM, but we did not know, until we asked, the extent of grantees’ best practices applied or their national role to expand and sustain the strategy.
 - **Equity** (*Jennifer Luna and a series of international experts via consultation*). As part of the Equity Learning Agenda, MCHIP created a compendium of tools to strengthen equity in programming with input from global experts. MCHIP will proceed by disseminating this compendium and adapting two tools for NGO use in PY5.
 - **Operation research portfolio analysis** (Data source: review of grantee reports and USAID guidance; MCHIP theme: quality). This was conducted by an OR expert (Jim Foreit) who concluded that: 1) NGOs have important role to play in innovation; 2)

International NGOs need to replicate successful interventions tested by affiliates; and
3) More capacity-building is needed.

MCHIP conducted other investigations into the CSHGP Portfolio regarding malaria, breastfeeding, family planning integration and HIV/AIDS integration (Data sources: review of grantee reports containing qualitative and quantitative data; MCHIP themes: scale, integration).

MCHIP created a report about malaria and behavior change results and shared it with PMI and partners at a TAG at JHU in September. Breastfeeding results from LiST and contextual analyses were shared at University of North Carolina's Breastfeeding Symposium in March. MCHIP contributed PVO/NGO experiences to a MICYN-FP K4H toolkit. Finally, MCHIP analyzed HIV/AIDS integration with MCH interventions and presented a poster describing how PVO/NGOs integrate these activities at the International AIDS Conference in July. Results from these studies are manifold; please contact info@mchipngo.net for specific information.

MCHIP supported the development of four articles for peer-reviewed publication and completed a case study about PVO/NGO work in Kenya (Data source: desk reviews of project data and key informant interviews; MCHIP themes: scale, equity, quality).

- **Validation of knowledge, practice, coverage (KPC) data through comparison to DHS in Rwanda** (*MCHIP theme: scale*). This article emerged from a “writeshop” hosted by MCHIP for three NGOs and the Rwanda MOH. This “expanded impact” project covered six districts in Rwanda. The article validates the project’s KPC data, furthering international discourse on the value and validity of small-sample surveys. The team is currently discussing appropriate journals for submission.
- **Moving toward an enhanced district health information system for low- and middle-income countries: serving the dual purpose of evaluating local health programs and providing the basis for a national evaluation platform.** MCHIP provides the resources for this article, which is being written by Bill Weiss (JHU) and Todd Nitkin at Medical Teams International (MTI) about MTI’s CSHGP project in Liberia. It will be submitted to the *Journal of Science and Practice*.
- **Reduction in child global undernutrition using the Care Group model of volunteer peer-to-peer education in Sofala Province, Mozambique.** MCHIP provides the resources for this article, which is being written by Henry Perry and Peter Winch (both JHU) and Tom Davis at Food for the Hungry (FH) about FH’s CSHGP project in Mozambique. It will be submitted to the *Journal of Science and Practice*.
- **Community-based intervention packages facilitated by NGOs demonstrate plausible evidence for child mortality impact.** MCHIP coauthored this article with USAID and CORE Group, and it has gained preliminary acceptance into *Health Policy and Planning*. The article demonstrates that NGO projects implementing community-based intervention packages appear to be effective in reducing child mortality in diverse settings.
- **Kenya: A Case Study on How Centrally-Funded CSHGP Grants Contribute to National Programming and Mission Priorities.** Kenya offers a promising example of how projects implemented through the CSHGP can inform and test national strategies for community-based programming before scale-up, and how a USAID Mission can leverage the maximum impact of resulting lessons learned by proactively seeking to involve all partners.

CORE GROUP

The partnership between CORE Group and MCHIP grew throughout Project Year 4, and focuses on integration of services, improving the performance of community health workers, increasing access and utilization of health services to communities, and increasing equity for integrated maternal child health programs. CORE Group strengthened its program learning activities on the above themes and generated dialogue on community health systems critical to reducing maternal, neonatal and child mortality. CORE Group widely diffused learning from MCHIP technical priorities through its *Community Health Network*, and linked CORE Working Groups with MCHIP technical teams to foster more collaboration between partners.

In Year 4, CORE Group and MCHIP produced several joint products, contributed to each other's meetings, conducted multiple presentations, cross-promoted resources and extended representation in global forums. CORE Group successfully held its 2011 Fall and 2012 Spring Meetings, began planning for the 2012 Fall Meeting and conducted several collaborative activities across multiple MCHIP teams, with special emphasis on MNCH, malaria, nutrition and TB.

CORE Group supported multiple activities related to several MCHIP Technical Priorities, which are included under the related areas earlier in the report where applicable (maternal, newborn and child health, immunization, family planning, malaria) or included below. Most of CORE Group's work is integrated and therefore cuts across multiple technical areas.

CORE Group (notably Karen LeBan) has been participating with others in MCHIP and beyond in a continuing effort to provide programmatic guidance on community health workers. This has included significant support to USAID's Evidence Summit on CHWs (including subsequent work on papers coming out of that effort). Linked to and building on this Evidence Summit work, MCHIP has also led a continuing multi-partner effort to develop a book-length guidance document on CHWs, drawing on experience with large-scale CHW programs over the past 2 decades. Over this program year, drafts have been developed, and it is expected that in PY5 this will culminate in a published journal supplement.

Global Leadership

- Under broader global leadership and advocacy, CORE Group was a member of the External Advocacy Group for the USG 5th Birthday Campaign. CORE Group contributed to the design of the campaign, sent out frequent listserv announcements to the *Community Health Network*, and posted content on social media. CORE Group participated in the drafting of a civil society pledge statement and co-sponsored a civil society reception the first day of the Call to Action to End Preventable Child Death meeting in order to secure more civil society organization endorsements. This led to the upcoming 2012 Fall Meeting having a related theme and content, which will feature updates from Amie Batson and dialogue forums with USAID and the PVO/NGO community about what should be done to end preventable child deaths.

Program Learning for CORE Group

Much of CORE Group's work centers on program learning and dissemination both within its extensive NGO network, as well as to USAID and other key global technical partners. Key achievements include contributions to global iCCM efforts, the CHW Evidence Summit and the Call to Action to End Preventable Child Deaths.

- CORE Group successfully convened and expanded its *Community Health Network* through strategically increasing its membership, associate and partner engagement, program learning platforms, and participation in its eight technical Working Groups, five Interest

Groups and Practitioner Academy.⁴ With the expansion of the network, CORE Group increased its dissemination platform and enhanced organizational learning for the uptake of best practices and lifesaving interventions such as iCCM, ENC and HBB. Working Groups and Interest Groups continued to collaborate on technical updates, resource development, and diffusion and cross-linking with MCHIP priorities. The M&E Working Group finalized a guide that will be discussed at the CORE Group Fall Meeting prior to further dissemination, *The Mortality Impact System: An NGO Field Manual for Registering Vital Events and Assessing Child Survival Impact Using the Care Group Model*, with guidance and input from Henry Perry and Bill Weiss, JHSPH. CORE Group also participated in a World Bank Knowledge Management Fair showcasing MCHIP-related products that led to potential new program partnerships and sharing of joint CORE Group and MCHIP resources.

- Through its Practitioner Academy, CORE Group held a 5-day Designing for Behavior Change Training in Washington, D.C., with 25 participants from 19 organizations, two independent consultants and two MCHIP representatives; hosted its first site visit learning workshop at the Comprehensive Rural Health Project (CRHP) in Jamkhed, India; and contributed to and presented at a regional CCM State-of-the-Art Workshop in Kigali, Rwanda, hosted by CORE Group member Organization World Vision. This workshop introduced community implementers to existing CCM experiences and resources, including CCM Central and CCM Essentials, and prepared them for the introduction or scale-up of CCM in their country programs.

CORE Group successfully convened its Fall Meeting entitled “*Windows of Opportunity for Health and Well-Being*” in Washington, D.C., October 13–14, 2011, with 211 participants from more than 70 organizations. MCHIP led multiple sessions on issues related to equity, CSHGP, PPH and PE/E, and OR for community-oriented health programs. Presentations and the meeting report are available at: <http://www.coregroup.org/resources/meetingreports/229-core-group-fall-meeting-2011>.

- CORE Group successfully convened its Spring Meeting entitled “*Demystifying & Using Data for Community Health Impact*” in Wilmington, Delaware, from April 30–May 4, 2012, with 225 participants from 89 organizations and 17 countries. Participants explored a variety of methods and ideas on when, why and how we might measure community health and development efforts, and how to use the measurement outcomes to improve programming. Implementation Science and Ethnographic Research were featured plenaries. MCHIP led or contributed to several sessions on specific areas including: scale, sustainability, CSHGP, OR, family planning and nutrition integration, MIP, anemia and CCM, and disseminated technical resources. Presentations and the meeting report are available at: <http://www.coregroup.org/resources/meetingreports/254-core-group-spring-meeting-2012>.
- CORE Group successfully supported strategic communications efforts with MCHIP while improving and expanding its network and program learning platforms to share related MNCH state-of-the-art knowledge and best practices. Improvements and expansions were made in multiple modes of communication. These included social media and the website, which directly facilitated cross-learning and the advancement of collaborative MCHIP and CORE Group activities, significantly increasing overall collective reach and diffusion mechanisms.⁵ Featured on the website, video clips from an interview with Isatou Jallow, World Food Programme, highlighted the successful baby-friendly community initiative.

⁴ 58 NGO Member Organizations, 15 Associate Organizations, 18 Individual Associates. New members included Partners In Health, Operation Smile and Handicap International. Working Groups: CCH (+223; Total: 346); HIV/AIDS (+167; Total: 284); Malaria (+145; Total: 241); M&E (+217; Total: 316); Nutrition (+196; Total: 318); SBC (+209; Total: 345); SMRH (+226; Total: 333); TB (+228; Total: 282).

⁵ 18,129 total and 10,691 unique website visitors; 2325 Tweets, 794 followers; and 913 LinkedIn members.

- CORE Group engaged with the CSHGP by providing technical input and support for the program learning agenda on CCM, community health and maternal health, and diffusion of CSHGP grantee innovation and OR activities. Several grantees were highlighted at the CORE Group Fall and Spring Meetings, including a plenary session on *Bringing Operations Research to Life: Case Studies from Benin, Honduras, and Nepal*, and concurrent sessions on *Scale Experience from CSHGP's Expanded Impact Category 2006-2011*, and *CSHGP Special Studies in Nepal and Ethiopia*. CORE Group contributed to the completion of a presentation slide deck designed to highlight the partnership structures, the best of the CSHGP portfolio, and to communicate the program's priorities as well as the results from the past 5–10 years.

Core Group focused on strategic analysis and dissemination of program learning around equity and community health work by hosting several related sessions at the Fall and Spring Meetings. Additionally, Core Group completed the “How Social Capital in Community Systems Strengthens Health Systems: People, Structures, Processes” paper, and disseminated it widely. Core Group also continued to participate with the chwcentral.org technical advisory group, and contributed to the USG community health worker evidence summit. Core Group led the development of a paper on community trust as a key factor influencing CHW performance, provided input into the development and writing of the paper on community support for CHW effectiveness, and participated in a two-day CHW summit deliberations. Core Group participated in the steering committee for a journal supplement on CHWs at national scale and the development of a draft outline for a chapter on CHWs in relation to the community.

STRATEGIC COMMUNICATIONS

During the reporting period, MCHIP continued to leverage other existing platforms within the global community in order to communicate the work of the program in multiple areas. The project has fully *harnessed a multitude of communication tools* to promote the work of USAID's flagship project, utilizing technologies such as the re-designed website, a monthly electronic newsletter, program blog, social media outlets (e.g., Facebook and Twitter) and traditional media, as well as conferences, special events and products. In addition, the MCHIP communications working group continued to meet monthly to collaborate, share and be strategic in promotional efforts.

The MCHIP communications team *hosted or supported 32 events/conferences* on a variety of MNCH-related topics, including such high-level events as the Symposium on Misoprostol, the Asia Regional Meeting on Interventions for Impact in Essential Obstetric and Newborn Care in Dhaka, Bangladesh, two very high profile Congressional Receptions on Capitol Hill, a special event at the Woodrow Wilson Center, the Child Survival Call to Action Global Meeting, the 50th Anniversary Distinguished Speakers series event, the MCHIP Program Learning meeting and the WHO-PEPFAR Meeting for the Scale-Up of VMMC in Johannesburg, South Africa. MCHIP also *had a presence at 11 conferences* to include APHA, Interaction, International Family Planning, ICASA, IAS and USGLC Smart Power Expo.

The team *contributed to the production of over 150 resources, briefs or toolkits*, which were disseminated through the MCHIP website, events, conferences and social media outlets and shared among partner organizations to ensure other existing platforms were fully utilized. *MCHIP social media sites markedly increased their number of followers and influence within this sphere of communication with over 3.6 million impressions* from Twitter and Facebook in the last year (an aggregate of the number of people that saw each tweet, post, retweeted, etc.). In addition, key technical experts from multiple technical teams and MCHIP programs were published externally, from “ABC News” to *Huffington Post* and throughout many esteemed global health journals.

Special Events/Conferences

The MCHIP communications team responded to multiple unplanned and yet very high-visibility requests for event support by USAID. MCHIP hosted and provided support to 32 events/conferences throughout this reporting cycle, including logistics, collateral and other support as required.

November 3, 2011, was not only the 50th anniversary of USAID, but also the day when more than 100 people, including congresswomen, policymakers and MCHIP partners and staff, gathered on Capitol Hill to promote continued investments in global health. The event—“Continuing U.S. Investments Made in Global Health: Why It Matters More Than Ever”—was sponsored by USAID, MCHIP and its partners. It provided a unique opportunity to learn more about the work being done on the ground directly from those on the front lines: our 35 field staff who were visiting from 15 countries in Africa, Asia and Latin America for the MCHIP-organized Program Learning Meeting.

In April, during the week of the Maternal Health Evidence Summit, MCHIP helped with logistics and protocol for visiting Ministers of Health, and also hosted two events: one at the Woodrow Wilson Center and another, once again, on Capitol Hill on “Maternal Survival: Celebrating Progress and Accelerating Action.” Ten Members of Congress attended the Hill event and gave remarks on the importance of investments in global health and how they would continue to support USAID’s efforts to improve the health of women and children in developing countries. Administrator Shah gave the keynote address and Lois Quam, Executive Director of the Global Health Initiative, and Ariel Pablos-Mendez, Assistant Administrator for Global Health at USAID, were honored speakers. Four Ministers of Health were also honored for their countries’ leadership and improvements to health in the presence of over 300 attendees in the historic Kennedy Caucus Room of the US Senate.

MCHIP also contributed to the recent Child Survival Call to Action held in June in Washington, D.C., by managing all events planning logistics. As part of this and USAID’s 50th Anniversary Distinguished Speakers Series, MCHIP co-sponsored an event with USAID with four giants in the field of child health in the 1980s to discuss their experiences, challenges/lessons learned and ideas for the future of this important health priority. MCHIP was also actively involved in the 5th Birthday campaign run by USAID through numerous working groups and participatory efforts.

Most recently, the team planned and executed the WHO-PEPFAR Meeting for the Scale-Up of Voluntary Medical Male Circumcision in East and Southern Africa in Johannesburg, South Africa from 25–28 September. Organized on behalf of PEPFAR and USAID, this event brought together over 160 VMMC experts from Ministries of Health, Missions, USG headquarters (USAID, Department of Defense and CDC) and implementing partners. Support also included all travel logistics and financial support for 25 sponsored Ministry of Health representatives.

Many of the other PY4 events are highlighted in greater detail in their respective technical sections, and a list of events is provided in the Annex.

Website/Social Media

- Continue to *post regularly to Facebook (1,033 posts) and Twitter feed (3,041 tweets)*. Facebook has increased to 825 followers, up from 450 at the end of PY3. There are approximately 400 site visits per week to Facebook—individuals not only visiting regularly, but also commenting and asking for more information. Our most reached cities include Washington, D.C.; Kampala, Uganda; New Delhi, India; Takengon, Aceh, Indonesia; Kigali, Rwanda; Nairobi, Kenya; and Accra, Ghana. We have 1,790 followers on Twitter, up from 828 at the end of PY3 and on twitter *MCHIP has been mentioned over 1,200 times and our tweets have been re-tweeted over 1,000 times*. K. Agarwal, T. Adamu, J. Smith, H. Rosen and A. Ergo are among our MCHIP staff to join Twitter and engage in the online conversation

from wherever they are in the world, which has allowed MCHIP to significantly expand our reach in this realm and truly poise our experts as media-savvy and regular communicators. Our posts consist of links to content on mchip.net, photos from the field, as well as interesting news and research on MNCH and global health issues. MCHIP participated in AIDS.gov's World AIDS Day 2011 social media campaign and supported USAID's FWD campaign through social media. MCHIP has participated in a number of other social media chats and campaigns, including the #5thbday campaign for the Child Survival Call to Action and a Maternal Health focused Mother's Day chat.

- MCHIP *fully utilized social media and new media technologies for the Asia Regional Meeting on Interventions for Impact in Essential Obstetric and Newborn Care* with great success. In an effort to reach audiences that were unable to join the conference due to time/fiscal/travel restraints, reach atypical publics, elevate MCHIP's online presence and develop a reputation for innovation as well as engage those online and act as their "voice" at the conference, MCHIP employed the following tools for online engagement: webcast with associated viewing parties in Pakistan and India and a sharing session in Nepal (almost 1,500 views from over 13 countries to include Cambodia, Afghanistan, Japan and the UJ); social media (new followers on Facebook increased 700% and on twitter 300% with 313,490 impressions); an online depository of presentations via "scribd" (almost 10,500 reads); a guest blogger series (read over 1,000 times); and YouTube videos (85) of the meeting in its entirety.
- There are approximately 6,000 unique visitors to MCHIP's site every month. Communications continues to post *new content to the website multiple times a week, amounting to 237 new pieces* since October 2011: 96 articles, 67 blogs, 38 event announcements, 20 "in the news" pieces, 10 multimedia and 6 news releases. In addition, more than 150 resources were uploaded during this reporting period. Page views for each of the aforementioned range from over 500 to 10,000. Topics include: release of the Quality of Care Surveys; launch of Malawi's voluntary medical male circumcision campaign; countries set for introduction of pneumococcal and/or rotavirus vaccines; MCHIP and USAID's first LAC annual conference on KMC; 12,000 MCHIP-trained community health workers saving lives in Rwanda; live blogging series from the Asia Regional Conference; First Lady of Tanzania officiating at MCHIP-supported vaccine advocacy meeting; Ambassador Goosby visiting an MCHIP-supported site in Lesotho; and MCHIP and USAID hosting an event on learning from the child survival revolution of the 1980s.
- MCHIP *celebrated 10 International Health Themes* with banner graphics, flyers, handouts, blogs, slideshows, articles and/or social media for the following: World Humanitarian Day; World Contraception Day; World Pneumonia Day; Handwashing Awareness Week; World AIDS Day; International Women's Day; Nutrition Month; Cancer Prevention Month/World Cancer Day; and HIV Testing Day. MCHIP also used the home page slideshow to highlight: Asia Regional Conference expert bloggers series; 47% reduction in global maternal mortality and related NYC event; PFP Statement for Collective Action; 2012 MCHIP PPH and PE/E Programs Global Status Report; Father's Day/KMC; Tanzania/male circumcision success; and use of misoprostol in postpartum hemorrhage prevention.
- As a result of the external mid-term evaluation of MCHIP, many key recommendations were made with respect to the Program website. During this reporting period, significant changes to the site were made to enrich the content and user experience, thus increasing not only traffic to the site but length of time in which visitors remains on the site. These include: re-designing the home page and secondary pages to increase usability and navigation; updating all technical areas to better showcase current work; overhauling the resource section—including the addition of more than *150 new resources—to feature all MCHIP-produced resources with links to others in the community of interest; updating the interactive world map to a more user-friendly template reflecting 44 MCHIP countries with associated country landing pages and indicator profiles; and creating four non-English pages (in*

French, Portuguese, Spanish and Swahili) linked from the home page to assist non-English speakers in finding general Program information and resources in their language.

- In December 2011, MCHIP sent out its inaugural monthly “*MCHIP Update*,” an electronic newsletter, to a mailing list of nearly 4,000 subscribers. The newsletter has generated a “click through” rate as high as 35% (compared to a 10% average, according to Internet research), and in March we were named “2011 All Star” by mailing provider Constant Contact, an annual designation that only 10% of their customers receive. The All Star Awards are in recognition of customers who “stand out from the more than 500,000 organizations who use [Constant Contact’s] services.” This “Update” includes a Letter from the Director, Program Highlights, Blog Spotlights, Key Resources and Global Leadership and Learning. In this program year, 10 updates have gone out on a timely basis each month.

Media Placements

- Successfully placed MCHIP work in several external blogs included USAID, Healthy Newborn Network, Bill & Melinda Gates Foundation, New York Times online edition, AAP, Engender Health Blog, WHO, GlobalHealthMagazine.com, State Department, White Ribbon Alliance, Maternal Health Task Force, Huffington Post, Science Speaks Blog at the Center for Global Health Policy, and Community Health Workers Central. This has allowed MCHIP to leverage other communications venues and share content being created for the site with a broader community, thus extending our reach, and shows that there are multiple audiences in the global health community and beyond who are interested in the work that MCHIP is doing.
- Multiple MCHIP experts’ blogs were published to the *Huffington Post* as part of the Child Survival Call to Action series: Dyness Kasungami on importance of diarrheal disease and pneumonia efforts in child health; Kul Gutuam on a summary of the child survival revolution in the 1980’s and the MCHIP sponsored event for the Child Survival Call to Action; Koki Agarwal on Child Health; and Robert Steinglass on immunization—some of which were also reposted elsewhere, including the Kaiser Family Foundation. This was a very high-visibility blog series and the number of acceptances we had truly showcased MCHIP’s ability to speak to a number of interesting topics as it pertained to Child Survival.
- MCHIP promoted published research findings by technical teams to include the *International Journal of Gynecology and Obstetrics*, *Midwifery*, *Journal of Infectious Diseases*, *International Health* and *PLoS Medicine*. A full listing of all published work during PY4 can be found in the Annex.
- Positive local media coverage was received both domestically and internationally, to include Kenya, ABC News, The Independent (Bangladeshi newspaper), Bangladesh Daily Star, The African Star, The Sacramento Bee, The Root, South Africa’s The Mail & Guardian, Uganda’s New Vision, Thomas Reuter’s AlertNet, and Nigerian Tribune.

Program Learning

This was a year in which MCHIP made Program Learning a more systematic and focused process. In November 2011, MCHIP brought together MCHIP staff from 16 country programs, along with 45 MCHIP/Washington staff and 9 USAID/W staff, plus 31 CSHGP grantees, for a 3-day meeting in Washington with five objectives:

1. Share lessons from the field
2. Develop a common framework and individual plans for capturing priority learning
3. Increase effectiveness for stakeholder engagement and uptake of lessons
4. Better ensure shared learning between CSHGP and MCHIP country programs
5. Reach a shared understanding for next steps for advancing Program Learning

The themes of scale-up, integration, quality and measurement were emphasized. Tools and best practices were shared and discussed. The use of scale-up maps was diffused from the Maternal Health Team to other teams. Much of the material was posted to Sharepoint. The site has since then become the preferred method for sharing and communication for MCHIP, including the country programs.

Following this meeting, MCHIP held a retreat on Program Learning in the Spring of 2012, and began to more systematically track program learning activities and products. In August 2012, Jim Ricca was hired as the Senior Advisor for Program Learning. He has followed up this previous work, and has coordinated with and advised all technical teams and begun to coordinate with country teams to help standardize and align program learning information and approaches. This coordination work will culminate in a systematic plan for Program Learning to be finalized and agreed upon with USAID in the first quarter of Year 5.

The matrix below and each of the technical sections of the report describe the many individual program learning activities in which MCHIP is engaged. Each of the technical teams is involved in four to six major program learning activities. Most of these are focused on the strategic technical areas of the MCHIP project (e.g., PPH prevention, Pre-Eclampsia /Eclampsia Control, iCCM, Routine Immunization, Postpartum Family Planning, etc.) but are sometimes outside this scope in order to respond to the needs and priorities of other global technical partners and individual country contexts. The majority of the Program Learning topics deal with MCHIP's overall cross-cutting themes as well—scale-up, integration, quality improvement and its measurement, and community-based services. The matrix shows which of these topics were completed in Program Year 4 and which will carry over for completion in Year 5.

MCHIP Year 4 Annual Report: Program Learning Matrix

| TEAM | PROGRAM LEARNING QUESTION(S) | HOW/WHERE WILL DATA BE COLLECTED? | CONTINUE IN YEAR 5? (Y/N) | DISSEMINATION MECHANISM(S) |
|----------------------|---|--|---------------------------|--|
| Maternal Health | Are all the necessary components in place and are countries successfully scaling up best practices in prevention and management of PPH and PE/E? | <ul style="list-style-type: none"> Multi-country analysis: survey in 37 countries Analysis of service delivery guidelines for PPH prevention and essential medicines lists for oxytocin and misoprostol | Y (dissemination) | <ul style="list-style-type: none"> Electronic dissemination to all countries, partners and working groups Presented at Asia Regional Meeting (May 2012) Plan to present in PY5: FIGO (October 2012), APHA conference (October 2012), CORE Group Fall Meeting (October 2012) |
| Maternal Health | In misoprostol programs for PPH prevention with distribution through ANC/community for self administration, can quality be maintained in realistic programmatic settings likely to be encountered during scale-up? What results can be achieved at scale in five countries? | <ul style="list-style-type: none"> Review of all completed PPH misoprostol programs through 2012 Pilot interventions in South Sudan, Rwanda and Madagascar Plans to begin programs in Liberia and Guinea in PY5 Monitoring in Mozambique | Y | <ul style="list-style-type: none"> Dissemination at national level Plan to present at international conferences including the Maternal Health Task Force meeting in Arusha, Tanzania (January 2013) |
| Maternal Health | How can uterotonic potency be improved in Zimbabwe? | Oxytocin potency study in Zimbabwe | Y | <ul style="list-style-type: none"> Dissemination of national level Results used to inform PY5 activities related to improving storage processes for oxytocin |
| Maternal - Nutrition | What is the role of nutrition in obstetric complications? | Literature review | Y | Plan to submit paper to MH/nutrition journal in PY5 |
| Newborn Health | What is required to introduce and sustainably scale up facility-based KMC services in a country? | KMC multi-country review (Malawi, Mali, Rwanda and Uganda): questionnaire and checklist | Y | Plan to present at International KMC Conference (November 2012) |
| Newborn Health | Can countries use scale-up maps and benchmark to assess progress in scale-up of newborn interventions? | <ul style="list-style-type: none"> SNL scale-up readiness benchmarks and MCHIP scale-up mapping tool applied in Liberia Plans to apply both tools in Zambia and Cambodia in PY5 | Y | <ul style="list-style-type: none"> Plan to draft multi-country brief on the uses of these tools |
| Newborn Health | Is it feasible to initiate and continue KMC at home with the support of community-based Health Extension Workers in Ethiopia? | Questionnaires and interviews implemented in Ethiopia | Y | |

| TEAM | PROGRAM LEARNING QUESTION(S) | HOW/WHERE WILL DATA BE COLLECTED? | CONTINUE IN YEAR 5? (Y/N) | DISSEMINATION MECHANISM(S) |
|-----------------------|---|---|-------------------------------------|---|
| Newborn Health | What factors facilitate scale-up of the management of newborn asphyxia through the Helping Babies Breathe approach? What results can be achieved at scale in 13 districts in Malawi with respect to health system performance, provider competence, quality of care, and newborn outcomes? | Performance evaluation of HBB program in Malawi | Y | Plan to prepare and submit manuscript summarizing findings from the study in PY6 |
| Newborn Health | How can PNC home visits be introduced and scaled up and what conditions are necessary to achieve high coverage and quality at scale? | <ul style="list-style-type: none"> ▪ Document and data review ▪ Country visits and interviews with MOH staff and stakeholders (Malawi, Rwanda, Bangladesh, Nepal) ▪ Phone interviews (Nigeria) | Y (finalize report and disseminate) | Preliminary results shared at WHO PNC meeting in Geneva (February 2012) |
| Child Health, Malaria | How do selected PMI countries incorporate WHO Guidance on case management of malaria in children into country-level IMCI Training and Supervision Guidelines? What factors facilitate or hinder scale-up of WHO diagnostic testing and treatment guidelines for malaria within the context of Integrated Management of Childhood Illness? | <ul style="list-style-type: none"> ▪ Desk review ▪ Key informant interviews in PMI countries | Y | Plan to present findings to USAID and key stakeholders in PY5 |
| Child Health | How has the private sector been utilized to improve coverage of child health services through community-based mechanisms? | Field assessment of SHOPS program in three regions of Tanzania | Y | <ul style="list-style-type: none"> ▪ Preliminary findings presented to USAID ▪ Full dissemination in PY5 with plan to present to USAID |
| Child Health | What factors facilitate OR hinder scale-up of the use of oral rehydration salts and zinc in low- and high-performing countries? | <ul style="list-style-type: none"> ▪ Desk review ▪ Key informant interviews in four countries (Malawi, Zambia, Mali, Senegal) | Y | Plan to disseminate findings in a peer-reviewed journal |
| Child Health | How effective is the use of Aquatabs for water disinfection in preventing diarrheal disease in children in urban slums? | Double blind randomized control trial in Orissa, India | N | Findings disseminated through partner PSI |
| Family Planning | What needs remain unmet in global postpartum family planning? | Reanalysis of DHS data for women 2 years postpartum | N | <ul style="list-style-type: none"> ▪ 10 descriptive country profiles produced and posted on PFPF Toolkit (K4H) ▪ Profiles shared with in-country stakeholders |
| Family Planning | What have been the program experiences and lessons learned around use of PFPF as an opportunity to strengthen linkages with MNCH/FP integration? | <ul style="list-style-type: none"> ▪ Literature review ▪ Program-specific information (gathered through online PFPF Community of Practice discussion forums; MIYCN-FP and FP/Immunization Integration Working Groups) | Y | <ul style="list-style-type: none"> ▪ MIYCN-FP Toolkit disseminated on K4H and regularly updated ▪ Plan to finalize HIP for Family Planning brief on FP/Immunization Integration |

| TEAM | PROGRAM LEARNING QUESTION(S) | HOW/WHERE WILL DATA BE COLLECTED? | CONTINUE IN YEAR 5? (Y/N) | DISSEMINATION MECHANISM(S) |
|-----------------|---|---|---------------------------|--|
| Family Planning | What are the key programing elements in FP/immunization and what are the influences in FP use and immunization service utilization? | <ul style="list-style-type: none"> Model development in 10 facilities in two counties in Liberia Ongoing data monitoring through supportive supervision | Y | <ul style="list-style-type: none"> Assessment reports and training tools developed Plan to propose national scale-up strategy in PY5 |
| Family Planning | What are the key program elements in MIYCN/FP integration and how does it affect FP use among postpartum women? | Service statistics; baseline and endline data in Bondo District, Kenya | Y | <ul style="list-style-type: none"> Baseline assessment report, advocacy materials and training materials developed Plan to expand coverage in PY5 |
| Family Planning | What factors facilitate in-service capacity strengthening and scale-up of PPIUCD in India? | PPIUCD follow-up study in support of Indian Ministry of Health and Family Welfare and Government of India | Y | <ul style="list-style-type: none"> Results shared with global and in-country level stakeholders Plan to submit at least one publication through peer-reviewed journal |
| Family Planning | What improvements have been made in the use of thenPostpartum IUCD in Paraguay? | Retrospective case series of over 3,000 PPIUCD insertions over 10 years in Asunción, Paraguay | N | <ul style="list-style-type: none"> Abstract accepted for publication in <i>Contraception</i> Findings presented at ARHP conference in New Orleans (September 2012) |
| Family Planning | What is the impact of FP integration on a community-based MNH program in Bangladesh? What are the perceptions of community members regarding postpartum return to fertility? | Healthy Fertility Study in Bangladesh | Y | <ul style="list-style-type: none"> HFS BCC and Community Mobilization Brief developed Plan to produce seven manuscripts Plan to finalize brief on MaMoni application and scale-up of HFS model Plan to publish two articles in PY5 |
| Immunization | What is the impact of new vaccine introduction on immunization programs and health systems? | Literature review | N | Findings presented in report; accepted to be published in journal <i>Vaccine</i> . |
| Immunization | How can measles and rubella campaigns be used to strengthen routine immunization and surveillance? | <ul style="list-style-type: none"> WHO-supported field work in two countries Previous studies conducted by London School of Hygiene and Tropical Medicine | N | <ul style="list-style-type: none"> Planning module to be disseminated by WHO Journal article submitted for publication in supplement to <i>Vaccine</i> (August 2012) |

| TEAM | PROGRAM LEARNING QUESTION(S) | HOW/WHERE WILL DATA BE COLLECTED? | CONTINUE IN YEAR 5? (Y/N) | DISSEMINATION MECHANISM(S) |
|--------------|--|--|---------------------------|--|
| Immunization | What are the demographic, health system or family characteristics that put children at risk for being unimmunized? What are the more immediate, direct causes to children being either partially immunized or not immunized at all? | <ul style="list-style-type: none"> Literature review | N | <ul style="list-style-type: none"> Disseminated to partners and decision makers Accepted for publication in <i>International Health</i> (March 2012) |
| Immunization | What impact does service integration have on immunization programs? | <ul style="list-style-type: none"> Literature review | N | Published in <i>Journal of Infectious Diseases</i> (March 2012) |
| Immunization | What areas of research are required to strengthen routine service delivery in developing countries? How can coverage be increased with existing vaccines and new vaccines be introduced? How can other services be integrated with immunization? How can immunization best be financed? | <ul style="list-style-type: none"> Panel of external experts organized by CDC | N | Article published in <i>Vaccine</i> (November 2011) |
| Immunization | What progress has been made toward polio eradication, and what are the lessons learned? | <ul style="list-style-type: none"> Paper drafted based on data from CORE India polio program | N | <ul style="list-style-type: none"> Two research papers drafted for submission to peer-reviewed journals Expanded web-based resource platform: site reorganized and restructured; new knowledge summaries added; social networking space established |
| Malaria | What are the program successes, challenges and lessons learned in PMI countries performing comparatively well on key MIP indicators? | <ul style="list-style-type: none"> Case studies (including key informant interviews) conducted in Zambia, Senegal and Malawi Desk review | N | <ul style="list-style-type: none"> Case studies shared with PMI and stakeholders in each country through dissemination meetings Case studies and summary brief shared through mechanisms such as RBM and CORE Group Presentation to occur at ASTMH Annual meeting in Atlanta in Y5 Q1 |
| Malaria | What are the cross-cutting findings and lessons learned from CCM programs at scale in key countries? | <ul style="list-style-type: none"> Desk review of iCCM reports in Senegal, DRC and Malawi | N | <ul style="list-style-type: none"> Findings presented to USAID Washington technical officers (December 2011) Webinar coordinated by CORE Group (January 2012) |
| HIV | What are the differences in outcomes between client-initiated voluntary and provider-initiated testing and counseling programs? | Desk review of Zimbabwe's program-level data | Y | Plan to present and disseminate findings in a report in PY5 |

| TEAM | PROGRAM LEARNING QUESTION(S) | HOW/WHERE WILL DATA BE COLLECTED? | CONTINUE IN YEAR 5? (Y/N) | DISSEMINATION MECHANISM(S) |
|---------|---|--|---------------------------|---|
| HIV | Is the Centership model an effective way to deliver integrated HIV interventions? | <ul style="list-style-type: none"> Site visits to Centership Project sites in Namibia during FY 2012 Second midline assessment July 2012 Phase 2 of project to be conducted through July 2013 | Y | Final evaluation to be presented in case study report |
| HIV | How can access and utilization of integrated PMTCT services be improved? | <ul style="list-style-type: none"> Pilot adaptation of immunization's Reaching Every District approach implemented in Bondo District, Kenya (October 2010–June 2012) | N | Findings shared in conference in Kenya focusing on integration |
| HIV | What factors facilitate rapid and effective scale-up of VMMC for HIV prevention? | 14 priority countries | Y | <ul style="list-style-type: none"> Key guidance documents developed and disseminated to country programs Contributions to <i>PLoS</i> peer-reviewed journal articles Findings and experiences shared at various meetings as part of a series to examine future possibilities of VMMC devices in service provision |
| PVO/NGO | How can the learning agendas of MNH, CCM and Equity be advanced and used in scale-up? | <ul style="list-style-type: none"> Investigations into CSHGP Portfolio Review of qualitative and quantitative data in grantee reports | Y (dissemination) | <ul style="list-style-type: none"> Plan to disseminate results in summary report Plan to present findings at CORE Group Fall Meeting (October 2012) |
| PVO/NGO | How can the CSHGP Portfolio contents regarding malaria, breastfeeding, family planning integration and HIV/AIDS integration be advanced and used in scale-up? | <ul style="list-style-type: none"> Investigations into CSHGP Portfolio Review of qualitative and quantitative data in grantee reports | Y (dissemination) | <ul style="list-style-type: none"> Report about malaria and behavior change results shared with PMI and partners (September 2012) Breastfeeding results from LiST and contextual analyses shared at UNC Breastfeeding Symposium (March 2012) Analysis HIV/AIDS integration with MCH interventions presented as poster at International AIDS Conference (July 2012) |

| TEAM | PROGRAM LEARNING QUESTION(S) | HOW/WHERE WILL DATA BE COLLECTED? | CONTINUE IN YEAR 5? (Y/N) | DISSEMINATION MECHANISM(S) |
|------------------------------|--|---|---------------------------|--|
| PVO/NGO | How can PVO/NGO project data best be used for scale-up of key child health interventions? | <ul style="list-style-type: none"> ▪ Desk review of project data ▪ Key informant interviews (Kenya) | Y | <ul style="list-style-type: none"> ▪ Four articles developed for peer-reviewed publications ▪ Case study about PVO/NGO work in Kenya completed |
| CORE Group | How can we best use program learning findings in collaboration with others in the field? | <ul style="list-style-type: none"> • Work with network partners | Y | <ul style="list-style-type: none"> ▪ Community Health Network convened and expanded ▪ Five-day Designing for Behavior Change Training held in Washington, D.C. ▪ Spring Meeting successfully convened (April–May 2012) ▪ Fall Meeting to be held in PY5 (October 2012) ▪ Strategic communications efforts expanded and supported ▪ Technical input and support provided to CSHGP, with several grantees highlighted at CORE Group Fall and Spring Meetings |
| LAC Bureau – Maternal Health | How can oxytocin in Uniject (OiU) be used to promote the administration of oxytocin as part of AMTSL? | Pilot studies in Nicaragua and Honduras | Y (dissemination) | <ul style="list-style-type: none"> ▪ Plan for national and international dissemination in PY5 through journals and conferences ▪ Plan to work with Pan American Health Organization (PAHO) to include OiU on the Strategic Fund Products List |
| LAC Bureau – Maternal Health | What interventions will most increase uptake and scale-up of AMTSL and reduce the use of routine episiotomies? | Results from implementing intervention in selected facilities | Y (dissemination) | Plan for national and international dissemination in PY5 through journals and conferences |
| LAC Bureau – Maternal Health | What are providers' perceptions of the reasons for high cesarean birth rates? What are possible interventions to reduce the rate of cesarean births? | Data collected in PY4 and PY5 (Nicaragua) | Y | Plan to present findings in report and disseminate through journals and conferences |
| LAC Bureau – Maternal Health | How can the process of competency-based education be systematized to guide replication of South to South capacity building in one or two Central American countries? | Trip report data from South to South capacity building and technical assistance between Paraguay and Peru (PY4) | Y | Plan to disseminate findings as guidance for developing similar approach in other CA countries |

| TEAM | PROGRAM LEARNING QUESTION(S) | HOW/WHERE WILL DATA BE COLLECTED? | CONTINUE IN YEAR 5? (Y/N) | DISSEMINATION MECHANISM(S) |
|------------------------------|--|--|---------------------------|----------------------------|
| LAC Bureau – Maternal Health | How can distance learning best be used by CRMA for continuing professional development? | <ul style="list-style-type: none"> ▪ DL experiences and lessons learned in selected countries ▪ Documentation of process developed for use by Caribbean Regional Midwives Association (CRMA) | Y | |
| LAC Bureau – Newborn Health | Is the LAC Newborn Health Alliance an effective mechanism for disseminating findings on HBB and KMC? | LAC Newborn Health Alliance activities | Y | |
| LAC Bureau – Newborn Health | What factors facilitate scale-up of quality improvement of prevention and treatment of newborn sepsis, HBB integrated into ENC, and KMC? | <ul style="list-style-type: none"> ▪ Infection prevention interventions at health facilities in Paraguay ▪ HBB indicators and HBB registration online ▪ Regional KMC indicators | Y | |

Challenges and Opportunities

CHALLENGES

1. **Delays associated with working with multiple stakeholders and partners.** Many technical teams reported challenges linked to completing deliverables because of slow response from other partners. For instance, the CCM indicator guide has benefited tremendously from input from different partners; however, this has slowed down during the finalization process. The East, Central and Southern Africa College of Nursing (ECSACON) and RCQHC work on pre-service education for newborn health has been a slow and challenging. Similarly, the HIV/AIDS team has experienced slow progress in developing global VMMC documents because of the need to involve multiple partners. Long delays in the completion of materials with Unilever for handwashing for newborn health left a very short period for implementation in Indonesia. These materials were rolled out in October 2012, in concert with Global Handwashing Day. MCHIP's support to convening certain task forces has been challenging with respect to developing and carrying out workplans related to each of the specific areas in PPH and PE/E.

Such delays are not unusual, and in anticipation, MCHIP has developed some solutions. As an example, to overcome the delays, MCHIP commissioned an M&E specialist to support the final stages of the work on CCM Indicators guide. USAID and MCHIP agreed that MCHIP would focus its efforts on Malawi for pre-service newborn education, while remaining available to provide technical assistance to the regional curriculum harmonization effort. In Year 5 and beyond, MCHIP will continue to support the larger working groups as a forum to share resources and information, but will discontinue the smaller task forces for PPH and PE/E.

2. **Conflict in certain countries** have delayed programs. The March 2012 coup d'état in Mali resulted in severe delays in implementing planned activities. While the situation has improved and program activities have been reinitiated, continued restrictions preventing direct collaboration with the Government make coordination challenging and makes long-term strategic vision impossible. Conflict in northern Nigeria has continued to slow progress of the newborn sepsis management supervision and data collection. MCHIP will be hiring a local consultant in Q1 of Year 5 to conduct the evaluation originally planned for Year 4.
3. **Exclusive focus on certain diseases and program elements.** Financial investment in global immunization has become very imbalanced. External resources are earmarked for individual diseases, primarily polio, and for individual vaccines, primarily the purchase of new vaccines through GAVI. (Details in MCHIP blog⁶ in the *Huffington Post* in June coinciding with the Call to Action on Child Survival). With the recent declaration of polio eradication becoming a global public health emergency, there is a challenge in accepting rhetorical claims that investment in the short term to eradicate polio will strengthen the routine immunization program for the long term. This would continue to distract scarce financial and human resources (both external and domestic) from the effort to strengthen routine immunization programs.
4. **Changes to workplan over time.** Activities that may have been proposed do not always happen. This may be due to lack of interest from MCHIP counties. For instance, initial interest from eight or nine countries in the testing of uterotonic potency has waned to just one, Zimbabwe. MCHIP's HIV core workplan has been modified throughout FY12. In FY12 there have been multiple requests for the addition of new activities. This can affect staff workload and competing priorities with the original ongoing activities.

⁶ (http://www.huffingtonpost.com/robert-steinglass/immunization-investments_b_1594056.html)

OPPORTUNITIES

1. New events that create a favorable policy environment.

- a. Using the Child Survival Call to Action platform, MCHIP will coordinate with the CCM TF and CORE Group in the dissemination of key lessons learned to date in order to build momentum for iCCM programs at scale.
- b. There is a strong momentum to address and reprioritize MIP programming from donors and governments alike. MCHIP is well-positioned to support countries in their efforts to combat MIP through sharing knowledge acquired in the MIP case studies and the country-level bottleneck analysis.
- c. The new Multi-Partner Commission on MCH supplies is working to ensure availability of essential drugs for reducing maternal and newborn mortality. MCHIP is working closely with the Commission to ensure that this Commission helps countries prevent stock-outs.
- d. MCHIP will also work to coordinate with global supply chain technical projects (including DELIVER, SC4CCM, and SIAPS) to facilitate refinement of supply chain tools for use in specific CCM countries.
- e. As the CCM TF Secretariat, MCHIP will work to reactivate the logistics subgroup to provide leadership and enhance momentum to address supply chain issues faced by many CCM programs.
- f. In August, the Bill & Melinda Gates Foundation decided to invest in a routine immunization strategy for the first time. Their move beyond technological and catalytic fixes would signal a major shift in donor and agency priorities.
- g. With the prospect of more funds flowing to immunization, now that the World Health Assembly has endorsed the Global Vaccine Action Plan as a part of the Decade of Vaccine initiative, new partners have become interested in global immunization—some for the first time.
- h. MCHIP has been involved in the discussions of integrating MC devices, specifically PrePax and Shang Ring, into programs once they have been approved. MCHIP is in an excellent position to provide guidance and leadership in this area, especially in device-related training, operational research, integration and scale-up.

2. Program learning from MCHIP: building on several global meetings. As MCHIP moves into its last year of full implementation, there are opportunities to link with the large global meetings to share Program Learning from MCHIP. MCHIP is working to include sessions on malaria, maternal health and newborn health within the Maternal Health Task Force meeting, Women Deliver, CORE Group Spring and Fall Meetings, etc. MCHIP-FP is communicating with the organizers of the 2013 Women Deliver Conference about showcasing postpartum family planning on the agenda. MCHIP hopes to use the conference as a platform for sharing lessons learned from the work of MCHIP and other partners in postpartum family planning globally. In addition, MCHIP is planning to host a pre-conference event to formally launch the Statement for Collective Action for PFP, possibly, it is hoped, with WHO's RHR department.

3. Adding evidence-based interventions within new global priorities. New vaccine introduction has captured the attention of policymakers and funding agencies. Because a new vaccine immediately becomes a part of the routine immunization program after the launch, MCHIP and counterparts have an opportunity to use the introduction to re-focus on the routine immunization program.

Annex A: Year 4 Financial Summary

As of the end of Program Year 4 (September 2012) MCHIP received core and field obligations totaling \$239M, which represents 40% of the MCHIP award ceiling of \$600M. Funding continues to come in primarily for field activities. Of the \$117.3M obligated in Program Year 4, \$90.7M or 77% represents field funds. This shift in funding from core to field fits within USAID's vision during the Request for Assistance phase. USAID had anticipated that 90% of the award ceiling amount of \$600M would come from field funds. Of the \$239M in obligated funding as of Sept 2012, 72% is field funding.

Table 2. MCHIP Program Years 1 through 4: Total Core and Field Funding

| Core PYs 1 through 4 | Program Year 1 | Program Year 2 | Program Year 3 | Program Year 4 | Total |
|---------------------------|----------------|----------------|----------------|----------------|----------|
| Obligations | \$5.52 | \$23.61 | \$11.00 | \$26.61 | \$66.74 |
| Expenses | \$3.14 | \$15.10 | \$16.31 | \$13.36 | \$47.92 |
| Pipeline | \$2.37 | \$8.51 | (\$5.31) | \$13.25 | \$18.83 |
| Field PYs 1 through 4 | Program Year 1 | Program Year 2 | Program Year 3 | Program Year 4 | Total |
| Obligations | \$4.70 | \$28.34 | \$48.55 | \$90.70 | \$172.29 |
| Expenses | \$0.75 | \$16.32 | \$37.16 | \$56.52 | \$110.75 |
| Pipeline | \$3.95 | \$12.02 | \$11.39 | \$34.18 | \$61.55 |
| TOTAL ALL FUNDING SOURCES | Program Year 1 | Program Year 2 | Program Year 3 | Program Year 4 | TOTAL |
| Obligations | \$10.22 | \$51.96 | \$59.55 | \$117.31 | \$239.04 |
| Expenses | \$3.89 | \$31.42 | \$53.47 | \$69.88 | \$158.66 |
| Pipeline | \$6.33 | \$20.54 | \$6.08 | \$47.43 | \$80.37 |

Looking at PY3 only, core expenses were higher than funding received for that specific (twelve month) time frame reviewed. This was primarily due to funding having been obligated in a prior fiscal period, but for use during PY3. While the funding ceilings overall were never exceeded, more was spent than received during PY3. As such, the negative pipeline that reflects one year spending only, rather than inception to date, is correct.

Annex B: Africa S/D Results

INTRODUCTION

The Maternal and Child Health Integrated Program (MCHIP) seeks to contribute to reductions in maternal, newborn and under-5 child mortality in U.S. Agency for International Development (USAID) priority countries. MCHIP is a five-year, \$600 million Leader with Associate Awards to Jhpiego in collaboration with Save the Children; John Snow, Inc. (JSI); Johns Hopkins University/Institute for International Programs (JHU/IIP); ICF International; PATH; Broad Branch Associates; and Population Services International (PSI).

Africa Bureau funds are used strategically to support Africa Bureau priorities as well as to strengthen and advance specific technical components under MCHIP. Complementary use of Africa Bureau funds has reached over 25 countries in Africa. This report presents MCHIP program results that were achieved with the support of Africa SD funds during the period from October 1, 2011 to September 30, 2012.

SUMMARY OF ACHIEVEMENTS

Maternal Health

- EONC literature review conducted of 150 articles; 20 selected for the development of the annotated bibliography for the EONC toolkit. WHO/AFRO EONC Resource Package of materials on Policy, Advocacy, Service Delivery, Quality Improvement, Education and Training, Monitoring and Evaluation K4Health toolkit created; resources uploading in progress.
- In collaboration with USAID, the West Africa Health Organization, ECSA and WHO/AFRO, selected 10 countries (five Anglophone and five francophone) for the EONC Champions in Africa for Advocacy and Training activity. They include: Kenya, Liberia, South Sudan, Uganda, Zambia, Benin, Guinea, Madagascar, Mali and Senegal.
 - 30 participants were selected out of a total of 106 applicants. The 30 selected participants are made up of teams of three from 10 countries (midwife, pediatrician and obstetrician).
 - Anglophone training was held 7–19 May 2012 in Kenya and 17–25 September 2012 in Ethiopia; Francophone training was held 14–26 May in Burkina Faso and 17–26 September in Guinea. The first training was a clinical training update and standardization course and the second training was an introduction to training and education competencies.
 - Follow-up visits were made to all Champion teams following the first training, and reports were finalized with recommendations for development of a second round of action plans. Teams in Madagascar, Senegal, Guinea, Mali and Zambia met with USAID Missions, and all teams met with in-country partners including MOH and H4+ groups⁷ to introduce themselves and share their action plans.
 - Participants were oriented to the “Qstream” web-based EONC training platform to prepare for trainings in May, and it was in full use by the September course. Evaluations of Qstream and Community of Practice were prepared and administered at September courses. Evaluations showed that participants preferred a blended learning approach, which allowed them to remain engaged in between workshops.
 - Presented on Designing Modules for Regional Continuing Professional Development (CPD) at the African Health Professions Regulatory Collaborative (ARC) conference in Arusha, Tanzania, in October. The purpose was to promote distance learning education as

⁷ UNFPA, UNICEF, WHO, and the World Bank, as well as UNAIDS – leading United National agencies targeting health issues—have joined forces as the Health 4+ (H4+) as a coordinated initiative aimed at reducing maternal and newborn and mortality.

an approach for CPD that would allow developing country professionals to obtain required continuing education credits without facing heavy financial burdens or removing them from practice in areas of low human resource capacity. This activity was to support one or more of the recipients of the ARC country proposals that were focused on CPD. Two countries were focused on CPD activities; Malawi and Swaziland. MCHIP offered to provide CPD in the area of high-impact maternal health interventions in early 2012. Subsequent communications were to include participation in a follow-on ARC meeting in spring 2012. During this time, further communications were not forthcoming. In June 2012, the offer was repeated but there was no further follow-up. Related to this activity was a review of the CPD manual for Malawi, which was completed in Q2 of 2012.

NEWBORN HEALTH

Newborn Sepsis Management

- MCHIP conducted a newborn health technical assistance visit in October 2011 to monitor and support the newborn sepsis activity in Nigeria, including reviewing data and discussing plans for documentation. Because MCHIP Nigeria closed in December 2011—and there were only 5 months of actual implementation—MCHIP discussed with SC (Save the Children)-UK in Nigeria and SNL headquarters their willingness to provide supportive supervision to MCHIP-supported facilities in Katsina and Zamfara States—thereby extending the implementation period to allow for adequate data to be generated. This supervision will be in addition to support they are providing to their own sites that are also implementing this intervention. Facilities in Kano were not included because SC-UK is not operational there. The Letter of Understanding is currently being signed for the program to continue to move forward and for process documentation to take place.
- Dialogue was initiated with staff of the Rebuilding Basic Health Services (RBHS) Project and MCHIP in Liberia to plan for a rapid newborn health situation analysis. This situation analysis would be a prelude to engaging the MOH, donors and their implementing partners on addressing neonatal deaths due to newborn infections.
- MCHIP is participating, on an ongoing basis, in the newborn sepsis management technical working group, which is presently focused on the development of a Newborn Sepsis Management Implementation Guide.

Scaling Up Newborn Resuscitation

- MCHIP met with African Strategies for Health (ASH) Technical Director and MNCH Specialist (November 2011) and learned that ASH will not necessarily support the same partners as Africa 2010 did. The **ECSACON/RCQHC collaboration on pre-service curricula** harmonization advanced in Year 4. MCHIP reviewed the draft combined report from Malawi, Tanzania and Uganda, which will be shared at the harmonization meeting in Q4. At the same time, MCHIP provided support to strengthen skills labs for newborn care (with a focus on resuscitation) in 10 pre-service institutions in Malawi. MCHIP provided a total of 56 NeoNatalies to **12** pre-service institutions for use by tutors and students, as well as HBB training materials. MCHIP conducted an HBB training of trainers for two tutors in each college, or a total of 24 tutors. These tutors are responsible for orienting fellow tutors and lecturers in the colleges as well as for teaching students the ENC course that includes the new HBB component. In addition, MCHIP provided supervision to six of the colleges and plans to continue supervision visits in PY5.

CHILD HEALTH

Community Case Management

- MCHIP served as Secretariat of the CCM Task Force, illustrating how partnerships can be effective in achieving global collaboration. Part of this process entailed redefining the Terms of Reference and workplans for TF working groups. This restructuring will guide the future of the TF, ensuring that value is added through the partnership.
- MCHIP supported the finalization of CCM indicators, working closely with the Monitoring and Evaluation working group of the CCM TF. It is anticipated that during the next program year, an indicators workshop/regional meeting will be held to disseminate these indicators to countries and advocate for their use. This technical support will enable countries to strengthen their use and reporting on CCM indicators.
- In October 2011, MCHIP participated in the Global Action Plan for the Prevention and Control of Pneumonia/Diarrhea (GAPP) meetings in Rwanda, contributing to sharing lessons and effective practices with countries. MCHIP facilitated the Guinea country team to develop a broad implementation plan for the introduction of iCCM. Through this important forum, MCHIP provides technical assistance to country action plans to increase access to and use of interventions against childhood pneumonia and diarrhea.
- **Following an invitation from UNICEF, MCHIP co-facilitated a national workshop** on the Health for the Poorest Populations (HPP) project funded by CIDA, which focused on UNICEF's new district strengthening strategy. This activity opened an opportunity to collaborate with UNICEF in Zambia. The workshop reviewed NGO capabilities and implementation issues. MCHIP has been invited to provide technical assistance for the development of an implementation guideline for the Zambia HPP project.
- **One post-GAPP technical support mission was undertaken in Zambia**, which followed up on the action plan developed during the January 2011 Kenya GAPP meeting. The Mission found that Zambia has initiated all of the actions specified in the plan. Specific challenges and further support needs were identified in the areas of: harmonizing support for community health workers, improving drug supply for CCM, harmonizing CCM implementation tools, and monitoring and evaluation.

Diarrheal Disease Prevention and Control

- **At the global leadership level**, MCHIP has actively and substantially contributed to global momentum to increase visibility of the importance of child health programming. Specifically, MCHIP brought key stakeholders together to discuss available and potential forums for influencing diarrhea control efforts and how to work collaboratively to ensure global leadership. In Year 4, MCHIP supported and contributed to the growing momentum, which led up to the Child Survival Call to Action, the Declaration on Scaling Up Treatment of Diarrhea and Pneumonia, and the establishment of the UN Commission on Commodities for Women's and Children's Health.
- MCHIP contributed as a panel presenter and moderator to the "Why Does Diarrhea Matter" webinar series, hosted by MCHIP program partner the CORE Group. This series brought together global and country-level stakeholders to raise awareness of the global diarrheal disease burden, to discuss how to address low coverage of effective diarrheal disease interventions and to share lessons learned surrounding promising practices at country level.

Immunization

- WHO IST Regional Managers Meetings (West, Central, East and Southern Africa): MCHIP headquarters staff and technical immunization staff from Tanzania, Malawi, Ethiopia, Zimbabwe, Rwanda and Kenya participated in the multi-agency Central, West, Eastern and

Southern African regional annual expanded program on immunization (EPI) managers' meeting in March 2012. MCHIP contributed to discussions and provided feedback during sessions on polio eradication, accelerated disease control, routine immunization and new vaccines introduction. MCHIP staff also actively participated in country-based meetings to outline and provide progress updates on key immunization activities and support between partners and country teams for 2012. Several side meetings were also organized by MCHIP (e.g., with GAVI, WHO, Clinton Health Access Initiative, UNICEF and EPI managers and country teams) to further discuss collaboration and joint activities at regional and country levels.

- Multi-agency external EPI reviews: MCHIP participated in and provided technical contributions to multi-agency external EPI reviews in three countries (Liberia, DRC and Ghana).
- Mid-Level Managers (MLM)
 - Communication Module: At the request of WHO/AFRO, MCHIP provided extensive revisions to the WHO/AFRO MLM Communication Module, to be published next quarter as an updated series of immunization MLM Modules to train mid-level managers throughout Africa (to which MCHIP staff provided previous technical input in co-drafting and reviewing).
 - Facilitate MLM Trainings: At the request of WHO/AFRO, MCHIP staff worked with partners to co-facilitate MLM trainings in two countries in PY4 (Côte d'Ivoire and DRC), assisting countries in developing MLM training plans with implementation objectives and budget, in addition to working on adapting MLM modules to the context of each country.
- New and Under-utilized Vaccines Implementation (NUVI) planning meeting: An MCHIP team attended the Harare NUVI planning meeting and played the role of technical facilitator, along with WHO and UNICEF. The meeting involved 14 African countries, among which seven have conditional approval for rotavirus vaccine or pneumococcal conjugate vaccine. The countries were supported to address the GAVI conditions.
- Africa Annual Conference on Immunization (ARCI): MCHIP staff participated in the 2011 Annual ARCI. There were two breakout sessions on new vaccine introduction, where experiences and updates were discussed in the context of routine immunization, and financing in other sessions.
- Country Support: MCHIP provided technical assistance to address low coverage by targeting hard-to-reach populations through implementing all five components of the RED approach in three countries (DRC, Kenya and Zimbabwe).

MCHIP CONTRIBUTION TO STANDARD INDICATORS FOR USAID AFRICA BUREAU, OFFICE OF SUSTAINABLE DEVELOPMENT (AFR/SD) HEALTH ELEMENTS

Malaria

| | |
|--|-----|
| Number of people trained in monitoring and evaluation | n/a |
| Number of people trained in other strategic information management | n/a |

Maternal and Child Health

| | |
|---|----|
| Number of people trained in maternal and newborn health through USG-supported programs | 30 |
| Number of people trained in child health and nutrition through USG-supported programs | 0 |
| Number of improvements to laws, policies, regulations or guidelines related to improved Access to and use of health services drafted with USG support | 0 |

Annex C: LAC Bureau Results

In MCHIP Year 4, LAC has consolidated efforts to reduce maternal and especially neonatal mortality by implementing targeted technical interventions, spearheading midwifery education and exchanges, and providing global technical leadership through its participation on and collaboration with high-profile organizations. These organizations include the LAC Neonatal Alliance and the Regional Caribbean Midwives Association, both regional platforms through which MCHIP has successfully encouraged information-sharing and scale-up of evidence-based practices. By targeting the primary causes of mortality through its technical focus on Essential Newborn Care (ENC), Helping Babies Breathe (HBB), Kangaroo Mother Care (KMC), and infection prevention and management, MCHIP has achieved notable successes, including advocacy and progress toward increased uptake of priority newborn health interventions at the national and regional levels in LAC. Taking contextual realities into account—namely funding limitations—LAC has worked with partners to develop a feasible regional strategy that has been shown to improve the quality management of newborn sepsis with limited funds through its focus on the promotion of exclusive breastfeeding. Finally, MCHIP has succeeded in scaling up HBB at the country (in the Dominican Republic, Peru and Colombia) and regional levels through its active participation and leadership in regional forums for information-sharing and trainings.

MATERNAL HEALTH

- MCHIP successfully completed three studies in Nicaragua and Honduras, including data analysis and write-up of the results: 1) pilot introduction of OiU for use during AMTSL in Nicaragua and Honduras; 2) **CAMBIO (Changing AMTSL Behavior in Obstetrics)** intervention in Nicaragua to promote the administration of oxytocin as part of AMTSL and to reduce the use of routine episiotomies; and (3) formative research on the use of cesarean operations in Nicaragua.
- Maintenance of high rates of AMTSL and sustained reduction in episiotomy rates in Nicaragua were a direct result of the **CAMBIO (Changing AMTSL Behavior in Obstetrics)** intervention, a study to promote the administration of oxytocin as part of AMTSL and to reduce the use of routine episiotomies. The study involved the distribution and use of Oxytocin in Uniject (OiU) in selected community health centers and hospitals. The study report has been completed and during 2013 MCHIP will disseminate these findings to national and regional audiences through presentations at meetings and conferences, and through publication in international journals.
- The Honduran MOH and other key national stakeholders validated a similar **MCHIP OiU pilot in Honduras**, which targeted selected facilities. The Honduras, Guatemala, and Nicaragua MCHIP OiU study reports have been completed and disseminated in international forums through presentation of the results. The results have generated positive feedback and interest from countries such as Ecuador, who are considering doing pilots. MCHIP will continue to disseminate results in conferences as well as submit abstracts to journals in MCHIP PY5.
- The Nicaraguan MOH plans to use report findings from MCHIPs formative research on the use of **cesarean operations in Nicaragua**, to update guidelines and clinical protocols for obstetric care, with continued MCHIP technical assistance. Revised guidelines will include indications for performing a cesarean and protocols for mode of childbirth after a cesarean. The cesarean report has been disseminated in-country and internationally through MCHIP forums.
- MCHIP supported the development of a **Regional Caribbean Midwives Association** that helps 13 island nations work together to identify and address midwifery needs, including

empowering the Association with a framework for updating provider knowledge and skills through continuing professional education via distance learning.

- MCHIP TA and **South-to-South learning** led Paraguay's most prominent midwifery institution, the Instituto Andres Barbero (IAB) of the National University of Asuncion, to successfully adapt their curriculum to make it competency based, with the support of Peruvian faculty from the University of San Martin de Porres (USMP). In October 2011, a five-day workshop in Lima, Peru, which was led by USMP for seven midwives from Paraguay, five faculty from the Instituto Andres Barbero (IAB), and others, helped orient the Paraguay visitors to the implementation of the ICM competency-based curriculum, as well as review the education system for midwives at the national level in Peru, including certification and accreditation. They also developed an action plan that outlined the follow-up and TA to be provided by the Peruvian faculty to strengthen the curriculum in Paraguay. With continued USMP support, the Paraguay team revised curriculum, culminating in a February 2012 workshop to reinforce IAB faculty knowledge and skills. After a five-day MCHIP July 2012 workshop in Paraguay for 61 midwifery IAB faculty members and one member of the National Midwifery Association, the objective of which was to educate on how to develop the midwifery program or syllabus and evaluation tools in order to complete the curriculum revisions, the participating IAB faculty were able to define a new standards-based curriculum. They also developed a follow-up plan for the Peruvian team to continue providing TA that focuses on updating and reinforcing the midwives' faculty training and clinical skills to assure the adequate implementation of the new competency-based curriculum during the next year.
- MCHIP TA and **South-to-South learning involving Peruvian midwifery mentorship of Paraguayan midwifery faculty**—to support midwifery education in Paraguay—resulted in the signing of MOUs with the rectors of the five major universities with midwifery education programs committing to implementation of competency-based curricula based on the ICM global essential midwifery competencies. In July, the Peruvian faculty from the University of San Martin de Porres (USMP) met with representatives from the private midwifery universities to share experiences about competency-based curriculum development, and together developed an action plan that outlines the process for standardizing and implementing the curriculum nationally. The new schools are pursuing both distance and in-person educational sessions to review the curriculum in order to bring it into line with IAB. With MCHIP support, the private university representatives are working closely with the USMP team to prepare them to adopt this competency-based curriculum, which will also involve training on clinical skills and knowledge in Year 5. MCHIP TA is thus helping to build a consensus for the adoption of a unified national approach to midwifery teaching and management of midwifery schools, according to ICM educational standards.

NEWBORN HEALTH

- As **Chair of the LAC Neonatal Alliance** since 2011, MCHIP has provided technical leadership during a dynamic growth period. The LAC Neonatal Alliance expanded membership to include regional professional associations (Pediatric, Obstetrics and Gynecology, International Confederation of Midwives, and Nursing) and other new members, such as the Mesoamerica Health Initiative 2015 (SM2015) and the Colombian Kangaroo Mother Care Foundation. The purpose of the Alliance is to facilitate collaboration between the professional organizations and to further integrate newborn health efforts in the region. USAID and these partners have worked to foster a consensus among countries in the region on essential actions for newborn health through the establishment of a **regional strategy and the development of a regional action plan** to promote newborn health. In 2012, MCHIP co-organized and co-funded a LAC Neonatal Alliance work planning meeting with the participation of representatives of the professional associations and other partners from the region (UNFPA, CORE, UNICEF, Kangaroo Foundation) in Washington, D.C.

- MCHIP has helped to spearhead the development of a KMC regional network with its own community of practice by **coordinating the efforts and measurements of KMC implementation**, as well as facilitating the regional standardization of the KMC implementation approach, tools, and indicators. MCHIP continues to provide technical assistance through this newly formed regional KMC network. The establishment of this regional KMC network was a direct outcome of the first annual regional workshop, which MCHIP helped successfully carry out in the Dominican Republic in December in collaboration with URC/HCI, the MOH and the Kangaroo Foundation, and with participation from 15 implementing countries (Barbados, Guyana, Bahamas, Suriname, Honduras, Guatemala, El Salvador, Nicaragua, Ecuador, Paraguay, the Dominican Republic, Haiti, Peru, Colombia and Bolivia). Participants shared lessons learned. In PY5, the MCHIP Newborn Team will present a panel on experiences implementing KMC in Africa and LAC at the International KMC Conference to be held in India in November of 2012.
- MCHIP has successfully utilized the **LAC Neonatal Alliance** platform and partners to support the **implementation and scale-up of HBB** in the region, working with the Health Care Improvement Project (URC/HCI) countries of El Salvador, Nicaragua, Guatemala, Honduras and Ecuador, among other partners, implementing the curriculum in the Dominican Republic (DR), and carrying out regional and national trainings for various cadres of professionals. MCHIP disseminated HBB trainings to initiate and strengthen implementation at the country level as follows : 1) Colombia—National TOT with PAHO and HCI in May 2012; (2) Regional TOT during Caribbean ICM meeting in Trinidad and Tobago in April 2012; (3) TOT for Midwifery Association of Peru, June–July 2012. To utilize the strength of the LAC Neonatal Alliance platform and partners, trainings frequently take place in conjunction with regional meetings of partner professional organizations and others. Trainings of Master Trainer teams have been conducted in Trinidad and Tobago in coordination with the International Midwifery Confederation, in Colombia in coordination with PAHO and in Peru in coordination with the National Midwifery Association, among others. Trainings will continue throughout the region with support from the LAC Neonatal Alliance and other partners.
- MCHIP is scaling up quality improvement of **prevention and treatment of newborn sepsis in Paraguay and the Dominican Republic** by assisting partners to adopt proven quality improvement strategies. An assessment of the treatment of newborn infections in the Dominican Republic was conducted, and quality improvement changes will be recommended regionally in accordance with the findings. Activities will expand to other countries in the region through a regional network. Additionally, South-to-South virtual exchanges of experiences and technical updates between participating countries, as well as the sharing of experiences and lessons learned in regional forums, continued to take place during this program year.
- MCHIP is successfully utilizing an integrated approach to promote exchange and capacity-building by working with other complementary MCHIP teams. Together with the MCHIP Newborn Team, the LAC MCHIP team participated in the Asia regional MNH meeting in Bangladesh in May for demonstrations of priority interventions (ENC/handwashing, HBB, KMC) and field visits to HBB evaluation sites to observe and exchange LAC experiences in implementation.



Hospital staff at model KMC teaching hospital San Vicente de Paul greet doctors from all over the Americas, visiting as a part of the first annual Kangaroo Mother Care meeting, held in Santo Domingo, Dominican Republic, in December 2011.

MATERNAL (CHALLENGES/OPPORTUNITIES):

- A major challenge for promoting use and availability of OiU is funding. Oxytocin-Uniject is currently registered for commercial sale in Argentina, Bolivia, Guatemala, Honduras, Nicaragua, the Dominican Republic, Ecuador and Paraguay. Introduction studies in Guatemala, Honduras and Nicaragua have all had positive results. However, it is not yet on the PAHO list of essential medicines that can be purchased with their strategic fund. To facilitate procurement through PAHO, OiU will need to be added to PAHO's list of medications that can be purchased with their strategic fund. PATH will work with USAID/Washington to move this forward.
- A challenge to scaling up interventions in Nicaragua is the fact that USAID will no longer be intervening in-country and future activities will not be funded. However, results from the studies can be transferrable to other countries, and dissemination at international venues should allow other MOHs to capitalize on the results and, where possible, implement them.
- An important challenge for scaling up use of OiU in countries in which pilots have been conducted is the lack of local champions that can advocate and promote use of OiU during AMTSL. Unfortunately, the funding landscape in these countries is not favorable and there is constantly rotation of personnel at the MOH level. This rotation does not allow for continuity and follow-up of projects.
- The Paraguay midwifery team is working in segments on updating their curriculum, though the process has been slow going because the Peruvian midwifery participants must conduct their review. Although the Paraguay team has expressed their commitment to revising the curriculum, it may not be realistic to expect all five schools, given busy workloads, to submit the materials to the Peruvians for review on time.
- Opportunities to strengthen regional leaders in midwifery through participation in regional events will be limited, as the next large regional conferences (2012) are not in LAC. The next regional ICM is in 2013 in Ecuador.

NEWBORN (CHALLENGES/OPPORTUNITIES):

- The great regional interest and demand for HBB poses a challenge. It is also an opportunity about which MCHIP has been dialoguing with the Church of Latter Day Saints Charities and other partners such as PAHO, UNICEF, UNFPA and professional associations, which are doing HBB work in several countries in the region, in order to strengthen coordination and maximize the use of resources.
- MCHIP has been representing the LAC Neonatal Alliance at regional meetings of Neonatology (Colombia, October 2012), pediatric (Colombia, November 2012), and Caribbean ICM (Trinidad and Tobago, April 2012); and at the national Peruvian Midwifery Association (June–July in Lima). In addition, MCHIP was invited and funded by the non-profit Babies Without Borders to present at the national neonatology forum in Acapulco, Mexico, in August 2012.
- MCHIP plans to disseminate HBB training at the National TOT for general doctors and nurses during the Colombian Neonatology Association meeting in Cartagena, October 2012. An additional TOT will be held for regional IMNCI trainers in Bogota in October 2012 (HBB is going to be integrated into the IMNCI strategy at the national level), and a Regional TOT will be held with the AAP and other partners during the ALAPE Conference in Colombia in November 2012.

PROGRAM LEARNING SUPPORTED IN LAC

In the area of maternal health, MCHIP has focused its program learning efforts on educational systems capacity-building through support of South-to-South learning, midwifery exchanges and continuing professional development (CDP) using distance learning through the regional platform of the Caribbean Regional Midwives Association. In PY5, MCHIP will evaluate the sustainability and appropriateness of distance learning for CPD and regional leadership development. MCHIP has focused other program learning activities on various pilots to promote the uptake of interventions to prevent PPH, reduce the number of episiotomies and reduce the rates of caesarean operations. MCHIP will seek to assist stakeholders with the scale-up of these interventions in PY5.

In the case of newborn health, the LAC Newborn Alliance has provided MCHIP with a regional platform to advance HBB and KMC interventions, skills and knowledge as evidenced by active participation at various high-profile meetings, conferences and input into the development of various products (e.g., pamphlets). MCHIP will therefore strive in Program Year 5 to pinpoint elements of this regional approach that enable us to effectively scale up, so that other countries can more easily benefit from lessons already learned.

LAC Maternal Health

Pilots in Nicaragua and Honduras using OiU to promote the administration of oxytocin as part of AMTSL (MCHIP theme: Quality)

Based on positive results from the pilot, which led to sustained reductions in episiotomies and maintenance of high rates of AMTSL, MCHIP began work with PAHO to advocate for the inclusion of OiU to the PAHO Strategic Fund Products List. During PY5, MCHIP will focus on three activities related to the Honduran and Nicaraguan OiU pilot: 1) dissemination of results nationally and internationally, through journals and conferences; 2) work with PAHO to include OiU on the Strategic Fund Products List, which will give MOHs the opportunity to conduct pool procurement and purchase at a lower price; and 3) work with MOHs to place an order for OiU to PAHO's Strategic Fund.

Implementation of a multi-faceted intervention to increase uptake of AMTSL and to reduce the use of routine episiotomies (MCHIP themes: Quality and community)

Based on positive results from implementing the intervention in selected facilities, which led to sustained reductions in episiotomies and maintenance of high rates of AMTSL, MCHIP recommended scaling up use of the intervention to other facilities and possibly using the intervention for other maternal health interventions. During PY5, MCHIP will focus on disseminating results to both national and international audiences, through journals and conferences.

Formative research on cesarean operations in Nicaragua to evaluate providers' perceptions about the reasons for high cesarean birthrates and possible interventions to reduce the rate of cesarean births (MCHIP theme: Quality)

This research was conducted in PY4, and in PY5, MCHIP will focus on disseminating results of the study and use of the results for changes in protocols to both national and international audiences in journals and conferences.

South-to-South capacity-building and technical assistance between Paraguay and Peru for strengthening of midwifery education (MCHIP theme: Quality)

Based on analysis of trip reports, MCHIP has enabled a number of schools in Paraguay to chart a path for improving and modernizing their teaching methodology. In PY5, MCHIP will seek to

document the lessons learned from the South-to-South learning process between Paraguay and Peru for strengthening midwifery education.

Caribbean Regional Midwives Association (CRMA) use of distance learning (DL) for Continuing Professional Development (CPD)

Building on work initiated in PY4 toward the development of capacity for distance learning, MCHIP in PY5 will evaluate whether distance learning is a sustainable model for Continuing Professional Development (CPD) in small countries with little infrastructure for professional learning. MCHIP will also assess whether distance learning is an acceptable model for regional leadership development, based on documentation of the process developed for use by the Caribbean Regional Midwives Association, and how it was utilized to influence programming or national policy. Such documentation consists of correspondence with CRMA and Continuing Education committee members.

LAC Newborn Health

Contribute to activities of The Latin America and Caribbean Newborn Health Alliance (MCHIP theme: Integration)

MCHIP has contributed to the LAC Newborn Health Alliance activities by providing technical assistance and leadership as acting Chair. In PY5, MCHIP will seek to answer what the impact is of training on immediate care of the newborn—particularly with respect to provider practices at the time of delivery and in the postnatal period—and further, what the role of professional associations is in the scale-up and planning for sustainability of ENC in LAC.

Scale-up of quality improvement of prevention and treatment of newborn sepsis (MCHIP theme: Scale-up)

MCHIP's targeted efforts in the areas of newborn sepsis have led to notable progress toward the adoption of cost-effective infection prevention interventions, such as exclusive breastfeeding, at health facilities in Paraguay. In addition, MCHIP completed an assessment of the treatment of newborn infections in the Dominican Republic, and quality improvement changes will be recommended regionally in accordance with the findings in PY5. MCHIP will seek to answer in PY5 how a regional platform can be leveraged to improve the quality of management of newborn sepsis with limited funds, which is MCHIP's LAC regional strategy for newborn sepsis.

Technical support to in-country partners for implementation and scale-up of the Helping Babies Breathe curriculum integrated into ENC under a regional approach (MCHIP theme: Scale-up)

MCHIP has successfully used this regional platform to implement and scale up HBB in PY4 and in PY5 will seek to determine what the key programming elements are for ensuring a successful scale-up of improved newborn resuscitation skills at health facilities, using an analysis of HBB indicators and HBB registration online.

Technical support to in-country partners for implementation and scale-up of the Kangaroo Mother Care method under a regional approach (MCHIP theme: Scale-up)

MCHIP has successfully used this regional approach to scale up KMC in PY4. In PY5, MCHIP will seek to pinpoint which elements of a regional platform are critical to support advocacy and uptake of evidence-based interventions at the regional and national levels, using documentation and standardization of basic elements of the gold standards of KMC, including selected indicators for the region.

Annex D: MCHIP Success Stories

CORE-FUNDED

Successful MCHIP Start in Azerbaijan

October 2011

Through the US Agency for International Development (USAID) global Maternal and Child Health Integrated Program (MCHIP), Azerbaijan passed to a new level of cooperation and synergy between national and international health care professionals in the field of maternal and newborn health. Launched in Baku in May 2011, MCHIP aims to improve maternal and child health and reduce mortality by focusing on improving the competence and skills of clinicians who attend births. In the current initiative, Azerbaijan is developing training packages for Newborn Resuscitation and Assessment of the Healthy Newborn based on existing national clinical practice guidelines (CPG) for Neonatal Resuscitation and Newborn Assessment.



In discussion with key partners at the Ministry of Health, the Scientific-Research Institute of Obstetrics and Gynecology and the Scientific-Research Institute of Pediatrics among others, plans were made is to incorporate the MCHIP-produced training packages into the national medical education system, both for pre- and in-service training. The packages represent an innovative approach to medical education in Azerbaijan by creating training films using neonatologists from local clinics, and using materials complementing national CPG⁸, which are designed to help practitioners make decisions about appropriate health care for specific circumstances.

An issue that arose during project discussions with stakeholders was that Azerbaijan's CPG was four years out of date. Since updates in evidence-based medicine are continuous, the need to update CPG more frequently than every five years (Azerbaijan's practice) was highlighted. As a result MCHIP team members negotiated with members of the project's professional Working Group and the Ministry of Health to update the CPG in advance of scheduled time (2013), which enabled production of training films/packages using the most recent medical evidence for the benefit of all newborns in Azerbaijan.

The newborn resuscitation and clinical assessment of the healthy newborn training packages are ready for approval by the Ministry of Health in early 2012, after which their use will be rolled out through trainings for neonatologists, pediatricians, obstetricians and gynecologists and neonatal nurses in State Medical University, Medical Colleges and the State Institute for Postgraduate Medical Education.



Now, with USAID/MCHIP support, Azerbaijan is one step closer to achieving its Millennium Development Goals: significantly reducing under-five child mortality (MDG 4) and reducing maternal mortality ratio by three quarters (MDG 5).

⁸ The CPG in place when the project started were from 2008, and scheduled for updating in 2013.

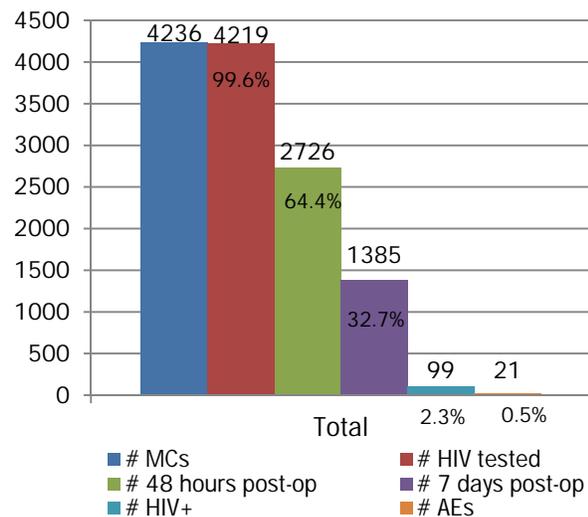
HIV Success Stories: Kenya, Malawi and Tanzania

Kenya

The MCHIP team in Kenya is proving that the use of existing tools can improve new programs, such as prevention of mother-to-child transmission of HIV (PMTCT). By adapting the Reaching Every District (RED) approach for PMTCT, in June 2012, MCHIP/Kenya and the Bondo District Health Office achieved 100% coverage of the district with the help of community health workers—up from 38% two years before (in June 2010). In addition, the proportion of those who completed four focused antenatal care (ANC) visits—a proxy indicator of early ANC attendance—improved from 25% to 41%, and delivery with a skilled attendant increased from 23% to 47% between 2010 and 2012. The proportion of HIV-infected mothers also decreased from 24% to 18%, and the proportion of HIV-exposed infants tested at six-weeks-old improved from 27% to 78%.

Malawi

With MCHIP support, the Ministry of Health in Malawi conducted its first voluntary medical male circumcision (VMMC) campaign between October and November 2011 in Mulanje district. The four-week campaign registered a total of 4,516 men to receive VMMC services—which accounts for 225% of the circumcisions performed in the country in the two years preceding the campaign (less than a 1,000 circumcisions per year⁹). HIV testing uptake was also high, with 4,237 (97.4%) of clients accepting testing.



Of these, 2.1% clients tested HIV positive. Adverse events were monitored at three different intervals: on the day of the procedure; at 48 hours post-operation; and at one week post-operation.

Tanzania

With MCHIP support, the VMMC program in Iringa, Tanzania—in collaboration with the regional medical office of Iringa—achieved an increase in the prevalence of circumcision in the region from 29% in 2009 to 50% in 2012. As a result, the VMMC program in Tanzania's Iringa region has become one of the few in Africa getting closer to achieving the 80% coverage target. As a result, in the next 10 years, this region should see a significant reduction in new HIV infections, which also means tremendous cost saving that otherwise would be spent on antiretroviral therapy and care. Moreover, the VMMC program's success has led to MCHIP taking a sizable role in the implementation of USAID's "combination prevention" intervention, an implementation science initiative, in Iringa and Njombe regions. Projected to achieve a 37% reduction in HIV incidence in the next 3–4 years, the intervention has the following components:

- Scaling up HIV counseling and testing to 100%;
- Scaling up VMMC to 100%;
- Providing PMTCT and HIV care and treatment for all eligible in the region (CD4 below 350/500 TBD);
- Providing community-based services with a distinct household comprehensive health intervention package; and
- Improving HIV prevention, care and treatment services for MARPs (female commercial sex workers) in the region.

⁹ Report of the Situational Analysis of Male Circumcision in Malawi, 2010

MCHIP and the LAC Neonatal Alliance Promote Priority Newborn Health Interventions

by: Minati Rath and Indrani Kashyap

In August, MCHIP's Dr. Goldy Mazia represented the Latin American and Caribbean (LAC) Neonatal Alliance at the first neonatology seminar hosted by "Babies without Borders"¹⁰ in Acapulco, Mexico. Attended by more than 1,500 professionals in child and newborn health from Mexico and newborn health experts from around the world, the three day conference included Dr. Mazia's presentation on the LAC Neonatal Alliance and its priority interventions for newborn health in the region. She was also a panelist in a discussion on the approaches needed to reduce neonatal mortality in the region, and formed part of the table of honor at the opening ceremony. Dr. Mazia officially closed the event, as well.



Dr. Mazia with Dr. Villamizar (ALAPE) and Drs. Sergio Riestra and Victor Sanchez Michaca (Babies without Borders)

MCHIP has been a member of the LAC Neonatal Alliance since 2009, with Dr. Mazia serving as Alliance Chair since 2011. The Alliance is supported by USAID and its partners, including the Pan American Health Organization, the CORE Group, Save the Children's Saving Newborn Lives, the Health Care Improvement Project (HCI), UNICEF, the Mesoamerica Health Initiative 2015 (SM2015), and the Colombian Kangaroo Foundation. Members also include Latin American regional professional associations such as the Regional Association of Pediatrics, the Regional Association of Obstetrics and Gynecology, the LAC chapter of the International Confederation of Midwives, and the Regional Nursing Association.

USAID and these Alliance partners have worked to foster a consensus among countries in the region on essential actions for newborn health by developing a

Regional Strategy and Action Plan to promote newborn health, with a special focus on the most vulnerable populations. Given the importance of examining the mother-newborn dyad in an integrated manner in order to have an impact on Millennium Development Goals four and five, the Alliance also includes the United Nations Population Fund (UNFPA) Sexual and Reproductive Health Unit and other maternal health organizations. These partners—in collaboration with the MCHIP maternal health team—disseminate messages through their constituencies and channels on management of maternal conditions that also impact the fetus/newborn.

During the seminar, Dr. Mazia met with the ALAPE (Asociación Latinoamericana de Pediatría) President Dr. Villamizar to plan for LAC Neonatal Alliance participation in ALAPE's upcoming regional meeting. At the November event, Dr. Mazia will lead a newborn resuscitation "Helping Babies Breathe" (HBB) training as requested by the American Academy of Pediatrics. She will also work with Babies without Borders representatives in Mexico to create collaborative links with MCHIP in implementing HBB at the community level, and to help strengthen the formation of a national neonatal alliance in the country.



Dr. Mazia during a panel presentation with ALAPE President Dr. Hernando Villamizar, Dr. Ola Saugstad (University of Oslo), and Dr. Rolando Cerezo (Neonatologist and PAHO consultant)

¹⁰ Babies without Borders, a nonprofit organization, was formed by Dr. Amed Soliz, a Bolivian-born neonatologist who serves as Medical Director of the Miami Children's Hospital Neonatal Intensive Care Unit. Dr. Soliz also serves as President of the Ibero-American Society of Neonatology, an organization that brings together neonatology specialists from Spain and the Americas to share knowledge and support research in neonatal health.



National Neonatal Alliances are now active in Barbados, Belize, Bolivia, Colombia, the Dominican Republic, El Salvador, Guatemala, Honduras, Nicaragua, Panama, Paraguay, and Peru.

MCHIP has been active and prominent in the LAC region, and Dr. Goldy Mazia has been honored with several invitations to serve as a newborn health expert on panels and in trainings around the world, including the LAC chapter of the World Health Organization's Commission on Information and Accountability for Women, Newborns, and Children; the International Kangaroo Mother Care Conference; and the Call to Action events focusing on child survival. The Child Survival Call to Action was a high-level event featuring hundreds of heads of state, ministers of health, and other policy experts who came together in June 2012 in Washington, D.C., to identify the actions needed to end preventable child deaths.

Africa “Champions” in Madagascar Use MCHIP Platform to Advocate for Lifesaving Drugs and Tools

by: Susan Moffson

When midwife Abéline was asked why she wanted to be an Africa “Champion”—or advocate—for MCHIP, she explained: “Because I want to share my knowledge and skills so that other midwives have more courage to act to save a woman or her baby.” As an instructor at a busy midwifery training institution in Antananarivo, Madagascar’s capital, she teaches students how to take care of pregnant women and their newborns before, during and after labor. And when she receives MCHIP training on the latest evidence-based practices and how to effectively teach these skills, she passes this newly acquired knowledge on to her students.

In Madagascar, about 1 in 45 women have a chance of dying of maternal causes. Sadly, the knowledge of doctors and midwives about how to treat the leading causes of maternal death in Madagascar (and many other African countries) is notably weak. An MCHIP Champion like Abéline helps to fill this knowledge gap by equipping other midwives with the necessary skills to reduce newborn and maternal mortality, which is the primary goal of the Africa Champions program. Madagascar is one of 10 key African countries—along with Benin, Guinea, Kenya, Liberia, Mali, Senegal, South Sudan, Uganda and Zambia—where the program is being implemented over two years (2011–2013).

Abéline developed an action plan with her fellow Malagasy Champions, one a pediatrician and the other an obstetrician, both of whom also teach courses. They revised course content to include vital information on the use of the partograph, a simple tool for recording the progress of labor and the condition of a woman and her baby. The partograph is widely known to be key to the prevention and treatment of prolonged and obstructed labor, the leading causes of death in mothers and newborns in the developing world. However, Madagascar is a country where this lifesaving tool is rarely used. When asked why midwives and doctors do not use this tool, the MCHIP-Madagascar Program Director said: “They don’t understand why it is important, so we have to make them understand that it is not only useful for the woman in labor, but also for the midwife.”

The Senior Technical Advisor for Maternal and Child Health supporting the Africa Champions Program, Patricia Gomez, strategized with the Madagascar Champions to begin promoting its use. Abéline is teaching her current 44 students, as she will her future students, the importance of using the partograph. “In fact,” explained Ms. Gomez, “Abéline is in a great position to have a positive impact as an



Midwives and doctors look on while Heritiana Randrianjafinimpanana—a pediatrician, trainer and MCHIP Champion—demonstrates how to use a ventilation mask during an MCHIP training held in Madagascar’s Capital, Antananarivo.

MCHIP Champion because she can influence so many students to start off on the right foot and learn these fundamental techniques.”

But Abéline still thinks more should be done on a wider scale: “We need to collaborate with other institutions so that even more students learn these new skills.” Because the MCHIP country program will work with private midwifery institutions in the coming year to teach about the partograph and other critical skills, Abéline is likely to see such improvements.

MCHIP Champion Dr. Pierana is also well placed to change things for the better, as he plays multiple roles as the director of a busy hospital, professor at a nearby medical school, and very active member of the Malagasy College of Obstetrics/Gynecology in Mahajanga, Northwestern Madagascar. As a respected leader in his field who is open to new ideas and innovations, Dr. Pierana met the selection criteria to be a Champion.

According to Dr. Jean Pierre, the on-going field activities of the MCHIP-Madagascar program are complementary to the work of the Madagascar Champions, so he is using his connections and expertise to support the three Champions as they advocate for key lifesaving practices. One such practice includes increasing the availability and use of an important drug known as magnesium sulfate, which is used to treat severe pre-eclampsia and eclampsia, conditions characterized by high blood pressure, protein in the urine, and convulsions (in the case of eclampsia). Because doctors and midwives often lack the skills and confidence to use this essential drug, Dr. Pierana is tasked with advocating for its use as part of his Africa Champion’s workplan.

This close working relationship between Dr. Pierana and the MCHIP Country Director has led to notable successes. For example, after recent stock-outs across the country of magnesium sulfate, Dr. Jean Pierre mobilized the Champions to meet with key partners in June 2012. After continual follow-up, they recently obtained assurances from the United Nations Population fund (UNFPA) that the magnesium sulfate had been ordered and would arrive in Madagascar in December 2012. The UNFPA will supply the drug in areas where they work, and also promised to provide it to sites where MCHIP has trained approximately 700 doctors and midwives on its use.

Complementing these advocacy efforts is MCHIP/Washington's on-going support for making available key maternal health medicines (such as magnesium sulfate) in all the countries where it has a presence. MCHIP provides technical assistance to a United Nations Commission on Lifesaving Commodities for Women and Children, and one of MCHIP's primary roles is to share information in target countries, including Madagascar, to help put in place systems for supplies of vital drugs.

Because MCHIP works in more than 40 countries, the impact of this well-coordinated drive to ensure sustainable supplies of these medicines has the potential to be far-reaching. Through this integrated approach—one that builds on the important work already being done by MCHIP Champions and country teams—MCHIP's efforts to promote the availability and use of magnesium sulfate are more likely to be successful.

While the Madagascar team awaits the arrival of magnesium sulfate, Dr. Jean Pierre and the Champions are spreading the word to doctors, especially those in rural settings, where medical supplies may be harder to come by, that this drug can be found in some pharmacies. Dr. Jean Pierre explained: "We will develop explicit instructions about how to calculate proper dosages based on concentrations available in the pharmacies, and we will include that in the trainings." The in-country team has also supplied the Champions and other professional association members who have received MCHIP training with visual job aids that depict the flasks, syringes and dosages of the drug to be used. "Students must then demonstrate how to mix and administer the drug, so they quickly learn that it is easy to master," said Dr. Pierana.

By making vital tools such as the partograph and job aids—as well as essential drugs such as magnesium sulfate—available to doctors and midwives, MCHIP is empowering them to treat women and newborns with severe, life-threatening complications, and helping to reduce both maternal and newborn deaths in Madagascar. Perhaps even more significantly, MCHIP is providing a global platform for the advocacy of lifesaving maternal health supplies, tools and training in the more than 40 countries where the Program works.

CAMBIO Intervention: Changing Minds, Saving Lives in Nicaragua

During a monitoring visit to Chinandega SILAIS, a meeting with the sites' facilitators was held to assess difficulties in the implementation of the CAMBIO (Changing AMTSL Behaviors in Obstetrics) intervention, and to identify barriers among health professionals to changing behavior in relation to the use of restrictive episiotomies. One of the facilitators stressed the difficulty of "persuading" older doctors—who often have difficulty trusting evidence more than experience—of the benefits and safety of restrictive episiotomies in women delivering for the first time. However, she said that they had a great experience recently with one of these doctors, who was approached during an academic visit.

Although scientific evidence in favor of restrictive episiotomies was discussed, this doctor still showed reluctance regarding their use in first time deliveries. Some days later, this doctor assisted such a delivery and both facilitators were present. They witnessed how, despite his many years of performing episiotomies, he followed the recommended practice and avoided performing an episiotomy without any complications. The facilitator viewed this experience as a success of the intervention implementation, because they believed that this change in behavior had been impossible before the CAMBIO project.

This anecdote is consistent with the indicators obtained from the data collection, which show an increased restriction of episiotomy use since the implementation of the intervention (71% in baseline data, 55% in November–December 2011, and 49% in January–February 2012). This is an example of an intended or expected outcome of the intervention and, as the differences between proportions of episiotomy in each period are statistically significant, it cannot be attributable to chance.

Facilitators also stressed the consistency of the CAMBIO intervention with the Delivery Humanization Program and Cultural Adaptation of the Delivery, which is being promoted by the Ministry of Health, which also could have contributed to the successful implementation of the intervention.

Community Health Workers Saving Lives in Rwanda

Jean D'arc Kayitesi is a 28-year-old single mother living in Kavumu Village in Southern Rwanda. When her four-year-old son, Kennedy, developed a cough and fever, she recognized the danger signs and sought care from her village's community health worker (CHW), Concessa Kantarama.

When Concessa saw Kennedy, she took immediate action. Using the respiratory timer in her supply kit, she counted Kennedy's respirations and determined that he was breathing faster than normal for a child of his age. Concessa also recognized that Kennedy had a high fever. She followed an algorithm to diagnose Kennedy with both malaria and pneumonia, and immediately started treatment for the illnesses.

In addition to providing Kennedy with initial treatment, Concessa also advised his mother on how to give the remaining doses of medicine, how to care for him, and what to do if Kennedy's condition did not improve or became worse. Furthermore, Concessa counseled Jean D'arc on preventative practices to avoid future incidence of malaria and pneumonia, as well as on proper nutritional practices for children.

"I am very proud that my assessment and treatment were correct, because the health center advised Kennedy's mother to continue giving the medicines I gave."
—Concessa

"I was worried when my son got a fever and a cough, but I think it is good that there is a CHW here in my village. I can visit her whenever I need to, even if there is no one to accompany me. I felt confident to give the medicines that Concessa had recommended, especially after the nurse at hospital said to continue with them."
—Jean D'arc

The next day, despite giving Kennedy the prescribed medicines according to Concessa's instructions, he still had a high fever, so Jean D'arc returned to Concessa's with Kennedy. When the CHW found that his respiration rate had increased, she sent Jean D'arc to the nearest health center with a referral note. Once there, Kennedy was fully assessed by a medical professional, who advised Jean D'arc to continue with the medicines prescribed by Concessa. And before sending Kennedy home, the health center staff also gave Jean D'arc a counter referral slip so that Concessa could follow up with Kennedy at home, which she did until he was healthy again.

Over a five year period (October 2006–September 2011), the *Kabeho Mwana* ("Life for a Child") project supported initiatives that train and supervise CHWs like



Kennedy with his mother one month after his illness.

Concessa, and worked at local and district levels to strengthen the health system and increase linkages from the community to the health center. *Kabeho Mwana* was an expanded impact project implemented under the auspices of a USAID Child Survival and Health Grants Program award. It was designed to scale up community case management of malaria, diarrhea and pneumonia, and to promote key community-level health promotion and disease prevention actions in collaboration with Rwanda's Ministry of Health. Concern Worldwide was the lead agency and implemented the project in partnership with the International Rescue Committee and World Relief. The project covered six districts in Southern and Eastern Rwanda: Gisagara, Kirehe, Ngoma, Nyamagabe, Nyamasheke and Nyaruguru, representing one-fifth of the districts of Rwanda and 18% of the country's total population.

As a result of continual field presence and ongoing supervision and support, appropriate care seeking for fever in the six districts reached 75%, and appropriate treatment jumped from 20% to 43%. Moreover, care seeking for respiratory symptoms progressed from 13% to 63%. In 2010 alone, CHWs supported by *Kabeho Mwana* in Gisagara district treated 1,050 children under five with pneumonia; 96% of these children recovered following treatment by a community health worker, none of the children died, and 4% were referred to a health facility. One of the most notable results achieved—as illustrated in the interaction between Jean D'arc and Concessa—was making CHWs the first line of treatment for caretakers of children with fever, respiratory symptoms, and diarrhea. By the end of the project, 69% of mothers of children 0–23 months had consulted one of nearly 6,200 CHWs trained under *Kabeho Mwana* at least once regarding the sickness of their child.

FIELD-FUNDED

100th Safe Delivery at Improved Union Health and Family Welfare Center in Bangladesh

8 August 2012

Tania Begum's first child, a two-year-old girl named Rina, was delivered at home by a traditional birth attendant. At that time, Tania and her family were not aware of the possibility of delivering in a facility. After a prolonged labor, her daughter was born, but had difficulty breathing. Thankfully, she survived due to the intervention of a village doctor.

When Tania became pregnant again, the 25-year-old mother decided to attend antenatal care and, ultimately, to deliver her baby at the MCHIP-supported Murakuri Union Health & Family Welfare Center (UH & FWC) instead. Tania's newborn son became the 100th baby safely delivered at Murakuri UH & FWC, and she and her family were overjoyed with her care and the smooth delivery she experienced.

In December 2011, MaMoni initiated the renovation and staffing of three UH & FWCs, including Murakuri, to provide high-quality maternal and newborn health and family planning services, and to ensure round-the-clock normal delivery services. MaMoni is a safe motherhood, newborn care and FP project under MCHIP that is implemented by Save the Children in Bangladesh and two national nongovernmental organizations (Shimantik and FIVDB) that work in 15 resource poor Upazilas (sub-districts) of Sylhet Division in Bangladesh. The project renovated Murakuri UH & FWC using USAID funds to serve as a model facility.

The Korean government, through Save the Children-Korea, similarly supported the renovation of Shibpasha and Kakailseo UH & FWCs in Ajmiriganj Upazila. Additional providers were recruited and placed in these facilities, and given hands-on training at the District Hospital and Maternal Child Welfare Center in normal deliveries.

Newborn Saved in Bangladesh through Helping Babies Breathe Initiative

9 February 2012

Shortly after 24 year-old Sabina Yeasmin delivered a baby girl at a health facility in southwestern Bangladesh, Nurse Nomita Rani noticed that the newborn was not crying or breathing as she should. And because Nomita had attended a Helping Babies Breathe (HBB) training for skilled birth attendants just two days before Sabina's delivery, she knew that the newborn needed immediate assistance to breathe.

HBB is a training program developed for low resource settings by the American Academy of Pediatrics. The Scaling-up of HBB Initiative to Strengthen Newborn Resuscitation in Bangladesh project is being implemented in partnership with Ministry of Health, MCHIP, Save the Children, Bangabandhu Sheikh Mujib Medical University, UNICEF and others.

Using her newly acquired knowledge and skills, Nomita kept the newborn on Sabina's abdomen, turning the baby over on one side and rubbing the skin over her backbone to stimulate her. Despite this, she was still not breathing. Nomita responded quickly, providing suction to clean the newborn's airway and assisted ventilation via a bag and mask. Within seconds, the baby began breathing.

Because Nomita was confident in her ability to resuscitate the baby using equipment provided by the project, she was able to save the newborn's life. Nomita is one of approximately 20,000 skilled birth attendants who will be trained by 2013 on immediate newborn care, including newborn resuscitation, under the initiative in Bangladesh. As a result, today Sabina and her husband have a beautiful, healthy baby daughter.

In Bolivia, Simulation Exercise Gauges Quality of Care in Additional Health Networks

3 July 2012

As Director of Reproductive Health Services in the Santa Cruz Departmental Health Services, Nurse Ruth Galvez was invited to participate in a simulated obstetric emergency exercise with MCHIP and its partners. She watched as the exercise—which aimed to test the quality and efficacy of the health system's response in the health network of Roboré—clearly had a motivating effect on the network's health providers, community members and municipality representatives.

Impressed by what she saw, Galvez concluded: "This is a good strategy that should be replicated in the whole country to know what the response capacity is for these emergencies among the health services, the community and the municipality."

The exercise in Roboré helped the network to tangibly identify the strengths and weaknesses in its capacity to respond to such emergencies, and stimulated the network leadership to work together to address the gaps. It also marked the end of MCHIP and USAID's technical assistance in the province of Santa Cruz.

Galvez began to seek financial and political support to replicate the simulation in two additional networks, linking the initiative to efforts to achieve the Millennium Development Goals. She identified two networks that had not received technical assistance from MCHIP—Obispo Santisteban and Andrés Ibáñez. The support she generated provided refreshments and transport for the exercise, and she was also able to secure an alliance with Nur University to film the simulation.

"The simulation strategy is an innovative strategy that allows us to evaluate the response capacity of the services that are working in quality improvement processes when faced with an emergency, as well as the community organization and the means of communication that is the reality that we face daily," Nurse Galvez said.

There were two participating secondary hospitals: Montero Hospital and El Torno Hospital. The first is located in the municipality of Montero, 60 kilometers from the city of Santa Cruz. It is a secondary hospital that serves as a referral center for three sub-regions of the province of Santa Cruz. The majority of the population works in agriculture in the rural areas, and in both the formal and informal economies in the city of Montero.

The second hospital, El Torno, is 38 kilometers from Santa Cruz, and three blocks off the highway that connects El Torno with the cities of La Angostura and Santa Cruz. The majority of the population migrated from the interior of the country and works in agriculture. Nevertheless, resources are scarce and the population often works as tenant farmers.

The tertiary hospitals that serve as referral hospitals for Montero and El Torno are the Japanese Hospital and Dr. Percy Boland Women's Hospital, both of which are in the city of Santa Cruz. Driving access to these hospitals is often made extremely difficult by heavy urban traffic during rush hours, complicating referrals.

"The premise is to save lives and in this we are working based on what we learned from MCHIP's technical assistance," Nurse Galvez said.

A Remote Village in Bolivia Leads by Example to Help Women Survive Childbirth

by: Laura Goodman and Karina Cabrera

Strengthening emergency obstetric care in Bolivia is helping women survive childbirth.

La Paz, Bolivia -- In the isolated Bolivian municipality of Bermejo, a dusty, jugged road leads past sugar factories to Colonia Linares, a village of 1,500 people with a thriving health center at the forefront of local efforts to prevent women from dying of childbirth complications.

With support from the U.S. Agency for International Development's (USAID's) flagship Maternal and Child Health Integrated Program (MCHIP), Colonia Linares Health Center has become a cornerstone of the Bermejo Obstetric Network, equipped with a two-way radio, access to transportation via ambulance, and staff trained in basic emergency obstetric care (BEmOC). MCHIP, through Jhpiego and partners, has worked to develop a comprehensive maternal and reproductive health program and to strengthen delivery of care in key areas.

"These doctors have been trained in the most up-to-date technical norms," says Dr. Wilber Leyton from SEDES Tarija, the regional office of the Bolivian Ministry of Health that oversees the Bermejo municipality. "This is a model municipality."

In the past two years, MCHIP has trained 615 health providers, including 265 doctors and 350 nurses and auxiliary nurses across four provinces. As many as 2,450 pregnant women a month attend prenatal care services and are benefitting from the new skills acquired by these health providers.

As part of this work, MCHIP staff provides technical updates in maternal health and BEmOC, as well as supportive supervision to the MCHIP-trained health workers in the Bermejo Obstetric Network and nine other networks. According to the Director of the Bermejo network, Dr. Milton Visacho, in order to keep mothers and their children healthy, "we decided to focus on maternal child health with MCHIP."

MCHIP builds on Jhpiego's previous capacity-building efforts in Bolivia, which began in the early 1990s under the USAID-funded Training in Reproductive Health Project. This work included strengthening pre-service education for reproductive health and family planning at two medical and five nursing schools, and supporting the development of policy and strategies to strengthen human resources for health.

Under MCHIP, Jhpiego has also successfully advocated for the implementation of the Standards-Based Management and Recognition (SBM-R®) approach to improve the quality of services in USAID's four target regions across Bolivia, including Tarija. Of the 71 health facilities where MCHIP has introduced SBM-R, 65 have fully implemented the approach, including conducting a baseline assessment and at least two follow-up monitoring reviews. Forty-one facilities have gone further, to carry out at least three reviews.



Community health workers and Miriam Tapia (second from left), representing local partner, Socios para el Desarrollo, at the MCHIP-supported Colonia Linares Health Center, which provides care to pregnant women in the Bermejo Obstetric Network.

This quality improvement project is part of Jhpiego's ongoing efforts to partner with countries in building the capacity of health care workers and strengthening health systems to prevent the needless deaths of women and families. The organization develops innovative, solutions to address today's global health challenges and works with communities to increase frontline health workers' ability to deliver lifesaving care.

In Colonia Linares, MCHIP's efforts have led to a two-fold advantage in saving lives. First, fewer obstetric emergencies need to be referred to the hospital in Bermejo, lessening the load on the staff there. Second, the decentralized provision of services at Colonia Linares Health Center means fewer delays for women facing obstetric emergencies—delays in reaching a health facility and in receiving quality services once at a facility.

Reducing these delays has contributed to continued health improvements for the families of Colonia Linares, where not a single maternal death has occurred in the health center's responsible area since 2005, according to local officials. MCHIP envisions that its capacity-building efforts will support other health facilities in Bolivia to follow the Colonia Linares' example.

Mothers and Babies Thriving Thanks to MCHIP KMC Programs

by: Molly Miller-Petrie, Program Assistant, MCHIP/PATH

Eighteen-year-old mother Joanna Inirio Ramón flashes a big grin for the cameras, while tiny baby Estarling Manuel sleeps on, tightly secured to his mother's chest. When Estarling was born, premature and weighing only 3.5 pounds, he entered the most dangerous time of his life: more than nine million children die each year before they reach five years of age, three-quarters of them during their first week of life. In Latin America and the Caribbean, a full 24% of neonatal deaths are attributable to premature births and low birth weight,¹¹ and the neonatal mortality is estimated to be 15 per 1,000 live births, accounting for 36% of under-five mortality,¹² but there are great differences between and within countries.

Fortunately for Joanna and Estarling, their local hospital staff have knowledge of Kangaroo Mother Care (KMC), an MCHIP-supported and scientifically venerated technique which has been shown to greatly reduce newborn mortality and morbidity in premature and low-birth-weight babies. Originally conceived in Colombia due to lack of enough incubators and other high tech tools for the care of premature and low-birth-weight babies, KMC requires, if possible, constant skin-to-skin contact, exclusive breastfeeding, and close follow-up.

Directly and through the Latin American and Caribbean network, MCHIP currently supports 10 KMC programs in 8 countries, potentially impacting more than 20,000 mothers and their children.

Several hours north of Santo Domingo, in the Dominican Republic, is one such program at the hospital San Vicente de Paul. There Joanna and Estarling are among many mothers and babies who are thriving due to MCHIP's KMC program. They sit, wrapped gently together, on a bed in a ward reserved for mothers who live too far or are otherwise unable to return to hospital for the multiple visits a week required in the first stage of the program. Other mothers are gathered with their children, many already outgrowing their need for direct skin-to-skin contact, but not for other services. Doctors from all over the Latin American and Caribbean region have come to visit the hospital's KMC program as part of MCHIP's first annual conference in the region on the KMC method.

The conference gathered together more than 60 doctors, nurses and experts from over 12 countries for three days this December in Santo Domingo. Participants came together to learn from each other, share experiences and tools, discuss challenges, brainstorm solutions, and begin to build a community of practice. The newest research and innovations in the field were shared, as well as new USAID tools for creating sustainable scale-ups and regional indicators.



Photo credit: Molly Miller-Petrie, MCHIP/PATH

In a demonstration of community support for the project, representatives from the mayor's office and the regional governor attended the ceremonies. Their enthusiasm was shared by doctors and patients. Joanna told several doctors from Bolivia: "The important thing is for my baby to be comfortable. With this project, I always have him with me. You feel good keeping them close to you."



Photo credit: Molly Miller-Petrie, MCHIP/PATH

¹¹ Neonatal Alliance. Advancing in Newborn Health Through Alliances. 2009

¹² Reducing Neonatal Mortality and Morbidity in Latin America and The Caribbean: An Interagency Strategic Consensus. 2007

At right, Kangaroo mother Cesarina Estrella and her daughter Edy Jania Estrella sit with MCHIP Newborn Health Advisor Dr. Goldy Mazia at the opening ceremonies. Cesarina told the audience: “The Kangaroo Mother Care program is a program of love, caring and compassion for us mothers. I tell other mothers in my situation to join this program so that they too can feel the great care that it provides for mothers and their babies.”

To learn more about KMC, please visit the Kangaroo Foundation website. A nonprofit foundation and pilot center in Bogota, Colombia, the Kangaroo Foundation acts as a model for other KMC programs in the country and abroad.

At right, Kangaroo mother Cesarina Estrella and her daughter Edy Jania Estrella sit with MCHIP Newborn Health Advisor Dr. Goldy Mazia at the opening ceremonies. Cesarina told the audience: “The Kangaroo Mother Care program is a program of love, caring and compassion for us mothers. I tell other mothers in my situation to join this program so that they too can feel the great care that it provides for mothers and their babies.”

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SMART Project: Improving Maternal, Infant and Young Child Nutrition to Reduce Stunting

by: Rae Galloway, MCHIP Technical Director for Nutrition

On a recent visit to the Sharqia Governorate in Egypt, Team Leader Amani Saleh supervised training now taking place under the USAID-funded MCHIP project called SMART. SMART works through community development associations in Upper and Lower Egypt, training physicians and community health workers (CHWs) to improve newborn care, nutrition, and the use of modern family planning methods.

“In Sharqia,” Ms. Saleh points out, “half of children younger than five years of age are stunted (low height for age) in their growth due to poor nutrition during the first 1,000 days of life.” To reduce stunting, SMART is focusing on interventions and messages to improve maternal diet, including promoting the consumption of iron-folic acid supplements during pregnancy, increasing rates of exclusive breastfeeding in the first six months of life, and improving complementary feeding practices with continued breastfeeding in children 6-23 months.

Amani Saleh was impressed with the enthusiasm from physicians and CHWs about the new information they were receiving. One CHW commented: “We had no idea that stunting was a problem in our children and that the major cause is inadequate infant and young child feeding.” Physicians also commented that they were surprised about the prevalence, consequences, and causes of stunting.

Physicians and CHWs will take this new information back to their communities and work with mothers, fathers, and other family members to improve their nutrition by using new maternal, infant and young child nutrition behaviors.

MCHIP Helps Egyptian Hospital to Improve Emergency Care for Newborns

May 2012, Bahir Dar—After resuscitating an asphyxiated newborn and seeing the joyful face of the baby’s mother, Ethiopian Pediatric Nurse Agernesh Alem was inspired to increase the quality of care at Feleghiwote Hospital where she works.

At 34-years-old, Agernesh heads the pediatric ward at the Feleghiwote Hospital in northern Ethiopia. She is the daughter of a school teacher, and came from a family that valued her education, eventually graduating from the University of Gondar as a health officer.

In July 2011, Agernesh was selected by the hospital to participate in MCHIP’s essential newborn care (ENC) training, a new approach to strengthen newborn health. Due to her high performance in the training, she was chosen by MCHIP to be an instructor for future ENC courses. And thanks to these opportunities—as well as MCHIP’s ongoing support—Agernesh and her ward are now equipped with baby resuscitation equipment and a staff that is capable of providing essential life saving techniques and managing the newborn intensive care unit and pediatric ward to a higher standard.

Most importantly, as the quality of service provision increased, so did the health of the 20-30 newborns coming to the ward each month. One such baby, who arrived in January 2012, was barely breathing and suffering from hypothermia. Agernesh recalls the family’s condition: “They were hopeless. They had given up on their baby’s life.” She and her colleagues immediately brought the baby into the newborn intensive care unit, began resuscitating the baby, and kept it warm through skin-to-skin contact with the child’s mother—a technique Agernesh learned in the MCHIP training known as Kangaroo Mother Care.

“The baby recovered, and I’m certain if this had happened before the training, we, the health providers, would have been just as hopeless as this family,” she said. As the head of the ward, Agernesh has made sure that all of her colleagues are trained on newborn resuscitation and other ENC techniques.

“One day, while walking in town, I crossed paths with the family whose daughter I had resuscitated,” Agernesh added. “The mother called me ‘sister’ and, when I turned, she said ‘you saved the life of my daughter.’”



Nurse Agernesh Alem cares for a premature newborn in the ward’s intensive care unit.

Family Planning Encourages Healthy Timing and Spacing of Pregnancies in Ethiopia

6 August 2012

"A mother needs to have time and money to provide appropriate care for her children." - Abdela Abdosh

Shashemene, Ethiopia—In March 2012, a 30-year-old mother of seven arrived at the labor and delivery unit of the Shashemene hospital in southeast Ethiopia with intense labor pains. After her eighth child was born and the nurse brought the baby to the mother, she turned her head away and sobbed silently.

The midwives on call were worried and confused; most had never seen this happen before. The mother explained that she had no means to care for her newborn child. She described how tragic it was to add another soul a family, all the while knowing that she could not afford to feed and support the baby, and said that her other seven children had never set foot in a classroom, instead spending their days toiling on neighboring farms. "If only I could have prevented this pregnancy," she lamented.

Abdela Abdosh, a midwife in Shashemene hospital, listened to the mother with empathy, understood her concern, and provided counseling and a family planning method of her choice.

"I always feel empty when I remember that mother. She wanted to use family planning before she came to us, but could not get any. Her story tells me how late we are. It also reminds me of the presence of millions of mothers out there that share her story," he recalls.

Abdela more than likely prevented the birth of her ninth, tenth and, perhaps, eleventh child. For the next 12 years, the mother will be safe from unwanted pregnancy through the use of a postpartum intrauterine contraceptive device (PPIUCD).

Twenty-three year old Abdela has worked in the Shashemene hospital for the last two years. He was born to a farmer in Bale in southeastern Ethiopia, and he himself comes from a family of 11 children. Today more than ever before, he believes Ethiopian postpartum mothers are interested in using modern family planning methods.

"The memory of labor pain is still fresh in newly delivered mothers, and they don't want to become pregnant at least within a short period of time. The postpartum period is one of the best opportunities to counsel them on postpartum family planning (PPFP). I don't think any health professional should miss that opportunity," he says.

Abdela's awareness is in part due to training received from MCHIP. The PPFP and PPIUCD training provides easy to use techniques for PPIUCD insertion and

effective counseling methods. In addition to the training, MCHIP provided the hospital with two sets of PPIUCD insertion kits, aprons, gloves, drapes, chlorine solution, soaps and infection prevention buckets.

Today, Abdela provides PPFP counseling for all mothers who deliver at Shashemene hospital and has trained his fellow midwives in the skills he learned from MCHIP. In the one month since the training, the midwives have inserted 10 PPIUCDs.

Despite counseling, many Ethiopian mothers have misconceptions about IUCDs, believing them to damage the body and cause long term side effects. Abdela and his team work hard to dispel these myths and to encourage mothers to share correct information with their neighbors.

To increase uptake of family planning methods among postpartum women more effectively, Abdela continues to orient his colleagues, strengthen linkages with other departments of the hospital (particularly the antenatal care unit), and organize periodic meetings among relevant staff to discuss the progress of PPFP program implementation in the hospital.

MCHIP began its program implementation in Ethiopia in 2010 and started training on PPFP in 2012, during which a total of 47 nurses and midwives were trained on PPFP counseling. Of these, 18 went on to attend a four-day training on PPIUCD insertion techniques. The program is currently being implemented in 16 health facilities in Ethiopia.

"I am grateful to MCHIP for the training that allowed me to share that mother's pain and respond properly. I hope to do the same for many more mothers," Abdela says proudly.

Helping Babies Breathe Training Improves Teaching Skills in Ghana

At 35 nursing, medical assistant, and midwifery schools in Ghana, MCHIP is strengthening the skills and competencies of tutors and their students. The Program is training these teachers and future providers in current best practices for HIV/AIDS, tuberculosis, malaria, family planning, and newborn resuscitation, while also addressing issues of stigma and discrimination. In addition, MCHIP is working with targeted midwifery schools to equip their skills labs, strengthen tutors' skills and competencies in basic emergency obstetric and newborn care, and improve preceptors' clinical skills and teaching competencies.

In July, 17 tutors from 10 community health nursing schools came together for a Helping Babies Breathe (HBB) training to improve their ability to teach HBB skills, such as newborn resuscitation and essential newborn care to their students. A pre-test was conducted to assess both knowledge and skills, with results showing an average knowledge level of 75% and indicating a strong knowledge of HBB among the participants. However, the skills assessment revealed low competency (54% in practice) due to the participants still using outdated skills such as suction of every baby, holding babies upside down, and using methylated spirit on babies to stimulate breathing.

After presentations, demonstrations, and coaching and practice sessions using the NeoNatalie newborn simulator, there was remarkable improvement in both post-course knowledge and skills assessments. Knowledge increased from an average of 75% to 85%, and skills increased dramatically—from 54% to 87%.

And the words of participant summarized why these trainings are so important. As soon as she gets back to her station, she said, she is going to retrain her students on what she had taught three weeks before the training, using her newly acquired knowledge and skills.



Newborn resuscitation simulation using the NeoNatalie anatomic model during MCHIP HBB training.

Guinea: Family Planning Success Story

Family Planning Success Story 1

Madame Delamou is 34 years old. She has given birth to six children. Her youngest child is six months old. Her husband works as a mason. The couple lives in the Gbama II neighborhood of Nzérékoré. Delamou received a free Jadelle® implant during a training for service providers organized by MCHIP/Guinea in the Nzérékoré prefecture. After receiving the implant, her husband said,



“We learned about family planning by listening to a rural radio station in Nzérékoré. We found out about this training and the offer of this new method. We said to each other that this was an opportunity we shouldn’t miss. That’s why I decided to accompany my wife when she received this family planning method—the implant. Our only motivation is that we no longer want to have another child because the cost of raising a child is enormous. I am only a simple mason. We just get by.”

Family Planning Story 2

Madame Théa is a young woman 19 years old. She is a housekeeper and she lives in the Tilepoulou neighborhood of Nzérékoré. Her husband, who is 32, was trained as an engineer. He is currently unemployed. The young couple has a 13-month-old daughter.

After hearing messages about family planning on the radio, the couple decided to use a family planning method. The radio program was supported by MCHIP/Jhpiego. The key messages focused on family planning and birth spacing, with a particular emphasis on the use of IUDs as a long-acting family planning method.

Madame Théa’s husband had this to say: “I opted for birth spacing due to the fact that I am responsible for paying household expenses, my wife is illiterate, and I am unemployed. Family planning is beneficial



for the children because each one will know who is the oldest and my wife will be able to accompany me to cultivate rice in the fields.”

The radio programs encourage men to discuss family planning with their wives. This point is very important because contraceptive prevalence is higher when men are involved in the decision-making process.

Family Planning and Maternal Health Success Story 3



Madame Camara is a 35-year-old housekeeper and wife of a farmer. Her family lives in the Mohamed V neighborhood of Macenta. She has five living children. One of her children is deceased. Camara recently gave birth to triplets—all girls—at the Hermakono health center. After the

birth, she was counseled on long-acting family planning methods and she received a postpartum IUD. Camara expressed herself by saying,

“When the labor pains started last night, I called my doctor to come examine me. She directed me to the Hermakono health center where she works. I already have children in my care, I was not expecting triplets, and my husband is in Liberia. When the doctors asked me if I wanted to have other children, I told them no. For me, triplets are another responsibility and I want to rest for at least five years. After being counseled on various family planning methods, I chose to use the PPIUD—a method I wasn’t familiar with before.”

The urban health center in Hermakono is supported by the MCHIP/Jhpiego project where the SBM-R approach was integrated a year ago. Today, the facility’s providers are trained in EmONC and long-acting, reversible family planning methods (IUD, PPIUD, implants, etc.).

Story 4: Community participation in provision of EmONC at the Rural Health Center (CSR) of Kalinko-Dinguiraye

Kalinko is a subprefecture of 40,723 inhabitants. It is the site of a rural health facility located 75 kilometers from the administrative center of the Dinguiraye prefecture, where the referral hospital is located.

The SBM-R process was initiated at the Rural Health Center in September 2010. The facility has completed the training modules and is a candidate for recognition of its performance in family planning, EmONC, and infection prevention.

The SBM-R process, which identified current gaps and ways to address them, allowed the Kalinko community to:

- Repair a well that had been broken for more than three years, thereby improving access to water for the health center and the neighboring population
- Invite expatriates living in Angola to donate an ambulance to the health center, citing the example of the Fodécariah district (which donated a motorcycle-ambulance to its health post) for inspiration

Madame Aminata Cissé, a housekeeper in Kalinko, said, "The arrival of the ambulance is a huge relief, for the women of my community in particular, because if our children become sick or our sisters have complications during childbirth that require care at the Dinguiraye hospital, we no longer have to worry about transportation. It was not always easy before. We had to wait for the hospital's ambulance or borrow a vehicle from the weekly market. For that reason, we bless the health agents from Kalinko and the Health and Hygiene Committee (which represents the community) who initiated this idea. Above all, we bless our sons who are in Angola."



Today this ambulance transports women who have been referred for emergency obstetrical care and other patients to the Dinguiraye hospital regularly and without delay.

An Auxiliary Nurse-Midwife in India Sets an Example for Family Planning

by: Minati Rath and Indrani Kashyap

Majra, India—Seema Verma is on a mission. An auxiliary nurse-midwife at the Majra Urban Health Center in the hilly state of Uttarakhand, India, the 32-year-old mother of two daughters wants to help other women make an informed choice about family planning services just as she was able to do.

“I want to pass on the same hope and possibilities to other women in my community,” she says.

When she was pregnant for the second time and looking for a viable, long-term family planning method to limit future pregnancies, Seema received counseling by a visiting team from the U.S. Agency for International Development’s global flagship Maternal and Child Health Integrated Program (MCHIP).

The Majra facility is one of 20 health care centers established in the urban slums of Uttarakhand by local nongovernmental organizations as part of a public-private partnership with the Uttarakhand government. MCHIP, which is providing technical assistance to the project, set up the family planning services as a part of an integrated program of maternal and child health and nutrition services for the urban poor. As part of its work, MCHIP, with the help of Jhpiego experts, is focused on ensuring quality family planning services at these urban health centers, as well as revitalizing postpartum family planning and postpartum intrauterine contraceptive device (IUCD) services in the state.

The team that counseled Seema explained the importance of using contraceptives after delivery to delay or prevent the next pregnancy, and told her about the copper-bearing IUCD, which can be inserted within 48 hours after delivery. The MCHIP team also informed her and the rest of the Majra staff about facilities where they had trained doctors to insert postpartum IUCDs. As a result of this counseling, Seema chose to deliver her baby at Women’s Hospital, Dehradun—an MCHIP intervention site—so that she could get an IUCD immediately after the birth of her daughter, Ritika, who is now three months old.

For Seema, an IUCD was the best family planning choice because it was free under government policy, lasts for 10 years and could be inserted while she was still in the hospital. Moreover, she appreciates that she doesn’t need to remember to take an oral pill every day.



Seema Verma (right), mother of two, champions family planning services after receiving help from an MCHIP team visiting health facilities in the state of Uttarakhand.

“I got the IUCD inserted immediately after delivery of my second child and am leading a tension-free life. I know I can take good care of my husband and my children,” she said.

Seema was so enthusiastic about her family planning decision that while resting in the postpartum ward, she successfully counseled two other women who were sharing the room with her. They, too, chose to have an IUCD inserted.

Said one woman, named Sita, “I found the IUCD insertion hassle-free and quite painless. I’m now free from the burden of unwanted pregnancies. I can do my work well and focus on looking after my family.”

Seema not only feels strongly that other women in her community can benefit from this method of family planning, she is also optimistic that it offers a promising future for her own two daughters. One of four children in a poor family, Seema struggled to finish her schooling and became the most educated member of her family.

“I want my daughters to study more than me,” she said. “My husband and I want to work hard to make this possible.”

“Now I Know”: Women in Indonesia Crowd Classes on Healthy Pregnancy and Child Care

Abdul Jabbar, Field Officer, MCHIP Serang

Like the previous months, the pregnant women’s class activity in Posyandu Melati was always crowded with women both pregnant and those who had babies. This activity seemed to be a favorite in this posyandu. It was not surprising that participants in the class always exceeded capacity and had to be divided in two, and even then it was still too large for the ideal class size (12–15 people). The monthly report showed that the number of participants reached 42 women!

Of the many participants, one participant attracted my attention. She came with her 40-day old baby. It seemed she was a frequent visitor. She was Mrs. Sanah, 42-years old, wife of a driver who transported vegetables. She lived in Wadas Cikiray, Sindangsari village. Her house was approximately 2 km from the place where the class was held.

“She was one of participants who diligently attended the pregnant women’s class. She joined the class since she was pregnant with her third child,” said the village midwife.

While waiting for the other participants to come, I approached and talked with Mrs. Sanah to know more about her and her motivation to attend the class.

She said she had learned the information about the pregnant women’s class when she had her antenatal care visit at the posyandu seven months ago. At first, it crossed her mind that the activity would be the same as the education package she once completed to get a high school diploma. She asked a cadre, who explained to her that it was not like school. The pregnant women’s class turned out to be fun.

“I become more curious, sir. Sure enough, it was a very fun class, not only for me but all women were happy. Other than learning a lot about pregnancy and baby care, I also learned about exclusive breastfeeding and handwashing with soap. Now I know why the nipples of lactating women are often sore; it’s because the way she nurses that is wrong,” she recounted from her learning in the class.

She admitted that her knowledge from the class was applied during her last pregnancy. Mrs. Sanah tried to do what she learned, including the exclusive breastfeeding, when her third child was born. For her, the pregnant women’s class was a blessing.

“Through this activity, I now know all about how to be a good mother, and I became an active family planning user. It is very useful, not only for me but also for my family,” she said.

Now she was not only an active participant in the pregnant women’s class, but she also did not hesitate to invite other women she knew to join.

“Come on ladies, join the class. You will get many benefits,” said Mrs. Sanah when she invited other women to come along with her to the class.

Offering Services the Integrated Way: A Nurse in Kenya Overcomes Challenges

by: Nancy Kidula and Jacqueline Nyagah

Evelyn Otiwa, a nurse in Kenya, has been working at Bondo District Hospital's maternal and child health (MCH) clinic for about a year. Initially, she was stationed in the maternity ward, but now is in charge of the MCH clinic that offers services including family planning (FP), nutrition and immunization.

When Evelyn began working at the hospital, she was faced with numerous challenges. One of the biggest issues was the high number of "defaulters" and how to trace them. Defaulters included women who did not attend the required four antenatal clinic visits, those who initiated FP but did not continue with the services, those whose children failed to complete their immunization schedules, and those with malnourished children who did not follow through with the management protocols. But when MCHIP came in and began addressing these issues holistically, Evelyn knew she had a partner in health care.

Evelyn attended an orientation offered by MCHIP on integration of Maternal Infant and Young Child Nutrition (MIYCN) and FP. During the orientation, service providers were trained on offering integrated FP and nutrition counseling, and on services that maximize the opportunities to access and increase coverage of both services.

Although the project is still in its initial stages, Evelyn is already observing significant changes: "More women are now attending the clinics and accessing these services thanks to the follow-up from the CHWs [Community Health Workers]." These CHWs conduct home visits and refer women to nearby clinics for health services.

The MCH/FP clinic conducts daily health talks as a way of enhancing community awareness on key interventions or issues affecting the health of mothers and children in the community. These are usually conducted first thing in the morning in the triage area, where clients congregate before being sent to their service of choice.

"To illustrate the methods of FP as well as show how one should be eating a well-balanced diet, we use the counseling flip charts [counseling card for community health workers] provided by MCHIP and give some information brochures in the local language (dholuo) for the clients to take home with them," she says. And while each day has a specific health topic, the FP/MICYN health talk is given every day.

But even though MCHIP has brought welcome relief through capacity building and the provision of counseling tools and job aids, challenges remain. Some mothers have doubts about the effectiveness of the Lactational Amenorrhea Method (LAM)—a temporary contraceptive method that can be used after childbirth. "We offer further education to those who may have misconceptions," she says. As a result, there has been an increased uptake of this method with benefits both for mothers and babies, as LAM supports mothers to exclusively breastfeed their infants for the first six months.

Evelyn has also noted that women are averse to invasive procedures such as intrauterine contraceptive device (IUD) insertions and cervical cancer screening. And there are myths and misconceptions around FP methods. For example, she reports: "There are women who believe that the coil [from an IUD] can be dislodged and move around in the body, or that using any FP method leads to having an abnormal child. We educate these women more to ensure that they do away with these beliefs." MCHIP has provided the health worker with a publication and training on how to address these myths and misconceptions.

Despite the challenges, Evelyn is happy about the support and encourages MCHIP to continue empowering service providers and the community as a whole, and strengthening provision of integrated services.

Male Circumcision Takes Off in Lesotho with 6,960 Surgeries Performed

by: *Virgile Kikaya, MCHIP/Jhpiego*

20 November 2012

The 22-year-old man had been waiting all night – sleeping outside in the freezing cold of Lesotho’s harsh mountain winter – and was now next in line to receive voluntary medical male circumcision (VMMC) services at Scott Hospital in Morija, Lesotho. He knows that getting circumcised reduces the risk of acquiring HIV, something that Lesotho, with a 23% HIV prevalence, desperately needs.

This young man’s determination to access VMMC services is becoming a common occurrence in Lesotho, where young men queue for services being rolled out and provided to clients at no cost in district hospitals with the support of the Lesotho Ministry of Health (MOH). The VMMC program in Lesotho was launched in March 2012, an effort funded by the United States President’s Emergency Plan for AIDS Relief through USAID and implemented by MCHIP.

In contrast to other countries, where rapid scale up of VMMC services has encountered problems due to lack of demand, cultural sensitivities, or insufficient integration with existing health systems, the Lesotho MOH and MCHIP/Lesotho’s step-by-step approach is already reaping rewards. Providers are seeing no drop in demand: between March and September of this year, the program performed 6,960 circumcisions!

To get the activities started, a two-week training in February updated Lesotho MOH staff on the WHO/UNAIDS/Jhpiego manual on Male Circumcision under Local Anesthesia. After this training period, service provision was organized by the MOH and MCHIP and initiated two days of every week. In April, the second training course took place, with two other hospitals prepared to provide services by early May. The program is currently operating in four hospitals.

Much of the program’s success is due to the strong leadership of the Lesotho MOH, as well as MCHIP working with—rather than apart from—the existing health system. MCHIP has also respected the cultural norms that surround circumcision, including its role in initiating Basotho males into adulthood. Knowing this, MCHIP was clear from the start that the VMMC program must be led by the MOH, and held preparatory meetings with traditional leaders to ensure that appropriate messages about the program were communicated.

VMMC uptake in Lesotho has the ability to change the course of the epidemic: modeling shows that just five male circumcisions will avert one HIV infection and save millions of dollars in care and treatment. The challenge now remains to keep demand for VMMC services high, and to ensure that VMMC becomes fully integrated into the national HIV prevention plan.

How MCHIP is Using Regulation to Strengthen the Nursing Workforce in Lesotho

Alice Christensen and Laura Skolnik, MCHIP/Jhpiego

14 November 2012

When we think about strengthening the nursing workforce in Lesotho, our first thoughts generally focus on technical updates or clinical training, not developing policy and regulation. So how does regulation work as a mechanism to strengthen the professions of nursing and midwifery? Do we really know what regulation is?

Regulation refers to the legal instruments that impose obligations or constraints on private sector behaviors; this can include constitutions, legislation and licensing. Regulation allows society to work better. Similarly, regulation of nurses and health care systems allow them to be safe, successful and, more importantly, protect the safety of their patients.

The Lesotho Nursing Council (LNC) was legally established in 1966, the same year the Kingdom of Lesotho acquired independence from British rule. The council is mandated to regulate nurses and midwives through legislation and regulatory policy-making to assure the public's safety. MCHIP has been working with the LNC since 2010 to strengthen the organization to better regulate service and keep the public safe.

One of the functions of the LNC is to make sure all nurses in Lesotho are licensed and registered. This guarantees that each nurse has the necessary qualifications. The nursing registrar is in charge of making sure that all 1,200 nurses in Lesotho are licensed and registered. In order to determine if someone was licensed, the LNC used to have to sift through mountains of paperwork to find each nurse's license. MCHIP has worked closely with the LNC to develop an electronic database of all nurses in Lesotho. This is vital, as now the Registrar can quickly look up a nurse to see if he or she is correctly licensed and qualified to work in a hospital or clinic.

MCHIP has also supported the LNC in creating a five-year strategic plan to outline specific regulatory activities that will strengthen the nursing profession. One activity is the development of standards for the nursing schools, including making sure the curriculum is up-to-date and that nurses are receiving adequate clinical and didactic training.

These standards will guarantee that each student receives a high-quality education so that they are ready to join the nursing workforce. The LNC will visit each nursing school in Lesotho and work with them to review the identified standards. MCHIP will also continue working with the LNC to operationalize their strategic plan.

Although regulation may not be the first line of thought when we think about strengthening the nurse workforce, it is a vital "behind the scenes" activity that contributes to the development of the profession.

Men Queue for Voluntary Medical Male Circumcision at Facilities in Lesotho

29 March 2012

I cannot believe that in one day I have been tested for HIV and been circumcised – it is just incredible. – young man in his mid-20s (paraphrase).



Line of men waiting to be circumcised. Photo courtesy of Jhpiego.

The young man had just finished waiting hours for his turn to be circumcised at Mafeteng Hospital, one of the facilities now offering voluntary medical male circumcisions (VMMC) in accordance with the national guidelines and policies of Lesotho. MCHIP has been working closely with the Ministry of Health & Social Welfare (MOHSW) for the past year in order to mutually develop a gradual, facility-based scale up of VMMC services at government and private facilities across the country with the purpose of reducing the incidence of HIV infections among men.

MCHIP's first "Male Circumcision Under Local Anaesthesia" course was conducted under the leadership of the MOHSW in February in order to build capacity of four teams (4 doctors, 10 nurses, 4 counselors) from two medical facilities (Scott and Mafeteng Hospitals) to safely provide VMMC services to eligible men. Following four days of classroom-based theory and practical demonstrations, the teams went to their respective facilities for six days of clinical practice.

Upon arrival to the hospitals, the teams found an unexpectedly long line of men awaiting the free VMMC service. That first day, the dedicated teams in training refused to stop for lunch and worked late into the evening to ensure that no client was turned away. The following days of clinical practice continued to bring lines of men, so that approximately 250 men were circumcised at the two facilities during the six days of training.



A trained doctor with MCHIP's MC technical advisor preparing the theatre. Photo courtesy of Jhpiego.

This turnout allowed the four teams the clinical practice necessary to become competent in providing VMMC services. This interest in services also indicates that with demand generation efforts in line with the MOHSW's communications plans there is the possibility for continued expansion of VMMC services. MCHIP plans to continue to support these facilities and continue working in close association with the MOHSW. With further funding, MCHIP will train additional VMMC teams and scale up VMMC services to facilities across the country.



One of the trained nurses preparing supplies. Photo courtesy of Jhpiego.

Taking Action to Strengthen Family Planning Service Delivery in Liberia

by: *Chelsea Cooper and Holly Blanchard*

Bong County, Liberia—During a routine immunization visit for her infant at Phebe Hospital, a mother listened intently as the vaccinator shared information vital to the woman's health. Mothers who delay pregnancy for at least two years after giving birth are better able to care for themselves and their families, the mother was told.



Vaccinator sharing family planning information during a child's immunization visit, an example of integrating maternal health services. (Photo by C.Cooper)

Interested to know more, the woman was referred that day to family planning services where she met midwife Anna Flomo.

At 41, this mother had been pregnant 10 times, given birth to eight children and had seen seven survive. As Flomo counseled the woman on the family planning methods available at the hospital, the mother knew she didn't want to be pregnant again. The woman chose a tubal ligation, expressing relief that she wouldn't have to face another unwanted pregnancy.

More than half of the women who brought their children for vaccinations on this day sought family planning services, following a conversation with a vaccinator. For Flomo, this was her first opportunity to provide such family planning education and counseling in an integrated service setting since attending a capacity-building workshop on this innovative approach.

Phebe Hospital is among 10 health facilities in Liberia where the Ministry of Health and Social Welfare has integrated family planning with routine infant immunization services through the U.S. Agency for International Development's global Maternal and Child Health Integrated Program (MCHIP), led by Jhpiego. Supported by MCHIP, the ministry embarked on this pilot project to address Liberian women's unmet need for family planning, build skills among health providers and strengthen the country's health system. MCHIP partners, Jhpiego and JSI, participated in this work.

The latest Liberia Demographic and Health Survey (DHS 2007) reported contraceptive prevalence among married women at 10.3 percent for modern methods, a total fertility rate of 5.2 and a maternal mortality ratio of 994 per 100,000 live births, one of the highest in the world. According to an MCHIP analysis of Liberian health data, 82 percent of Liberian women who are within two years of giving birth report an unmet need for family planning services.

An integrated approach to meeting this need is not only innovative, but has shown promise in other countries. Through routine child immunizations, caregivers have multiple contacts with mothers in the year after birth. These frequent contacts present a clear opportunity to reach women with family planning services while they are already at the health facility.

Vaccinators provide a few short, targeted family planning messages to mothers during routine immunization visits. For women who express interest in learning more about family planning options on the same day, vaccinators provide referrals to nearby services. Targeted job aids and information, education and counseling materials have also been developed to support the process of integrating services.

MCHIP began working in Liberia in 2010 to strengthen family planning services. It is part of Jhpiego's ongoing efforts to help countries build the capacity of health workers to deliver skilled and comprehensive care, strengthen health systems and innovate to save lives.

One of the facilities where MCHIP is working is Redemption Hospital, the largest free maternity hospital in Liberia, located in an urban slum of Monrovia. When MCHIP first began working there in 2010, the midwives required clients to show proof of current menses to rule out pregnancy before starting them on a modern contraception. This mandate undermined women's ability to obtain contraception.

Vicky Youqui and Anita K. Kollie, midwives at the Redemption Hospital's family planning clinic, participated in capacity-building family planning workshops, sponsored by MCHIP/Jhpiego. During these sessions, they learned about effective counseling skills, provision of long-acting methods, infection prevention practices and postpartum family planning. They now know how to be reasonably sure that a woman isn't pregnant by asking her six simple questions. And they have seen success.

To highlight the hospital's achievements, Youqui proudly showed an MCHIP trainer the family planning register. Between October 2011 and January 2012, she and Kollie have seen an average of approximately 1,100 clients per month. Kollie shared the reaction of one of many clients to whom she provided a long-acting contraceptive implant.

"The woman really appreciated the care, saying that she had an [unsafe] abortion and promised herself that she would never do that again. Now she can breathe easy."

Newly Trained Health Workers in Mali Spread Messages to Larger Communities

14 March 2012

Modibo Coulibaly and Fouleimatou Soucko are proof that trainings can have an enormous impact on the health of a community.

A nurse for more than five years in the area, Modibo is now the head of the Health Center in Niagane, a town in the Kita district. When he was promoted to Director, he was encouraged to participate in trainings on various topics, but rarely found them useful. When an invitation to an MCHIP training came, he felt sure it would be another routine training, without any new tangible knowledge or skills gained.

Modibo was happily surprised. During the training, he watched as MCHIP staff used an innovative approach, combining theoretical and practical courses with an emphasis on practice in the local context. His enthusiasm grew. By the end of the training, he was one of the participants with the highest improvement rates.

Modibo returned to Niagane and initiated a meeting with his peers to inform them of trainings he planned on a number of important health topics. To spread these messages further, he also organized an advocacy day with local authorities, religious leaders, community members, and women leaders, asking them to help promote postpartum family planning (PPFP) and healthy timing and spacing of pregnancy as part of the solution to saving mothers' lives.

In response to his campaigning, an Imam now organizes two sermons on FP/PPFP every Friday. And because Modibo's trainings include people outside of the formal health system--such as community health workers (CHWs)--these crucial behavior change messages are reaching both the facility and community levels.

One such CHW is Fouleimatou. A dynamic young woman, Fouleimatou was recruited to be a CHW from her village of Makana Bamaman, where she had been working for more than three years in community health promotion activities, including FP. Fouleimatou was trained with MCHIP support, during which she asked for more information on community mobilization.

After the training, she returned to her village, where she used her new knowledge and skills to mobilize men and women around FP services. She organized a meeting with both men and women, and set up a support group. Seeing her initiative and motivation, the Village Chief decided to support her work by providing her with equipment and building her a space where she now receives patients.

As a CHW, Fouleimatou counsels several women per week and refers them to larger and better equipped health centers, when needed. And as part of a women's social group, she also shares healthy behavior messages with an emphasis on PPFP during their weekly meetings.

Journalists Visit MaMoni Sites, Report on Improvements in Maternal and Newborn Health

by: Areba Panni, MCHIP/Bangladesh

25 September 2012

In mid-September, 20 selected journalists from local media were invited by the MaMoni project to visit five Upazilas (sub-districts) in Habiganj, Bangladesh, where work is underway to improve maternal and newborn health outcomes. MaMoni staff were on hand and proud to showcase the project's work.

The MaMoni project—USAID's associate award to the MCHIP Program, which is implemented by Save the Children in Bangladesh with local nongovernmental organizations FIVDB and Shimantik—is an integrated safe motherhood, newborn care and family planning project. Since 2009, MaMoni has engaged and mobilized the community by providing a large fleet of more than 12,000 community volunteers (CVs). These CVs are selected from and by the community and facilitate nearly 4,000 community action groups (CAGs) in Habiganj and Sylhet Districts to improve health seeking behavior of the mothers and community people.

Through this initiative, MaMoni has developed a unique platform for coordination among first line field workers, supervisors from health and family planning departments, and community volunteers to meet, update their records, fill gaps in service, and disseminate key health messages. This community microplanning (CMP) process creates an effective interface between the community and formal health systems, resulting in increased accountability and efficiency.

The journalists visited five sub-districts of Habiganj (Baniachong, Ajmiriganj, Lakhai, Madhabpur and Chunarughat) and had an opportunity to see CAG and CMP meetings in progress. They saw first-hand how empowered and proactive community volunteers and health workers (GO-NGO) work together and lead the process at the grassroots level, ultimately contributing to the formal health system to improve maternal, neonatal health and family planning outcomes. They also met with the local government Chairmen and were informed of how local leaders play a role to reach the same goals.

The reporters then visited the three renovated Union Health and Family Welfare Centres (UH&FWCs)—Murakuri, Kakailseo and Shibpasha. These existing government health facilities had previously only provided outdoor services; however, in October 2011, MaMoni renovated and upgraded the facilities for 24-hour safe delivery services. The visitors met with staff at the centers and had an opportunity to talk to the mothers who delivered that day. They expressed their relief and joy to have delivered their babies in the attendance of skilled providers.

The reporters were particularly impressed with the water ambulances at Lakhai, Baniachong and Ajmiriganj that are being used to provide satellite services in remote "haor" areas (wetlands), as well as for emergency referral to Habiganj Districts. The reporters took notes, interviewed service providers and beneficiaries, and recorded footages during the trip.

They visited the homes of the mothers who delivered babies at Murakuri and Shibpasha UH&FWC; these babies are particularly popular at MaMoni, having been the 100th and 200th safe deliveries at the facilities. The mothers and babies looked very well and the mother from Shibpasha said that her son, Hasan, was due for an immunization the next day.

From four different locations in a span of two days, Radio Today (a partner of Voice of America) broadcast live interviews with service providers—a health assistant, family welfare assistant, family welfare visitor, and community skilled birth attendants—as well as a beneficiary from the field.

MaMoni hopes to instill ownership and responsibility within the media to champion the project's causes in order to reach a wider audience. Already, reports of the visits have been posted in some Habiganj local newspapers and in an online news source read by Bangladeshi's all over the world. More media coverage is expected, and reporters are still calling the Dhaka and Habiganj MaMoni offices in the quest for more data and information as they are in the process of preparing their stories.

The journalists from Dhaka represented Channel I, The Daily Star, bdnews24, The Independent, Daily Sangbad, ABC Radio, and Radio Today; those from Habiganj represented Dainik Habiganj, Habiganj Samachar, bdnews24 Habiganj, Daily Independent, Channel I, ATN Bangla, Desh TV, ETV, Dainik Dinkal, Habiganj News24, and Habiganj Kaler Kantho.

During the debriefing with the media, Zannatul Bakiya, Senior Staff Correspondent from Channel I said: "I am impressed to see how the female community volunteers are empowered in the communities. There must be a way to sustain them even when the program is over."

Dr. Tareq Salahuddin, Editor of "Star Health," The Daily Star's Health section, added: "Star Health supports the cause to promote maternal and child health." (The Daily Star is the most widely circulated English language newspaper in Bangladesh.)

This was only the first visit organized for the media. MaMoni staff plan to keep the media involved in hopes of having them tell the stories of mothers and their babies, of the efforts of service providers and volunteers, and to inform the public of the gaps needing to be addressed to improve maternal and newborn health outcomes in Bangladesh.

Implementing a Quality Improvement Approach and Achieving Behavior Change in Mozambique



"Dear Colleagues, if we do not know these standards, we are not yet in the MMI, we must learn."
– Ruta Massunguine, the MCHIP-supported MCH nurse.

Applying the Standards-Based Management and Recognition (SBM-R) quality improvement approach in Model Maternities and cervical cancer prevention health facilities in Mozambique has been a challenge. The health workers shoulder a heavy workload and there is resistance to implementing a new methodology or approach.

To address this issue, Ruta Massunguine, the MCHIP-supported maternal and child health provincial nurse based in Inhambane Province, has been steadily working to advocate to her colleagues for the implementation of SBM-R in the health facilities. In order to stimulate behavior change and adoption of the SBM-R approach, she has provided ongoing encouragement to her colleagues and is working to create conditions that enhance motivation to implement the performance assessment tool, as well as showing the advantages of applying this approach.

As a result of her efforts, health workers in the Inhambane Model Maternities have shown increased interest and attention to measuring progress in their health facilities. During the last staff meeting—in September 2012—health workers requested the SBM-R assessment tools to understand the importance of performance assessment within the Model Maternities Initiative. They also began conducting internal SBM-R assessments in their respective facilities.

Results from the Inhambane health facilities included in the MMI are starting to show the results of this increased commitment and motivation:

- Chicuque Rural Hospital achieved 51.3% of standards at their last internal measurement, compared to 26.4% at baseline;
- Homoine Health Center achieved 43.6% of standards, compared to 37.7% at baseline;
- Massinga District Hospital has achieved 31.6% of standards, compared to 26.4% at baseline; and
- Vilanculos Rural Hospital has achieved 56.9% of standards, from 42.1% at baseline.



"We are not so good and we are not so bad. The reality is that we are not so good because we will only feel good when we reach 80% of SBM-R (standards)." - Dr. Elcídio Pambo, Clinical Director of Chicuque Rural Hospital, while speaking with health workers during a recent staff meeting.

Working With Local Health Councils in Paraguay to Combat Diarrheal Diseases

by: Maria Peña

The community of Acaraymi is located 38 kilometers from the city of Hernandarias, with an indigenous population known as the Ava Guarani. At the center of the community is a family health unit staffed by Dr. Paola Aguero, Nurse-Midwife Leticia Alonso and Nurse Assistant Nelly Acosta.

One of the main health problems that Paola, Leticia and Nelly see in their daily work is diarrheal diseases caused by the community's water, which is drawn from a source that is contaminated by agricultural toxins commonly used in soy bean plantations. The Acarymi population is also at high risk of malnutrition.

In Paraguay, local health councils serve as the major link between households and facilities. Recognizing the importance that these health councils play in getting the families of Acarymi the health care they need, MCHIP works closely with these councils to identify the priorities of the community and to mobilize resources to help bring about healthy changes.

As a first step, MCHIP coordinated with the Ministry of Health and the Hernandarias Health Council to hold a forum on MNH issues, entitled *Aty ñemonguetara sy ha mitakuera tesai porave hagua* (a term in the local language of Guarani that means "meeting to talk about maternal and infant health"). Managers from the Family Health Units, known locally as the *Unidad de Salud Familiar* (USF), along with community representatives and health council members, came together at this forum to identify their concerns, establish priorities, and prepare an action plan. They concluded with the development of an action plan to be implemented with the assistance of a community-based support network.



Maria Peña meets with community members from Hernandarias to prepare a forum on MNH issues. (Photo courtesy of Jhpiego.)

Participants' main concerns included the impact of diarrheal diseases (one of the main causes of child mortality) on women, newborns and children, due to the use of water exposed to agrottoxins. Thanks to this dialogue and action planning process, authorities from the Decima Region de Salud ("Tenth Health Region") have visited the area to conduct a feasibility study for the construction of water wells to provide healthy drinking water. In addition, USF managers moved forward with training on water purification.

Meanwhile, the Ministry of Health also recognized that the Acarymi population was at high risk of malnutrition and included this community in the PANI Program (Nutrition Subsidy Program). Beginning earlier this year, all children and pregnant women have begun receiving 4.4-pound bags of milk powder every month. The day that the unit received the first load of packets of milk, a happy text message was sent to the MCHIP Community Interventions Advisor celebrating these great strides in working toward a healthier community.

As a beneficiary of PANI, the USF now needs storage room for the supplies provided by the Ministry of Health. The Health Council is providing construction materials to expand the USF facilities to provide more storage space. In a follow-up activity, a team visited the area of Independiente, one of the most remote areas in Acarymi. They used the visit to build on the activities from the forum, delivering health care services for pregnant women, providing vaccinations, doing growth and development exams for children, and holding training on water purification techniques and preparation of milk powder for at-risk populations.

The participation of key stakeholders is critical to improving health conditions for women and their families. Maternal and child health forums (like that of Hernandarias) are helping to strengthen the role of health councils in improving the health of mothers and their families in both the Centro and Alto Paraná Regions of Paraguay.

Following the successful participation of 10 family health units and community representatives in the forum of Hernandarias, there are now six additional family health units and community representatives participating in similar MCHIP forums in the area around Minga Guazu. Building on the strengths of the communities, these forums will strengthen the role of local councils and promotes actions at each of these communities.

MCHIP Trainings Demonstrate the Value of Humanizing Care in Paraguay

by: *Vicente Bataglia*

A series of MCHIP training courses for hospital staff in Paraguay has resulted not only in increased quality of clinical care in health facilities targeted by the Program, but has also influenced the views of professionals caring for women during childbirth.

At the conclusion of the maternal and newborn health (MNH) technical updates and clinical skills standardization (TU/CSS) training courses, one participant—Dr. Elba Segovia of Hospital Mariano Roque Alonso—expressed this paradigm shift well. Standing up during the closing ceremony, she spoke to her colleagues about her experience, stating that beyond the important technical updates, the training had also opened her eyes to the value of humane treatment of her patients.

“I have realized after 30 years of clinical practice that the treatment of our patients as human beings is important,” she said. “The patients arrive with anxiety and fear, wanting to be treated courteously and with support from their families.”

Dr. Segovia spoke to her colleagues about how, in the last month, she put into practice what MCHIP had taught her about humanization of care, and that the intervention was producing incredible results—a pleasant surprise she had not expected. Dr. Segovia shared anecdotes and provided striking examples of situations in which she allowed husbands to enter the delivery room and provide support to their wives, something she had never allowed before.

This simple change had transformed the picture of despair and lack of cooperation into a proactive and cooperative environment, she said, and had ended in normal deliveries with no complications. Both mother and father expressed great satisfaction with being participants in this unique birth experience.

After Dr. Segovia’s impromptu speech, many of the other participants also approached the MCHIP team to share that they had experienced similar situations in the past month, since they began working to humanize the care they provide.

As a result of the training conducted by MCHIP in Paraguay, service providers, such as Dr. Segovia and her colleagues, have begun to make changes in their workplace. The hospital environments are becoming much more pleasant and safe, both for providers and for women and their families.



Mother and baby in Paraguay. (Photo courtesy of Jhpiego.)

In Rwanda, Emergency Obstetric and Newborn Care Trainings Help to Save Live

by Beata Mukarugwiro, Christopher Mazimba, Musengente Petronille and Abayisenga Glorioso

Running a labor room or ward can be challenging, especially if it is not staffed with health care providers who have updated lifesaving skills. For this reason, MCHIP—in collaboration with Rwanda’s Ministry of Health (MOH)—has been conducting in-service emergency obstetric and newborn care (EmONC) trainings for health care providers in nine target districts. MCHIP is also providing supportive supervision visits to reinforce these providers’ competencies in providing high-quality care to mothers and newborns.



“Following the training in EmONC by MCHIP, I was able to save this mother’s life when she bled after birth because of a cervical tear that I managed to suture,” says Mukamugenga Patricie (on the right), who works in Kirambo Health Center. The trained health providers say that the EmONC training and follow up has been the key to increased competencies in health facilities within the target districts.



“Following the training in EmONC by MCHIP, we made a big change in our hospital in terms of management of obstetric and neonatal complications. Among those changes, we can name the following: The team is able to act quickly in term of initial rapid evaluation when there is an emergency, and this saves lives of women and avoids complications; active management of the third stage of labor to prevent postpartum hemorrhage is done in a systematic and timely way; the management of pre-eclampsia/ eclampsia has been improved; and we made a big improvement in infection prevention. In addition, I’m feeling confident when I’m performing different EmONC procedures like breech deliveries, manual removal of placental, vaginal laceration repairs and the like. I managed to orient the rest of my team members who have not yet been able to be trained,” says Mujawayezu Jeannette (on the left), who is a midwife working in Nemba hospital.

“Following the training in EmONC, I have really appreciated the positive change in the Helping Babies Breathe program that we made in our hospital, especially how we emphasize the readiness to deliver in order to be able to help babies who have problems to breath within the ‘golden minute’”¹³ narrates M.Claire Dushimiyimana, a nurse working in Nemba hospital maternity.

¹³ Developed by the American Academy of Pediatrics, the Helping Babies BreatheSM (HBB) initiative was designed to equip birth attendants in developing countries with the skills they need to successfully resuscitate babies who do not breathe on their own. At the center of HBB is the concept of The Golden MinuteSM: within one minute of birth, a baby should be breathing well or should be ventilated with a bag and mask.

Community Gardens Campaign in Rwanda Aims to End Child Hunger and Malnutrition

by Jérémie Zoungrana, Odette Kamanzi and Tony Gershom



Community members being shown how a kitchen garden is made.

Rwanda has stepped up its campaign to eliminate cases of malnutrition among children with a call on every Rwandan family to ensure the provision of a balanced diet for their families.

“Adequate food and nutrition are a universal right and are essential for the physical, mental and emotional development of children, as well as [a good] quality of life for adults,” according to the Rwanda 2005 nutrition policy. “The elimination of cases of malnutrition among our children and pregnant mothers is a priority for our government this year.”

To increase knowledge of how to create a well-balanced diet, MCHIP in partnership with the Rwanda Agriculture Board (RAB) and Ministry of Health supported trainings on the establishment of akarima K’igikoni—or “kitchens gardens”—in the three districts of Gakenke (Northern Province), and Ruhango and Huye (Southern Province). Community health workers, village chiefs, and representatives from malnourished families in each village were selected and trained. This included learning about kitchen garden construction and how to grow vegetables such as cabbages, red onions, spinaches and carrots. RAB provided free seeds and technical support.

In Gakenke district, Nemba sector, Burange cell, Rukoji village, 80% of the population are relatively poor farmers, and poverty and malnutrition are big problems. As a result of this program, community members have organized themselves into an association called Baho Neza, which translated means “stay well.”

Headed by Bugwanzira Clement, a 46-year-old community health worker, the association has a membership of 20 people that promote eating a balanced diet and raise money from the sale of extra produce. Now, people have not only saved money and eaten better food, but also learned how to provide for their families.

Members managed to open a bank account to collectively save proceeds in hopes of buying a large

piece of land to extend the vegetable gardens. They also hope to share their acquired knowledge with the rest of the community, cooperate with different institutions (hospitals, schools), and establish a kitchen garden model.



Odette Uwera Kamanzi, MCHIP/Rwanda Nutrition Consultant talking about support to the Rwandan government on maternal and child health programs (nutrition interventions) in Ruhango district. This was during the launching ceremony of the national campaign to eliminate malnutrition in Ruhango District.

Within two months, previously distributed vegetable seeds were planted in the constructed kitchen gardens and were well managed, and the knowledge acquired was shared with the rest of the village members.

The pictures below show the health of these gardens two months post construction and training:

Gone are the days when rural residents with malnutrition problems blamed it on poverty, saying that a balanced diet is for urban people who can afford expensive food.



The Mayor of Ruhango called upon participants at the ceremony to endorse the Government commitment to eliminate malnutrition in children under five years and pregnant and breastfeeding mothers by having a kitchen garden at their home, eating a balanced diet, and practicing good hygiene.

Vaccine Launch in Rwanda Demonstrates Strong Partnership in Fight Against Child Mortality

by: Jérémie Zougrana and Augustin Gatera



First Rwandan child receiving the rotavirus vaccine.

A remarkable benchmark was achieved this summer, as Rwanda became one of the first African countries to administer the rotavirus vaccine as part of their routine immunization program. Rwanda has shown remarkable success in scaling up immunizations in the past years, having just introduced the Hepatitis B, Haemophilus influenzae type B, and 7 valent-pneumococcal conjugate vaccines in 2008 and 2009.

Rotavirus gastroenteritis is a mild to severe disease characterized by vomiting, watery diarrhea, and low grade fever, and is responsible for 25–50% of severe diarrhea cases worldwide. Due to the lack of access to prevention and treatment measures for diarrhea—such as access to clean water and sanitation and the use of oral rehydration solutions—rotavirus infection can lead to death due to dehydration. According to findings from the Rwanda health information and monitoring system in 2008, diarrhea is the third leading cause of death in the country and continues to cause a substantial number of child deaths today.

To fight diarrheal deaths and other causes of infant and child mortality, USAID and MCHIP have been working tirelessly alongside the Rwandan government to scale up evidence-based, high-impact maternal, newborn and child health interventions. MCHIP provided a remarkable contribution to the pre-induction activities surrounding the rotavirus vaccine administration in Rwanda, including: developing an introduction plan for the rotavirus vaccine; developing and submitting an application for vaccine introduction to the GAVI Secretariat; developing training materials; conducting training; and revising EPI management tools. MCHIP helped to facilitate a smooth introduction of the vaccine across the country with provision of technical support to the national Expanded Programme on Immunization and its partners.

It is in this regard that, through technical support, the Government of Rwanda sent a new vaccine introduction application to GAVI, which was successfully approved. In the first shipment, the country received 428,500 doses of rotavirus vaccine, which are targeted to serve 399,274 infants between the ages of 6 to 32 weeks.

The vaccine arrived at Kigali Airport on May 5, 2012, where it was met by a delegation from the Rwandan Ministry of Health, USAID and MCHIP, as well as representatives of UNICEF and WHO. Upon the vaccine's arrival, the Honorable Minister of Health Dr. Agnes Binagwaho spoke with excitement about integrating the rotavirus vaccine into the country's current immunization regimens in the hopes of decreasing infant mortality in the country. She also gave thanks to USAID and MCHIP for their continued support in implementing the vaccine.

The related launch event occurred three weeks later in a small village in Musanze District in the Northern Province. This event was particularly significant in its integration of administration of the new rotavirus vaccine, the human papilloma virus vaccine to prevent cervical cancer, and mebendazole tablets to prevent parasitic infections. Permanent Secretary for the Ministry of Health Dr. Uzziel Ndagijimana, who was the guest of honor at the event, applauded Rwanda's success in being the one of the first countries to use the rotavirus vaccine in their immunization program.

The rotavirus vaccine launch in Rwanda demonstrates the strong partnership between the Rwandan Ministry of Health, USAID, MCHIP, UNICEF and WHO in the fight against infant and child mortality. In the months ahead, the Rwandan government will roll out the rotavirus vaccine to all infants in the country; hopefully, other countries will follow their example.



Mothers with eligible infants waiting for the rotavirus vaccine at the launch.

Tubal Ligation under Local Anesthesia Now Accessible to Women in Rwanda

by Beata Mukarugwiro, Willy Shasha, William Twahirwa and Christopher Mazimba

In many health facilities throughout Rwanda, working in limited resource areas is challenging. What was most challenging for Dr. Fazili Hakizaimana, though, was to let women return home after giving birth without being able to offer them their requested family planning methods.

One of the methods Dr. Fazili was not able to provide to them was tubal ligation, a method normally done under spinal or general anesthesia, and most often associated with cesarean section. Due to the use of the anesthetic, this procedure can pose a high of risk of complication and possible death, and is not easily accessible to majority of women who want it.

Rwanda's Ministry of Health (MOH), in partnership with MCHIP, decided to tackle this problem by building the capacity of providers to perform tubal ligations. For the first phase of the project, six district hospital providers were targeted to be trained and equipped.

Dr. Fazili was one of the providers selected to attend the training on tubal ligation under local—rather than general—anesthesia. The 10-day training comprised both theoretical and practical sessions. Before the training, women were counseled on all methods including tubal ligation, which helped to recruit women for tubal ligation as well as to strengthen the counseling skills of providers. When Dr. Fazili was asked to give his impression about the training, he said:

"I'm very happy that the number of women coming to seek this service after the sensitization has increased because now they only [have to] come for 1–2 hours and do not require hospitalization and there has been no complaint of headache as it was before. As I'm talking to you now, I have three women in front of me waiting for this service."

While the MOH had planned to initiate mini-laparotomy for tubal ligation since 2008, MCHIP has now provided the training and resources to make the service available to Rwandese women.

South Sudanese Women Benefit from USAID Efforts to Reduce Maternal Mortality

24 September 2012

The article below ran in USAID's South Sudan September 2012 newsletter. The work described is being done by USAID through MCHIP. MCHIP works in 10 African and Asian countries—including South Sudan—using misoprostol at homebirths to prevent postpartum hemorrhage.

To help reduce maternal mortality in South Sudan, which has the world's highest rate of maternal mortality (2,054 deaths per 100,000 live births), USAID this summer launched a comprehensive program to reduce cases of hemorrhaging after childbirth. Through this program, USAID is providing thorough training to community health workers on how to encourage women to seek medical care in a facility during childbirth.

More than 80 percent of pregnant women in South Sudan give birth at home, without the assistance of a skilled attendant. According to the World Health Organization, postpartum hemorrhage is a major cause of maternal death in low-income countries, and attempts to reduce these deaths have been complicated by the fact that many deaths occur outside health facilities.

To reduce these deaths in South Sudan, USAID, in partnership with Venture Strategies Innovations, introduced the use of the drug misoprostol, which women will be given by trained community health workers and will self-administer following childbirth. USAID has begun the program in Western Equatoria state's Mvolo and Mundri East counties in collaboration with the South Sudan Ministry of Health, which is committed to reducing maternal mortality.

USAID partners Save the Children and the Mundri Relief and Development Association trained community health workers in August in the two counties, and the group has already initiated counseling of pregnant mothers.

Alice Nyalia was among the pregnant mothers counseled as a result of this first training, and was given a dose of misoprostol tablets on August 25. On August 26, she gave birth to a baby girl, and took the misoprostol tablets immediately after. She experienced normal bleeding, and mother and baby are both healthy.

In the first six months of this new program, USAID expects to reach approximately 1,660 pregnant women, who are counseled on how to store and take misoprostol to avoid postpartum hemorrhage.

Strengthening Skills and Saving Lives through Clinical Mentorship in Zambia

Matanda Rural Health Center (RHC) is a remote facility in Luapula Province in northern Zambia. The nearest hospital in Mansa is 60 kilometers away, 40 kilometers of which is rough, gravel road. The RHC also has no cell phone network; therefore, when emergencies arise, health center staff must walk or cycle 27 kilometers to call for an ambulance. For these reasons, MCHIP has worked to ensure that Nurse Esther Kabaye—until recently, the facility's only clinician—is able to competently and confidently perform the basic functions of emergency obstetric and neonatal care (EmONC).



Nurse Kabaye (R) with her new colleague and mentee, Nurse Kapandula (L)

In May, MCHIP began providing on-site clinical mentorship to Ms. Kabaye and, in June, the Program trained 14 more districts mentors. As a result, Ms. Kabaye receives a visit at least once a month during which she is provided support to refine key skills, such as management of postpartum hemorrhage, neonatal resuscitation, and assisted vaginal deliveries.

"With the support that [MCHIP has] given me through your mentorship, I am so happy that I am able to effectively handle emergencies and save lives which would have been lost," she said.

And she's right: numerous lives have been saved at Matanda thanks to Nurse Kabaya. One of the people saved was Agnes, a woman from a nearby village, who arrived at the clinic bleeding profusely due to a miscarriage. Now skilled in how to handle such a case, Ms. Kabaye immediately stabilized Agnes and expertly performed a manual vacuum aspiration. When Ms. Kabaye found out that this was Agnes' third miscarriage, she also counseled her and performed further tests, identifying a potential cause.

And this is not the only type of emergency that Ms. Kabaye has effectively handled. She has successfully resuscitated several asphyxiated newborns and, in June, helped manage a woman's postpartum hemorrhage. Helen, a 35-year-old woman from a nearby village, was brought to the health center in labor, where she delivered a healthy 3.5 kilogram baby. Although everything initially appeared well, Helen suddenly began bleeding profusely. Ms. Kabaye quickly stopped the bleeding by performing bi-manual compression of the uterus.

Ms. Kabaye's impressive work has not gone unnoticed. "The community, including the chief, appreciates my services such that they do not even want me to go on leave," says Ms. Kabaye. And these services also go beyond the Matanda community. According to Ms. Kabaye, "There is a health center just across the border [in DRC] manned by a nurse who refers all obstetric emergencies to this center."

This demonstrates the confidence that the community, including other health workers, have developed in her. Ms. Kabaye has also become confident enough to share her skills with other members of her staff, such as Dorcas Kapandula, a newly graduated nurse posted to her RHC and whom she has been mentoring.

"I have only been here for a short while but I have learnt a lot from Sister Kabaye," affirms Ms. Kapandula.

Helping Babies Breathe in Zambia "Changing the Way We Resuscitate Newborns"

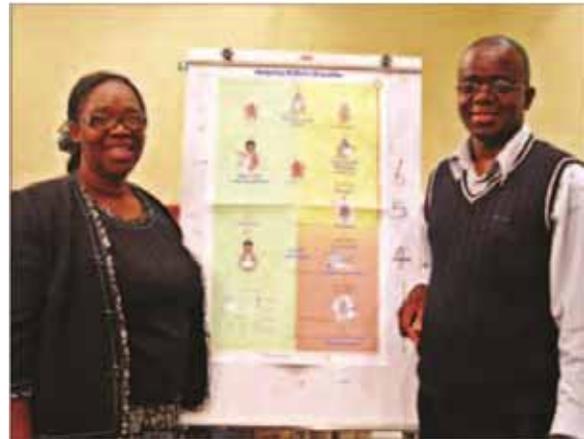
6 September 2012

This is for the mothers, providing life that may otherwise be lost. Sharing the occasion of new life with a mother is very joyful. You can't equate that feeling to anything. — Dr. Jonathan Musonda, pediatric anesthesiologist and new Helping Babies Breathe trainer.

Dr. Jonathan Musonda has always been passionate about the lives of mothers and their newborns. As a pediatric anesthesiologist at Ndola Central Hospital, Dr. Musonda has spent more than a decade in the Copperbelt Region of Zambia, using his skills as an emergency obstetric and newborn care (EmONC) provider and trainer to administer anesthesia and intubate babies who are unable to breathe on their own, as well as to train fellow colleagues in EmONC.

Despite his extensive training and skills, Dr. Musonda has found it quite challenging to optimally perform his role as an EmONC provider. Ndola Central Hospital is considered a tertiary health facility, meaning that it receives referrals for patients, including pregnant and delivering women, who require intensive medical care. Despite this, essential equipment—such as tracheal tubes and ventilators—are often lacking at the hospital, severely hindering health workers' ability to provide much-needed interventions. It is not unusual for providers to manually ventilate babies for several hours at a time; however, if staffing is short and client loads are high, newborns may be left to die. Dr. Musonda is determined not to let this practice continue.

Earlier this year, Dr. Musonda was one of 16 participants invited to attend a Helping Babies Breathe (HBB) Training of Trainers, a three-day workshop conducted by MCHIP in collaboration with the Zambia Ministry of Health (MOH) under the USG-sponsored Saving Mothers, Giving Life (SMGL) endeavor. The workshop participants were EmONC providers and trainers from the four SMGL target districts: Kalomo, Lundazi, Mansa and Nyimba. Through this training, they were equipped with the knowledge and skills to train and mentor their colleagues in neonatal resuscitation, using the HBB curriculum.



MCHIP technical advisor Martha Ndhlovu and the newly trained Dr. Musonda with the HBB action plan.

While neonatal resuscitation has long been a component of EmONC training in Zambia, HBB utilizes an innovative, simplified approach specifically designed for low-resource settings, such as those in which Dr. Musonda and his colleagues work. Focusing on the first "golden minute" of life, HBB centers around simple interventions—such as drying and warmth, clearing the airway, and bag and mask ventilation—which for 99% of babies will be all that is required to initiate breathing. Provider skills are developed through simulations on life-like anatomic models and through use of a color-coded action plans to guide clinical decision-making. With these new skills learned, the newly trained trainers developed district action plans in preparation for training their colleagues in rural hospitals and health centers in these lifesaving techniques.

Dr. Musonda foresees the impact of this training. Remarking on the way it effectively addressed the challenges that he has observed in his hospital, Dr. Musonda said: "This program will change the way we resuscitate newborns. Perhaps we can see a positive shift if we are able to pass on this information. If so, then there will be glorious outcomes with this new method."

Improved Performance of Village Health Workers in Zimbabwe Yields Lifesaving Impact

A village health worker (VHW) who has worked with MCHIP on community maternal, newborn and child health and performance quality improvement (PQI) activities, Joyce was visited by Program and Ministry of Health and Child Welfare staff during the VHW baseline assessment in August 2012. Unbeknownst to her at that time, the experience with MCHIP's VHW PQI baseline assessment—which challenged her to be more diligent and document her activities within the community—would enable her to save the life of a new mother not long after.

Joyce lives in Mutare district in the Marange Hospital catchment area, where on 16 September, a woman named Patience gave birth to her first child, a boy named Enock. Weighing only 2,500g at birth, the nurses decided to retain Enock and Patience to teach them Kangaroo Mother Care (KMC)—an alternative approach for providing thermal care for low birth weight infants—and to monitor their recovery.

Patience and Enock were discharged three days later, and Joyce immediately paid them a postnatal home visit to check on their progress. Both mother and baby were recovering well and Joyce reinforced the need for Patience to continue KMC, exclusively breastfeed her baby, and to return to the hospital for her postnatal check-up at seven days postpartum.

Less than a week later, Joyce visited Patience again to remind her of this postnatal care visit. On arrival, Joyce realized things “were not right.” The house was crowded and a traditional birth attendant had been invited because the baby was not breastfeeding. When Joyce examined mother and child, she observed that Patience’s legs were swollen and Enock was not breathing well. Joyce immediately told Patience’s husband to take his wife and child to the hospital and went ahead to warn the nurses of the incoming situation. Upon arrival, the nurses assessed the baby, classified him as having “severe disease,” and coordinated an immediate transfer to Mutare Provincial Hospital. Sadly, help came too late for Enock, who died the next day.



Joyce Myamunda, a village health worker serving Rubatso Village in Mutare, is committed to providing the best service she can to mothers and children in her catchment area.

Patience, however, survived. Thanks to Joyce, she was able to receive timely care and to recover from her potentially fatal condition. And while Joyce was devastated that Enock was unable to be saved, she is grateful for the training and supportive supervision she received from MCHIP, which prompted her to follow up with Patience, undoubtedly saving her life.

The baseline assessment experience also raised Joyce’s profile in the community, where she is now valued for her advice and relied on for help. Joyce feels very motivated and looks forward to the next PQI assessment, where she plans to demonstrate her improved skills in antenatal and postnatal care home visits and the identification of danger signs in mothers and newborns.

Annex E: List of Communications Events and Publications

Table 3. Communications Events Organized by MCHIP during October 2011 through September 2012

| EVENT | DATE | LOCATION | CO-SPONSORS | NOTES |
|---|----------|---|---|---|
| MCHIP AIDS Walk | October | Washington, D.C. | DC AIDS Walk and others | |
| MCHIP Exhibit at APHA Annual Conference | November | Washington, D.C. | | |
| Special event on Quality of Care in Developing Countries | November | Washington, D.C. Convention Center (APHA satellite session) | | Unveiled the Quality of Care survey results and shared experiences in-country with four field staff; moderated by D. Armbruster. |
| Special event on "Continuing Investments Made in Global Health" | November | Washington, D.C. | Global Health Council, implementing partners of MCHIP | Members of Congress participated, as did Amie Batson of USAID. Remarks from our field staff and an interactive photo gallery representing the people and places we serve. |
| MCHIP Program Learning Meeting | November | Washington, D.C. | | |
| International Family Planning Conference | November | Senegal | | Hosted a special satellite event. |
| ICASA Conference | December | Ethiopia | | Presented on several panels and had an MCHIP exhibit. |
| LAC Regional KMC Workshop | December | Dominican Republic | LAC Alliance, Kangaroo Mother Care Foundation, Ministry of Health | |
| mHealth Summit Exhibit | December | Washington, D.C. | | |
| Special event on mobile technologies | December | Washington, D.C. | PLAN International | "Tweet up" held with mHealth networking group as a side session. |
| Symposium on Misoprostol for Postpartum Hemorrhage Prevention | January | Washington, D.C. | On behalf of USAID | Brought together over 70 experts from around the world. Included remarks from Administrator Shah and Amie Batson of USAID. |
| Neonatal Alliance Meeting | February | Washington, D.C. | | All member groups of Neonatal Alliance participated. |
| PVO/NGO Learning Exchange Series Webinar | March | Washington, D.C. | CORE Group | Focused on the CSHGP Expanded Impact Project in Rwanda. |
| International Women's Day March for Women | March | Washington, D.C. | Women for Women International | Covered by local production company, Double R Productions. |
| Neonatal Alliance Annual LAC Meeting on "Newborn Care" | April | Dominican Republic | LAC Alliance | Provided communications support. |

| EVENT | DATE | LOCATION | CO-SPONSORS | NOTES |
|--|-----------|-----------------------|---|---|
| MCHIP "Immunization Program Learning" Meeting | April | Addis Ababa, Ethiopia | | Provided communications support. |
| Maternal Health Evidence Summit on "Maternal Health Commodities" | April | Washington, D.C. | | MCHIP provided support to Summit with the handling of distinguished guests to include MoH officials. |
| Woodrow Wilson Center Event on "Progress Made in Improving Maternal Health" | April | Washington, D.C. | Woodrow Wilson Center | Provided communications and logistical support to include reception hosted by MCHIP. |
| World Public Health Congress Exhibit | April | Addis Ababa, Ethiopia | | Exhibit |
| Congressional Reception "Supporting Progress in Reducing Maternal Mortality" | April | Washington, D.C. | MSH, Christian Connections, Abt Associates, Jhpiego, JSI | 10 Members of Congress participated in addition to Pablos-Mendez, Quam and Shah. |
| MCHIP workshop at Interaction Forum on the topic of "The Countdown to 2015" with regard to MNCH | May | Washington, D.C. | InterAction | L. Ryan, R. Steinglass, A. Ergo participated. |
| CORE Group Spring Meeting Exhibit and expert participation | April/May | Wilmington, Delaware | CORE Group | MCHIP presented on several panels and sessions; hosted exhibit table. |
| Asia Regional Meeting on "Maternal and Newborn Health to include HBB orientation and pre-Nutrition" meeting | May | Dhaka, Bangladesh | Bill & Melinda Gates Foundation Oxytocin Initiative, VSI, Women Deliver, FIGO, Beximco, American Academy of Pediatrics, ICM, Laerdal Foundation | Handled all communications-related activities to include promotion, social media interactions, webcasting, media outreach, collateral and on-site event management support. |
| USAID "Child Health Revolution of the 80's" Distinguished Speaker Series | June | Washington, D.C. | | Handled all communications and logistical aspects. |
| USAID "Child Survival Call to Action" | June | Washington, D.C. | | Handled logistics by way of managing contract with event management firm. |
| U.S. Global Leadership Coalition Smart Power at Work Expo Exhibit | July | Washington, D.C. | | Hosted exhibit table. |
| International AIDS Conference Exhibit | July | Washington, D.C. | | Hosted exhibit table. |
| Call to Action for Voluntary Medical Male Circumcision for HIV Prevention Satellite Event at the International AIDS Conference | July | Washington, D.C. | PEPFAR, WHO, UNAIDS, Champions for an HIV-Free Generation, AVAC | Organized panel event, which included presentations from 10 African leaders and champions for the elimination of HIV. |
| MCHIP Team in International AIDS Walk | July | Washington, D.C. | | MCHIP team marched in event. |

| EVENT | DATE | LOCATION | CO-SPONSORS | NOTES |
|--|-----------|----------------------------|--|---|
| WHO-PEPFAR Conference on VMMC for HIV Prevention in East and Southern Africa | August | Johannesburg, South Africa | PEPFAR, WHO | Organized meeting for over 165 participants from MOH, USG, WHO and implementing partners. Supported 25 sponsored MOH guests in all travel. |
| Maternal Health Event on Progress and Way Forward | September | NYC, New York | USAID, MCHIP, PATH, WRA, JSI, Abt, Merck, ExxonMobil | MCHIP sponsored and helped organize a meeting with over 100 attendees present with senior members of USAID and country representatives, and moderated by ABC's Richard Besser and <i>The Lancet's</i> Richard Horton. |
| "Ripple Effect" on Maternal Commodities | September | NYC, New York | USAID, MCHIP, PATH, JSI, etc. | MCHIP's work in Rwanda highlighted in photo gallery event and launch of coffee table book. |



Country representatives from the Kenyan Ministry of Health, US Government, WHO, and implementing partners discuss the future of Voluntary Medical Male Circumcision in Kenya during a country breakout session at the VMMC meeting in Johannesburg.

"It was a great meeting, kudos to the organizers."



Emmanuel Njeuhmeli (USAID's Office of HIV/AIDS); Jhpiego's Hally Mahler; Former President of Tanzania, Benjamin Mkapa; and Jhpiego's Kelly Curran support VMMC at the AIDS Conference satellite event.



MCHIP interns Aubrey Peterson and Anne Laterra at the MCHIP exhibit at the USGLC Smart Power at Work Expo.



The MCHIP team joins the march at the International AIDS Walk.



Visitors at the MCHIP exhibit at the International AIDS Conference were encouraged to sign a banner explaining why they support VMMC.



USAID's Dr. Ariel Pablos-Méndez opens the Distinguished Speaker Series on the Child Survival Revolution.



Proud midwives celebrate International Day of the Midwife at the Asia Regional Meeting in Dhaka, Bangladesh.



MCHIP Director Dr. Koki Agarwal opens the "Maternal Survival: Celebrating Progress and Accelerating Action" event in the Russell Senate Office Building with Ariel Pablos-Mendez, Assistant Administrator for Global Health at USAID.



His Excellency Mam Bunheng, Minister of Health of Cambodia, with an award from the U.S. Government for outstanding efforts to improve maternal health.



More than 300 attendees filled the historic Kennedy Caucus Room at the U.S. Senate for the special event.



Administrator of USAID, Rajiv Shah, speaks with Congressman Jim McDermott, who was among 10 Members of Congress to attend and give remarks.

"The Ministers and the MCH Director's voices were heard by our leadership at USAID and by the highest levels of USG, confirming that years of USG investment in maternal health have yielded results. The Ministers spoke and backed their words with data. That was powerful. It was wonderful to bring success stories to the doorstep of U.S. Congressmen and women. MCHIP's help was outstanding; it was impressive how they thought of every little detail. We have a huge group of country support teams from USAID helping the delegations as well but it was MCHIP that was the glue that kept it all together."



The MCHIP team walks with women around the world for International Women's Day.



Participants of the mobile health technologies “Tweet-up” at the mHealth Conference at National Harbor.

Continuing U.S. Investments Made in Global Health event at Reserve Officers Association of the United States.



Amie Batson, Deputy Assistant Administrator for Global Health at USAID



More than 150 people, including congresswomen, policymakers, and MCHIP partners and staff, gathered on Capitol Hill to promote continued investments in global health.



Congresswoman Lynn Woolsey with A. Batson and MCHIP Director Koki Agarwal watch a demonstration on Helping Babies Breathe.



Attendees showed their support for why they support the power of 1%.



AOR Deputy Lead, Malia Boggs, Koki Agarwal, Director of MCHIP, and Nahed Matta, lead AOR for MCHIP

"Congresswoman Lynn Woolsey (D-CA) and Senator Kay Hagan (D-NC) both expressed their thanks to all working to save lives around the world. Senator Hagan reminded the audience that what is truly tragic about millions of women and children dying is that most of these deaths can be prevented by the use of standard and inexpensive health practices. Congresswoman Woolsey stressed the importance of more resources to programs like MCHIP providing immunization, prenatal care, mosquito nets and other life-saving efforts to increase the scope and scale of their work in order to achieve global safety and security."

Photos from MCHIP Program Learning Meeting



Table 4. Published Articles

| OUTLET | TEAM | TITLE |
|---|-------------------|---|
| <i>International Health</i> | Immunization | Why Children Aren't Vaccinated: A review of the grey literature |
| <i>Journal of Infectious Diseases</i> | Immunization | Integrated Delivery of Health Services During Outreach Visits: A Literature Review of Program Experience Through a Routine Immunization |
| <i>Midwifery</i> | M&E | Reproductive health services in Malawi: An evaluation of a quality improvement intervention |
| <i>International Perspectives on Sexual and Reproductive Health</i> | Global Leadership | Spousal Separation and Interpretation of Contraceptive Use and Unmet Need in Rural Nepal |
| <i>Journal of Gynecology and Obstetrics</i> | Newborn | Report on Prenatal Corticosteroid Use in Low-and Middle Income Countries |
| <i>PLoS Medicine</i> | HIV | Four papers included in collection of nine articles showing scale-up of VMMC: <ul style="list-style-type: none"> ▪ Voluntary Medical Male Circumcision: A Qualitative Study Exploring the Challenges of Costing Demand Creation in Eastern and Southern Africa ▪ Voluntary Medical Male Circumcision: Strategies for Meeting the Human Resource Needs of Scale-Up in Southern and Eastern Africa ▪ Voluntary Medical Male Circumcision: Matching Demand and Supply with Quality and Efficiency in a High-Volume Campaign in Iringa Region, Tanzania ▪ Voluntary Medical Male Circumcision: Logistics, Commodities, and Waste Management Requirements for Scale-Up of Services |
| <i>International Journal of Gynecology and Obstetrics</i> | Newborn | A conference report on prenatal corticosteroid use in low and middle income countries |
| <i>Contraception</i> | Family Planning | Postpartum Use of the Copper T 380A Intrauterine Device: The 10-year experience at Hospital Nacional, Asunción, Paraguay" |
| <i>Vaccine</i> | Immunization | The impact of new vaccine introduction on immunization and health systems: A review of the published literature |
| <i>Vaccine</i> | Immunization | Researching routine immunization- do we know what we don't know? |
| <i>Vaccines in Practice</i> | Immunization | Delivering the immunization promise in India- a snapshot |

Annex F: Global Monitoring and Evaluation Framework for MCHIP

Table 5. MCHIP Global Monitoring and Evaluation Framework (*identifies an Investing in People/Operational Plan Indicator; **identifies a global HIDN results pathway indicator; ***identifies a MDG Countdown/Common Evaluation Framework indicator)

| INDICATOR | DEFINITION AND DISAGGREGATION | BASELINE DATA (2008 OR EARLIER) | FY2009/PY1 DATA | FY2010/PY2 DATA | FY2011/PY3 DATA | FY2012/PY4 DATA |
|---|---|--|-----------------|-----------------|-----------------|-----------------|
| 1. Number of MCHIP countries demonstrating reductions in maternal mortality since the last survey | <p>This may be measured or statistically modeled using LiST at the national or sub-national level (data will be disaggregated), depending on the scale of MCHIP-supported interventions, and includes contributions by CSHGP grantees.</p> <p>Note: In selected countries, a valid and reliable estimate of maternal mortality will be generated either by adapting existing measurement methods, i.e., DSS, DHS, census or modeled methods (e.g., UN estimates for MMR); or through innovative primary data collection efforts, i.e., verbal autopsy follow-up of deaths of women identified in the census; community-based vital events informants; use of or adaptation of methods to acquire adequate sample sizes, such as the Sampling at Service Sites method.</p> | <ul style="list-style-type: none"> ▪ Bangladesh – 340 ▪ Bolivia – 180 ▪ DRC – 670 ▪ Ethiopia – 470 ▪ Ghana – 350 ▪ Guyana – 270 ▪ India – 230 ▪ Indonesia – 240 ▪ Kenya – 530 ▪ Lesotho – 530 ▪ Liberia – 990 ▪ Madagascar – 440 ▪ Malawi – 510 ▪ Mali – 830 ▪ Nepal – 380 ▪ Nigeria – 840 ▪ Paraguay – 95 ▪ Rwanda – 540 ▪ Sierra Leone – 970 ▪ South Africa – 410 ▪ South Sudan – n/a ▪ Zimbabwe - 790 <p>Note: Two WHO data points, comparable across countries, from within the life-of-project are not available. WHO/UNICEF 2008 data have been provided as a baseline for all MCHIP countries with maternal health activities.</p> | N/A | N/A | N/A | N/A |

| INDICATOR | DEFINITION AND DISAGGREGATION | BASELINE DATA (2008 OR EARLIER) | FY2009/PY1 DATA | FY2010/PY2 DATA | FY2011/PY3 DATA | FY2012/PY4 DATA |
|---|---|--|-----------------|--|---|--|
| 2. Number of MCHIP countries demonstrating reductions in newborn and under-5 mortality (U5MR) since the last survey | <p>This may be measured or statistically modeled using LiST at the national or sub-national level (data will be disaggregated), depending on the scale of MCHIP-supported interventions. The indicator will be disaggregated by newborn and under five. This includes contributions by CSHGP grantees.</p> <p>Note: U5MR estimates for CSHGP projects were modeled using any indicators collected during a project that showed a statistically significant change and could be modeled in LiST. Projections were made using the most recent (regional if available) U5MRs prior to the start of the project as a baseline.</p> | <ul style="list-style-type: none"> ▪ NNMR ▪ Azerbaijan – 22 ▪ Bangladesh – 34 ▪ DRC – 48 ▪ Dom Rep – 18 ▪ Ethiopia – 38 ▪ India – 36 ▪ Indonesia – 20 ▪ Kenya – 30 ▪ Lesotho – 44 ▪ Madagascar – 26 ▪ Malawi – 33 ▪ Mali – 50 ▪ Mozambique – 43 ▪ Nepal – 33 ▪ Nigeria – 43 ▪ Paraguay – 16 ▪ Rwanda – 35 ▪ Senegal – 32 ▪ Sierra Leone – 49 ▪ South Africa – 22 ▪ U5MR ▪ DRC – 181.4 ▪ India – 73.2 ▪ Indonesia – 43.7 ▪ Kenya – 97.5 ▪ Mali – 195.2 ▪ Rwanda – 127.8 ▪ Senegal – 95.0 ▪ Tanzania – 102.8 ▪ Zimbabwe – 100.2 <p>Data Source: WHO/UNICEF 2005</p> <p>U5MR</p> <ul style="list-style-type: none"> ▪ Bangladesh – 88 (CSHGP, CRWRC 2004–2010) ▪ Cambodia – 101 (CSHGP, | | <ul style="list-style-type: none"> ▪ NNMR ▪ Azerbaijan – 19 ▪ Bangladesh – 27 ▪ DRC – 46 ▪ Dom Rep – 15 ▪ Ethiopia – 35 ▪ India – 32 ▪ Indonesia – 17 ▪ Kenya – 28 ▪ Lesotho – 35 ▪ Madagascar – 22 ▪ Malawi – 27 ▪ Mali – 48 ▪ Mozambique – 39 ▪ Nepal – 28 ▪ Nigeria – 40 ▪ Paraguay – 14 ▪ Rwanda – 29 ▪ Senegal – 27 ▪ Sierra Leone – 45 ▪ South Africa – 18 ▪ U5MR ▪ DRC – 169.90 ▪ India – 62.7 ▪ Indonesia – 35.3 ▪ Kenya – 84.7 ▪ Mali – 178.1 ▪ Rwanda – 91.1 ▪ Senegal – 75.8 ▪ Tanzania – 75.8 ▪ Zimbabwe – 79.8 <p>Data Source: WHO/UNICEF 2010</p> <p>U5MR</p> <ul style="list-style-type: none"> ▪ Bangladesh – 81 (CSHGP, CRWRC 2004–2010) | <p>Newborn mortality: 21 countries</p> <p>Under-5 mortality: nine countries</p> <p>Note: All 21 countries where MCHIP has newborn health programs have demonstrated a decrease in NNMR. All nine countries with child health programs have demonstrated a decrease in under-5 mortality. (Data from WHO/UNICEF, 2005–10)</p> | <p>U5MR</p> <p>Ethiopia – 125 (CSHGP, GOAL 2007–2011)</p> <p>Malawi – 118 (CSHGP, Save 2006–2011)</p> <p>Nepal – 48 (CSHGP, Plan 2007–2011)</p> <p>Nepal – 80 (CSHGP, CARE 2007–2011)</p> <p>Niger – 159 (CSHGP, Relief 2007–2011)</p> <p>Rwanda – 132 (CSHGP, Concern 2006–2011)</p> <p>Tanzania – 77 (CSHGP Wellshare 2006–2011)</p> |

| INDICATOR | DEFINITION AND DISAGGREGATION | BASELINE DATA (2008 OR EARLIER) | FY2009/PY1 DATA | FY2010/PY2 DATA | FY2011/PY3 DATA | FY2012/PY4 DATA |
|--|---|---|-----------------|--|--|---|
| | | IRD 2006–2010) <ul style="list-style-type: none"> ▪ DR Congo – 145 (CSHGP, CRS 2005–2010) ▪ India – 47 (CSHGP HOPEWW 2006–2010) ▪ Indonesia – 44 (CSHGP Mercy Corps 2006–2010) ▪ Kenya – 144 (CSHGP, AMREF 2005-2010) ▪ Kenya – 77 (CSHGP, HealthRight 2006-2010) ▪ Liberia – 142 (CSHGP, MTI 2006–2010) ▪ Mozambique – 205 (CSHGP, FH 2005–2010) ▪ Uganda – 181 (CSHGP, HealthPartners 2005–2010) ▪ Zambia – 148 (CSHGP, SAWSO 2005–2010) | | <ul style="list-style-type: none"> ▪ Cambodia – 88 (CSHGP, IRD 2006–2010) ▪ DR Congo – 134 (CSHGP, CRS 2005–2010) ▪ India – 44 (CSHGP HOPEWW 2006–2010) ▪ Indonesia – 44 (CSHGP Mercy Corps 2006–2010) ▪ Kenya – 128 (CSHGP, AMREF 2005–2010) ▪ Kenya – 66 (CSHGP, HealthRight 2006–2010) ▪ Liberia – 104 (CSHGP, MTI 2006–2010) ▪ Mozambique – 156 (CSHGP, FH 2005–2010) ▪ Uganda – 174 (CSHGP, HealthPartners 2005–2010) ▪ Zambia – 134 (CSHGP, SAWSO 2005–2010) | | |
| 3. Estimated number of lives saved among children under five in USAID MNCH focus countries as a result of MCHIP-supported interventions, | This will be disaggregated for CSHGP grantees versus achievements of other MNCH programs. These 10 focus countries include the five countries where MCHIP will scale up an integrated package of high-impact MNCH | | | <ul style="list-style-type: none"> ▪ 19, 990 ▪ Bangladesh – 200 (CSHGP, CRWRC 2004–2010) ▪ Cambodia – 100 (CSHGP, IRD 2006–2010) ▪ DR Congo – 3,000 (CSHGP, CRS 2005–2010) | Data are reported with a year lag. Data for FY11 will be reported in FY12. | Ethiopia – 200 (CSHGP, GOAL 2007–2011) Malawi – 2,000 (CSHGP, Save 2006–2011) Nepal – 800 (CSHGP, Plan 2007–2011) |

| INDICATOR | DEFINITION AND DISAGGREGATION | BASELINE DATA (2008 OR EARLIER) | FY2009/PY1 DATA | FY2010/PY2 DATA | FY2011/PY3 DATA | FY2012/PY4 DATA |
|---|---|---|-----------------|--|-----------------|--|
| Including CSHGP and MCP-supported grants in these countries ¹⁴ | <p>interventions.</p> <p>Note: Additional lives saved estimates for CSHGP projects were modeled using any indicators collected during a project that showed a statistically significant change and could be modeled in LIST.</p> | | | <ul style="list-style-type: none"> ▪ India – 100 (CSHGP HOPEWW 2006–2010) ▪ Indonesia – 0 (CSHGP Mercy Corps 2006–2010) ▪ Kenya – 900 (CSHGP, AMREF 2005–2010) ▪ Kenya – 700 (CSHGP, HealthRight 2006–2010) ▪ Liberia – 1,300 (CSHGP, MTI 2006–2010) ▪ Mozambique – 4,000 (CSHGP, FH 2005–2010) ▪ Uganda – 2,000 (CSHGP, HealthPartners 2005–2010) ▪ Zambia – 700 (CSHGP, SAWSO 2005–2010) | | <p>Nepal – 900 (CSHGP, CARE 2007–2011)</p> <p>Niger – 2,600 (CSHGP, Relief 2007–2011)</p> <p>Rwanda – 4,100 (CSHGP, Concern 2006–2011)</p> <p>Tanzania – 600 (CSHGP Wellshare 2006–2011)</p> |
| 4. Percentage of children aged 12–23 months who received 3 doses of DPT vaccine | <p>Numerator: Number of children aged 12–23 months receiving 3 doses of DPT vaccine</p> <p>Denominator: Total number of children aged 12–23 months surveyed</p> | <ul style="list-style-type: none"> ▪ Benin – 76% ▪ Bolivia – 81% ▪ Ethiopia – 56% ▪ Ghana – 80% ▪ Guinea – 43% ▪ India – 64% ▪ Liberia – 62% ▪ Nigeria – 26% ▪ Rwanda – 86% ▪ Senegal – 52% | | <ul style="list-style-type: none"> ▪ Benin – 83% ▪ Bolivia – 85% ▪ Ethiopia – 79% ▪ Ghana – 94% ▪ Guinea – 57% ▪ India – 66% ▪ Liberia – 64% ▪ Nigeria – 42% ▪ Rwanda – 97% ▪ Senegal – 86% | N/A | Nepal – 95.6% (CSHGP, CARE 2007–2011) |

¹⁴ The CSHGP program will calculate Lives Saved for all CSHGP grants—a percentage of which are in non-MCHIP countries-- for reporting purposes of the CSHGP's Annual Portfolio Review. MCP grantees are not required to conduct surveys, although several have done so, with support from MCHIP. Those data will be used to inform lives saved calculations for this indicator when available.

| INDICATOR | DEFINITION AND DISAGGREGATION | BASELINE DATA (2008 OR EARLIER) | FY2009/PY1 DATA | FY2010/PY2 DATA | FY2011/PY3 DATA | FY2012/PY4 DATA |
|-----------|-------------------------------|--|-----------------|--|-----------------|-----------------|
| | | <ul style="list-style-type: none"> ▪ South Sudan – n/a ▪ Tanzania – 85% ▪ Timor Leste – n/a ▪ Ukraine – 99% ▪ Zimbabwe – 75% <p>Data from: WHO/UNICEF, 2003</p> <p>Note: Data for MCHIP countries with population-based surveys and immunization activities.</p> <ul style="list-style-type: none"> ▪ Bangladesh – 35.9% (CSHGP, CRWRC 2004–2010) ▪ Cambodia – 78.0% (CSHGP, IRD 2006–2010) ▪ DR Congo – 11.6% (CSHGP, CRS 2005–2010) ▪ India – 33.9% (CSHGP HOPEWW 2006–2010) ▪ Indonesia – 27.4% (CSHGP Mercy Corps 2006-2010) ▪ Liberia – 30.6% (CSHGP, MTI 2006–2010) ▪ Mozambique – 85.9% (CSHGP, FH 2005–2010) ▪ Uganda – 76.7% (CSHGP, HealthPartners 2005–2010) ▪ Zambia – 32.6% (CSHGP, SAWSO 2005–2010) | | <ul style="list-style-type: none"> ▪ South Sudan – n/a ▪ Tanzania – 85% ▪ Timor Leste – 64.2% § ▪ Ukraine – 90% ▪ Zimbabwe – 73% <p>Data from: WHO/UNICEF, 2009 § DHS 2009–10</p> <ul style="list-style-type: none"> ▪ Bangladesh¹⁵ – 94%* (CSHGP, CRWRC 2004–2010) ▪ Cambodia¹⁶ – 81.2% (CSHGP, IRD 2006–2010) ▪ DR Congo¹⁵ – 50.2%* (CSHGP, CRS 2005–2010) ▪ India¹⁶ – 51.5% (CSHGP HOPEWW 2006–2010) ▪ Indonesia¹⁶ – 40.2% (CSHGP Mercy Corps 2006–2010) ▪ Liberia¹⁶ – 87.6%* (CSHGP, MTI 2006–2010) ▪ Mozambique¹⁵ – 69.1% (CSHGP, FH 2005–2010) ▪ Uganda¹⁵ – 60.4% (CSHGP, HealthPartners 2005–2010) | | |

¹⁵ 2000+ Rapid CATCH indicator definition: Percentage of children age 12–23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday.

¹⁶ 2006 Rapid CATCH indicator definition: Percentage of children age 12–23 months who received a DPT 3 vaccination before they reached 12 months.

| INDICATOR | DEFINITION AND DISAGGREGATION | BASELINE DATA (2008 OR EARLIER) | FY2009/PY1 DATA | FY2010/PY2 DATA | FY2011/PY3 DATA | FY2012/PY4 DATA |
|---|---|---|---|--|-----------------|---|
| | | | | <ul style="list-style-type: none"> Zambia¹⁵ – 55.8%* (CSHGP, SAWSO 2005–2010) | | |
| 5. Percentage of children aged 0–59 months with diarrhea receiving oral rehydration | <p>Numerator: Number of children aged 0–59 months with diarrhea in the 2 weeks prior to the survey receiving oral rehydration therapy (oral rehydration solution and/or recommended homemade fluids or increased fluids)</p> <p>Denominator: Total number of children aged 0–59 months with diarrhea in the 2 weeks prior to the survey</p> | <ul style="list-style-type: none"> DRC – 42.3% (2007) Kenya – 33.3% (2003) Rwanda – 23.7% (2005) Tanzania – 53.0% (2005) Zimbabwe – 46.7 (2006) <p>Data Source: UNICEF with year noted above in parentheses</p> <p>Note: Data are included for MCHIP countries with child health activities that had population-based surveys before or during MCHIP.</p> <ul style="list-style-type: none"> Bangladesh – 57.1% (CSHGP, CRWRC 2004–2010) Cambodia – 37.9% (CSHGP, IRD 2006–2010) India – 34.9% (CSHGP HOPEWW 2006–2010) Indonesia – 49.0% (CSHGP Mercy Corps 2006–2010) Liberia – 74.2% (CSHGP, MTI 2006–2010) Mozambique – 66% (CSHGP, FH 2005–2010) | <ul style="list-style-type: none"> Kenya – 42.6% (DHS 2008–09) Zimbabwe – 34.9% (UNICEF 2009) | <ul style="list-style-type: none"> Tanzania – 50.4% (DHS 2010) Bangladesh¹⁷ – 72.3% (CSHGP, CRWRC 2004–2010) Cambodia¹⁷ – 38.5% (CSHGP, IRD 2006–2010) India¹⁷ – 72.4%* (CSHGP HOPEWW 2006–2010) Indonesia¹⁷ – 43.1% (CSHGP Mercy Corps 2006–2010) Liberia¹⁷ – 84.1% (CSHGP, MTI 2006–2010) Mozambique¹⁷ – 93%* (CSHGP, FH 2005–2010) | N/A | <p>Niger – 49.7% (CSHGP, Relief 2007–2011) *denominator = 0–23 months</p> <p>Rwanda – 32.5% (CSHGP, Concern 2006–2011)</p> <p>Zimbabwe – 73.7% (2010–11 DHS)</p> <p>Rwanda – 48.1% (2010 DHS)</p> |

¹⁷ 2006 Rapid CATCH indicator definition: Percentage of children age 0–23 months with diarrhea in the last 2 weeks who received oral rehydration solution (ORS) and/or recommended home fluids (Note: neither continued feeding nor increased fluids is included).

| INDICATOR | DEFINITION AND DISAGGREGATION | BASELINE DATA (2008 OR EARLIER) | FY2009/PY1 DATA | FY2010/PY2 DATA | FY2011/PY3 DATA | FY2012/PY4 DATA |
|---|--|--|--|---|--|---|
| 6. Percentage of children aged 0–59 months with suspected pneumonia taken to an appropriate health provider | <p>Numerator: Number of children aged 0–59 months with suspected pneumonia in the 2 weeks prior to the survey who were taken to an appropriate health provider</p> <p>Denominator: Total number of children aged 0–59 months with suspected pneumonia in the 2 weeks prior to the survey</p> | <ul style="list-style-type: none"> ▪ DRC – 41.9% (2007 DHS) [5yrs] ▪ Kenya – 53.0% (2003 DHS) ▪ Rwanda – 28.6% (2007–08 Interim DHS) ▪ Tanzania – 60.6% (2004–05 DHS) ▪ Zimbabwe – 24.8% (2005–06 DHS) <p>Note: Data are included for MCHIP countries with child health activities that had population-based surveys before or during MCHIP.</p> <ul style="list-style-type: none"> ▪ Cambodia – 73.1% (CSHGP, IRD 2006–2010) ▪ India – 74.3% (CSHGP HOPEWW 2006–2010) ▪ Indonesia – 77.8% (CSHGP Mercy Corps 2006–2010) ▪ Liberia – 43.2% (CSHGP, MTI 2006–2010) ▪ Zambia – 81.3% (CSHGP, SAWSO 2005–2010) | Kenya – 57.3% (2008–09 DHS) | <ul style="list-style-type: none"> ▪ Rwanda – 50.2% (2010 Preliminary DHS) ▪ Tanzania – 71% (2010 DHS) ▪ Cambodia¹⁸ – 66.7% (CSHGP, IRD 2006–2010) ▪ India¹⁸ – 69.0% (CSHGP HOPEWW 2006–2010) ▪ Indonesia¹⁸ – 75.0% (CSHGP Mercy Corps 2006–2010) ▪ Liberia¹⁸ – 90.8%* (CSHGP, MTI 2006–2010) ▪ Zambia¹⁸ – 89.4% (CSHGP, SAWSO 2005–2010) | <ul style="list-style-type: none"> ▪ Zimbabwe – 47.4% (2010–11 Preliminary DHS) | <p>Rwanda – 66.3% (CSHGP, Concern 2006–2011)</p> <p>Tanzania – 91.1% (CSHGP Wellshare 2006–2011) *denominator = 0-23 months</p> <ul style="list-style-type: none"> ▪ Cambodia – 39.1% (2010 DHS) |
| 7. Percentage of children aged 0–59 months with suspected pneumonia receiving antibiotics | <p>Numerator: Number of children aged 0–59 months with suspected pneumonia in the 2 weeks prior to the survey receiving antibiotics</p> <p>Denominator: Total number of children aged 0–59 months with suspected pneumonia</p> | <ul style="list-style-type: none"> ▪ DRC – 41.9% (2007) ▪ India – 69% (2005-06) ▪ Indonesia* – 65.9% (2007) ▪ Kenya* – 43.5% (2003) ▪ Lesotho – 58.8% (2004) ▪ Mali – 38.1% (2006) ▪ Rwanda – 28.0% (2007–08) ▪ Senegal* – 40.6% (2005) | <ul style="list-style-type: none"> ▪ Kenya – 55.9% (2008–09 DHS) ▪ Rwanda – 50.2% (2010 Preliminary DHS) <p>Note: Data for MCHIP countries child health activities and population-based surveys. The DHS in some countries with</p> | <ul style="list-style-type: none"> ▪ Malawi – 70.3% (2010 DHS) | | <p>Zimbabwe – 31% (2010–11 DHS)</p> <p>Senegal – 49.9% (2010–11 DHS)</p> |

¹⁸ 2006 Rapid CATCH indicator definition: Percentage of children age 0–23 months with chest-related cough and fast and/or difficult breathing in the last 2 weeks who were taken to an appropriate health provider.

| INDICATOR | DEFINITION AND DISAGGREGATION | BASELINE DATA (2008 OR EARLIER) | FY2009/PY1 DATA | FY2010/PY2 DATA | FY2011/PY3 DATA | FY2012/PY4 DATA |
|---|--|---|---|--|-----------------|--|
| | in the 2 weeks prior to the survey | <ul style="list-style-type: none"> ▪ Tanzania* –56.6% (2004) ▪ Zimbabwe –24.9% (2005–06) <p>*Treatment of acute respiratory infection (ARI) and/or fever</p> <p>All baseline data are DHS by year given, unless otherwise indicated.</p> | MCHIP child health activities did not include ARI treatment data. *Lesotho 2009 data available only in data set, not in report. | | | |
| 8. Percentage of women attended at least four times during pregnancy by any provider (skilled or unskilled) for reasons related to the pregnancy in the 5 years prior to the survey | <p>Numerator: Number of women attended at least four times during pregnancy by any provider (skilled or unskilled) for reasons related to the pregnancy in the 5 years prior to the survey</p> <p>Denominator: Total number of women who had a live birth occurring in the same period</p> | <ul style="list-style-type: none"> ▪ Bangladesh – 20.6% (2007 DHS) ▪ Burkina Faso- 17.6% (2003 DHS) ▪ India – 37.0%; (2005–06 DHS) ▪ Indonesia – 81.5% (2007 DHS) ▪ Kenya – 52.3% (2003 DHS) ▪ Lesotho – 69.6% (2004 DHS) ▪ Liberia – 66.0% (2007 DHS) ▪ Madagascar – 39.9% (2003–04 DHS) ▪ Malawi – 57.1% (2004 DHS) ▪ Mozambique – 53.1% (2003 DHS) ▪ Nepal – 29.4% (2006 DHS) ▪ Nigeria – 44.8% (2008 DHS) ▪ Paraguay – 90.5 (2008) | <ul style="list-style-type: none"> ▪ Kenya – 47.1% (2008–09 DHS) ▪ Lesotho – 70.4% (2009 DHS) ▪ Madagascar – 49.3% (2008–09 DHS) | <ul style="list-style-type: none"> ▪ Malawi – 45.5% (2010 DHS) ▪ Rwanda – 35.4% (2010 Prelim DHS) ▪ India¹⁹ – 68%* (CSHGP HOPEWW 2006–2010) ▪ Kenya¹⁹ – 49%* (CSHGP, AMREF 2005–2010) ▪ Kenya²⁰ – 28% (CSHGP, HealthRight 2006–2010) | N/A | <p>Zimbabwe – 64.8% (2010-11 DHS)</p> <p>Nepal – 50.1% (2011 DHS)</p> <p>Nepal – 84.1% * (CSHGP, Plan 2007–2011)</p> <p>Nepal – 65.8% * (CSHGP, CARE 2007–2011)</p> <p>Tanzania – 55.0% * (CSHGP Wellshare 2006–2011)</p> <p>* denominator = 2 years prior to survey</p> |

¹⁹ 2008 Rapid CATCH indicator definition: Percentage of mothers of children age 0–23 months who had four or more antenatal visits when they were pregnant with the youngest child.

²⁰ Percentage of mothers of children 0–11 months who attended ANC at least four times during most recent pregnancy.

| INDICATOR | DEFINITION AND DISAGGREGATION | BASELINE DATA (2008 OR EARLIER) | FY2009/PY1 DATA | FY2010/PY2 DATA | FY2011/PY3 DATA | FY2012/PY4 DATA |
|---|--|--|-----------------|---|--|--|
| | | <p>RHS)</p> <ul style="list-style-type: none"> Rwanda – 23.9% (2007–08 Interim DHS) Zimbabwe – 71.1% (2005–06 DHS) <p>Note: Data for MCHIP countries' maternal health activities and population-based surveys.</p> <ul style="list-style-type: none"> India – 53% (CSHGP HOPEWW 2006–2010) Kenya – 32% (CSHGP, AMREF 2005–2010) Kenya – 28% (CSHGP, HealthRight 2006–2010) | | | | |
| 9. Percentage of women who received intermittent preventive treatment for malaria during their last pregnancy | <p>Numerator: Number of women at risk for malaria who received two or more doses of a recommended antimalarial drug treatment to prevent malaria during their last pregnancy that led to a live birth</p> <p>Denominator: Total number of women surveyed at risk for malaria who delivered a live baby within the last 2 years</p> | <ul style="list-style-type: none"> Burkina Faso – 64.3% (2003 DHS) Malawi – 81.8% (2004 DHS) Mozambique – n/a Nigeria – 22.3%; North West Zone – 10.6% (2008 DHS) Rwanda – 19.9% (2007–08 Interim DHS) Zimbabwe – 37.9% (2005–06 DHS) <p>Note: Data for MCHIP countries with malaria activities and recent population-based surveys and:</p> <ul style="list-style-type: none"> Kenya – 4% (CSHGP, HealthRight 2006-2010) Zambia – 83.8% (CSHGP, SAWSO 2005-2010) | | <ul style="list-style-type: none"> Burkina Faso – 11% (2010 Preliminary DHS) Malawi – 55% (2010 DHS) Rwanda – 13.3% (2010 Preliminary DHS) Kenya²¹ – 13%* (CSHGP, HealthRight 2006–2010) Zambia²² – 87.7% (CSHGP, SAWSO 2005–2010) | <ul style="list-style-type: none"> Mozambique – 20.5% (2011 Preliminary MIS) Zimbabwe – 23.2%(2010–11 Prelim DHS)²³ | Tanzania – 57.3% (CSHGP Wellshare 2006–2011) |

²¹ Percentage of mothers of children 0–11 months who received IPT at least twice during ANC.

²² Percentage of mothers of children 0–23 months who received IPT for malaria during their last pregnancy (confirmed by maternal health card).

²³ Percentage of last births in the 2 years preceding the survey for which the mother got intermittent preventive treatment (IPTp) during an antenatal visit.

| INDICATOR | DEFINITION AND DISAGGREGATION | BASELINE DATA (2008 OR EARLIER) | FY2009/PY1 DATA | FY2010/PY2 DATA | FY2011/PY3 DATA | FY2012/PY4 DATA |
|--|--|--|---|---|---|---|
| 10. Percentage of live births attended by skilled health personnel (doctor, nurse, midwife or auxiliary midwife) | <p>Numerator: Number of live births to women aged 15–49 years in the 5 years prior to the survey attended during delivery by skilled health personnel (doctor, nurse, midwife or auxiliary midwife)</p> <p>Denominator: Total number of live births to women aged 15–49 years in the 5 years prior to the survey (Note: This reference period may differ between surveys.)</p> | <ul style="list-style-type: none"> ▪ Ethiopia – 6.3% (2005 DHS) ▪ Kenya – 41.6% (2003 DHS) ▪ Lesotho – 55.2% (2004 DHS) ▪ Liberia – 49.4% (2008–09 DHS) ▪ Madagascar – 44.8% (2004 DHS) ▪ Malawi – 56.6% (2004 DHS) ▪ Mozambique – 49.1% (2003 DHS) ▪ Nepal – 25.0% (2006 DHS) ▪ Nigeria –Kano-12.7%, Katsina-4.7%, Zamfara-7.7% (2008 DHS) ▪ Rwanda – 57.8% (2007–08 Interim DHS) ▪ Zimbabwe – 67.3% (2005–06 DHS) <p>Note: Data for MCHIP countries' maternal health activities and population based surveys.</p> <ul style="list-style-type: none"> ▪ Bangladesh – 13.3% (CSHGP, CRWRC 2004–2010) ▪ Cambodia – 40.0% (CSHGP, IRD 2006–2010) ▪ DR Congo – 64.7% (CSHGP, CRS 2005–2010) ▪ India – 50.0% (CSHGP HOPEWW 2006–2010) ▪ Indonesia – 94.2% | <ul style="list-style-type: none"> ▪ Kenya – 45.2% (2008–09 DHS) ▪ Lesotho – 61.5% (2009 DHS) ▪ Madagascar – 43.3% (2008–09 DHS) | <ul style="list-style-type: none"> ▪ Malawi – 71.4% (2010 DHS) ▪ Rwanda – 69% (2010 Preliminary DHS) ▪ Bangladesh²⁴ – 19.1% (CSHGP, CRWRC 2004–2010) ▪ Cambodia – 83.5%* (CSHGP, IRD 2006–2010) ▪ DR Congo – 67.9% (CSHGP, CRS 2005–2010) ▪ India – 55.7% (CSHGP HOPEWW 2006–2010) ▪ Indonesia – 93.9% (CSHGP Mercy Corps 2006–2010) ▪ Kenya – 56.0%* (CSHGP, AMREF 2005–2010) ▪ Kenya²⁵ – 28.4% (CSHGP, HealthRight 2006–2010) ▪ Liberia – 34.7% (CSHGP, MTI 2006–2010) ▪ Mozambique – 77.5%* (CSHGP, FH 2005–2010) ▪ Uganda – 63.7% (CSHGP, HealthPartners 2005–2010) ▪ Zambia – 52.6% | <ul style="list-style-type: none"> ▪ Ethiopia – 10% (2011 Preliminary DHS) ▪ Nepal – 36% (2011 Preliminary DHS) ▪ Zimbabwe - 66.2% (2010–11 Preliminary DHS) | <p>Nepal – 77.6% * (CSHGP, Plan 2007–2011)</p> <p>Nepal – 52.1% * (CSHGP, CARE 2007–2011)</p> <p>Niger – 52.8% * (CSHGP, Relief 2007–2011)</p> <p>* denominator = 2 years prior to survey</p> |

²⁴ 2000+ and 2006 Rapid CATCH indicator definition: Percentage of children age 0–23 months whose births were attended by skilled personnel.

²⁵ Percentage of children age 0–11 months whose births were attended by skilled health personnel.

| INDICATOR | DEFINITION AND DISAGGREGATION | BASELINE DATA (2008 OR EARLIER) | FY2009/PY1 DATA | FY2010/PY2 DATA | FY2011/PY3 DATA | FY2012/PY4 DATA |
|---|--|---|--|--|-----------------|--|
| | | (CSHGP Mercy Corps 2006–2010) <ul style="list-style-type: none"> ▪ Kenya – 25.6% (CSHGP, AMREF 2005–2010) ▪ Kenya – 28.2% (CSHGP, HealthRight 2006–2010) ▪ Liberia – 21.3% (CSHGP, MTI 2006–2010) ▪ Mozambique – 55.6% (CSHGP, FH 2005–2010) ▪ Uganda – 47.4% (CSHGP, HealthPartners 2005–2010) ▪ Zambia – 41.6% (CSHGP, SAWSO 2005–2010) | | (CSHGP, SAWSO 2005–2010) | | |
| 11. Percentage of live births delivered by cesarean section | Numerator: Number of live births to women aged 15–49 years in the 5 years prior to the survey delivered by cesarean section Denominator: Total number of live births to women aged 15–49 years in the 5 years prior to the survey | <ul style="list-style-type: none"> ▪ Ethiopia – 1.0% (2005 DHS) <ul style="list-style-type: none"> ○ Urban: 9.4% ○ Rural: 0.3% ▪ Kenya – 4.0% (2003 DHS) <ul style="list-style-type: none"> ○ Urban: 9.4% ○ Rural: 4.0% ▪ Lesotho – 5.1% (2004 DHS) <ul style="list-style-type: none"> ○ Urban: 8% ○ Rural: 4.6% ▪ Liberia – 3.5% (2007 DHS) <ul style="list-style-type: none"> ○ Urban: 5.4% ○ Rural: 2.6% ▪ Madagascar – 1.0% (2003–04 DHS) <ul style="list-style-type: none"> ○ Urban: 2.2% ○ Rural: 0.8% ▪ Malawi – 3.1% (2004 DHS) <ul style="list-style-type: none"> ○ Urban: 4.4% ○ Rural: 2.9% ▪ Mozambique – 1.9% | <ul style="list-style-type: none"> ▪ Kenya – 6.2% (2008–09 DHS) <ul style="list-style-type: none"> ○ Urban: 11.3% ○ Rural: 5.1% ▪ Lesotho – 6.7% (2009 DHS) <ul style="list-style-type: none"> ○ Urban: 11.4% ○ Rural: 5.2% ▪ Madagascar – 1.5% (2008–09 DHS) <ul style="list-style-type: none"> ○ Urban: 5.7% ○ Rural: 0.9% | <ul style="list-style-type: none"> ▪ Malawi – 4.6% (2010 DHS) <ul style="list-style-type: none"> ○ Urban: 8.3% ○ Rural: 4.2% | N/A | <ul style="list-style-type: none"> ▪ Ethiopia – 1.5% (2011 DHS) <ul style="list-style-type: none"> ○ Urban: 8.1% ○ Rural: 0.5% ▪ Zimbabwe – 4.5% (2010-11 DHS) <ul style="list-style-type: none"> ○ Urban: 7.8% ○ Rural: 3.1% ▪ Nepal – 4.6% (2011 DHS) <ul style="list-style-type: none"> ○ Urban: 15.3% ○ Rural: 3.5% ▪ Rwanda – 7.1% (2010 DHS) <ul style="list-style-type: none"> Urban: 15.9% Rural: 5.9% |

| INDICATOR | DEFINITION AND DISAGGREGATION | BASELINE DATA (2008 OR EARLIER) | FY2009/PY1 DATA | FY2010/PY2 DATA | FY2011/PY3 DATA | FY2012/PY4 DATA |
|---|--|--|-----------------|---|-----------------|---|
| | | (2003 DHS) <ul style="list-style-type: none"> ○ Urban: 5.3% ○ Rural: 0.5% <ul style="list-style-type: none"> ▪ Nepal – 2.7% (2006 DHS) <ul style="list-style-type: none"> ○ Urban: 8.4% ○ Rural: 1.9% ▪ Nigeria –Kano-.6%, Katsina-.1%, Zamfara - 0.1% (2008 DHS) <ul style="list-style-type: none"> ○ Urban (nat'l): 3.7% ○ Rural (nat'l): 1% ▪ Rwanda – 2.9% (2007–08 Interim DHS) <ul style="list-style-type: none"> ○ Urban: n/a ○ Rural: n/a ▪ Zimbabwe – 4.8% (2005-06 DHS) <ul style="list-style-type: none"> ○ Urban: 8.7% ○ Rural: 3.2% <p>Note: Data for MCHIP countries maternal health activities and population based surveys.</p> | | | | |
| 12. Percentage of newborns put to the breast within 1 hour of birth | Numerator: Number of women with a live birth in the X years prior to the survey who put the newborn infant to the breast within 1 hour of birth Denominator: Total number of women with a live birth in the X years prior to the survey (Note: This reference | <p>Note: Data not included for MCHIP countries due to limitations. Indicator definition is standard for MICS, but not DHS, which uses the denominator of children ever breastfed rather than all children; anticipate having updated MICS data from the current round of MICS surveys in PY4.</p> <ul style="list-style-type: none"> ▪ India – 25% (CSHGP HOPEWW 2006–2010) | | <ul style="list-style-type: none"> ▪ India²⁶ – 34% (CSHGP HOPEWW 2006–2010) ▪ Kenya²⁷ – 66%* (CSHGP, HealthRight 2006–2010) ▪ Liberia²⁸ – 87.0%* (CSHGP, MTI 2006–2010) ▪ Zambia²⁹ – 71.6%* (CSHGP, | N/A | Ethiopia – 81.6% (CSHGP, GOAL 2007–2011) * denominator = 0-23 months Malawi – 94.7% Error! Bookmark not defined. (CSHGP, Save 2006–2011) * denominator = 0–11 months Nepal – 79.9% |

²⁶ Percentage of newborns who were put to the breast within 1 hour of delivery.

²⁷ Percentage of children aged 0–5 months who were exclusively breastfed within the first hour after birth.

²⁸ Percentage of newborns who were put to the breast within 1 hour of delivery and did not receive prelacteal feeds.

²⁹ Percentage of children 0–23 months who were breastfed within 1 hour of birth.

| INDICATOR | DEFINITION AND DISAGGREGATION | BASELINE DATA (2008 OR EARLIER) | FY2009/PY1 DATA | FY2010/PY2 DATA | FY2011/PY3 DATA | FY2012/PY4 DATA |
|---|---|--|---|---|-----------------|---|
| | period may differ between surveys.) | <ul style="list-style-type: none"> Kenya – 20% (CSHGP, HealthRight 2006–2010) Liberia – 33.7% (CSHGP, MTI 2006–2010) Zambia – 43.8% (CSHGP, SAWSO, 2005–2010) | | SAWSO, 2005–2010) | | (CSHGP, Plan 2007–2011) * denominator = 0–5 months Niger – 95% (CSHGP, Relief 2007–2011) * denominator = 0–23 months |
| 13. Percentage of mothers who received postnatal care visit within 2 days of childbirth | Numerator: Number of women who received a postnatal care visit within 2 days of childbirth (regardless of place of delivery) Denominator: Total number of women aged 15–49 years with a last live birth in the 5 years prior to the survey (regardless of place of delivery) | <ul style="list-style-type: none"> Bangladesh – 27% (DHS 2007) Dominican Republic – 82.1% (2007 DHS) Ethiopia – 4.6% (2005 DHS) Kenya – 10.0% (2003 DHS)³⁰ Lesotho – 47.9% (2009 DHS) Madagascar – 32.1% (2003–04 DHS) Malawi – 20.6% (2004 DHS) Mozambique – 12.1% (2003 DHS) Nigeria – Kano-12.9%, Katsina-7.1%, Zamfara-13.7% (2008 DHS) Paraguay – n/a Zimbabwe – 30.3% (2005–06 DHS) <p>Note: Data for MCHIP countries with population based surveys and newborn health activities.</p> <ul style="list-style-type: none"> Kenya – 23% (CSHGP, AMREF 2005–2010) | <ul style="list-style-type: none"> Kenya – 42.1% (2008–09 DHS) Lesotho – 47.9% (2009 DHS) Madagascar – 46.3% (2008–09 DHS) Kenya³¹ – 58%* (CSHGP, AMREF 2005–2010) | Malawi – 43% (2010 DHS) | N/A | Zimbabwe – 27.1% (2010–11 DHS) Ethiopia – 6.7% (2011 DHS) |
| 14. Percentage of | Numerator: Number of | <ul style="list-style-type: none"> Bangladesh- 27% (DHS | | <ul style="list-style-type: none"> Cambodia³² – | N/A | Malawi – 30.9% |

³⁰ Percentage distribution of women who had a non-institutional live birth in the 5 years preceding the survey by timing of postnatal care for the most recent non-institutional birth.

³¹Percentage of mothers 0–5 months who attend postnatal care within 2 days of delivery.

| INDICATOR | DEFINITION AND DISAGGREGATION | BASELINE DATA (2008 OR EARLIER) | FY2009/PY1 DATA | FY2010/PY2 DATA | FY2011/PY3 DATA | FY2012/PY4 DATA |
|--|---|---|---|--|---|--|
| babies who received a postnatal care visit within 2 days of birth | babies who received a postnatal care visit within 2 days of birth (regardless of place of delivery) Denominator: Total number of last-born babies in the X years prior to the survey | 2007) <ul style="list-style-type: none"> Dominican Republic- 82.1% (2007 DHS) Note: Data for other MCHIP countries from DHS not included due to limitations. Indicator definition is standard for MICS, but not older DHS; anticipate having updated MICS data from the current round of MICS surveys in PY4. <ul style="list-style-type: none"> Cambodia – 21.3% (CSHGP, IRD 2006–2010) India – 40.7% (CSHGP HOPEWW 2006–2010) Indonesia – 42.7% (CSHGP Mercy Corps 2006–2010) Kenya – 15.8% (CSHGP, HealthRight 2006–2010) Liberia – 7.0% (CSHGP, MTI 2006–2010) | | 67.0%* (CSHGP, IRD 2006–2010) <ul style="list-style-type: none"> India³² – 46.3% (CSHGP HOPEWW 2006–2010) Indonesia³² – 43.0% (CSHGP Mercy Corps 2006–2010) Kenya³³ – 54.7%* (CSHGP, HealthRight 2006–2010) Liberia³² – 40.3%* (CSHGP, MTI 2006–2010) | | (CSHGP, Save 2006–2011) * denominator = 0–23 months Nepal – 71.1% (CSHGP, Plan 2007–2011) * denominator = 0–5 months Nepal – 46.1% (CSHGP, CARE 2007–2011) * denominator = 0–23 months, within 3 days Tanzania – 82.5% (CSHGP Wellshare 2006–2011) * denominator = 0–23 months, within 3 days |
| 15. Percentage of mothers with children under 24 months who are currently using FP | Numerator: Number of mothers with children under 24 months who are currently using FP Denominator: Total number of mothers with children under 24 months <i>Data for contraceptive prevalence rate from DHS uses this definition (percent married women 15–49 using any form of contraception at the time of the survey).</i> | <ul style="list-style-type: none"> Bangladesh – 55.8% (DHS 2007) Ethiopia – 14.7% (2005 DHS) Guinea – 9.1% (2005 DHS) India – 56.3%; UP – 56.3%; Jharkhand [urban] – 60.0%, [rural] - 28.2% (2005–06 DHS) Kenya – 39.3% (2003 DHS) Malawi – 32.5% (2004 DHS) Mali – 8.2% (2006 DHS) Nepal – 48.0% (2006 | <ul style="list-style-type: none"> Kenya – 45.5% (2008–09 DHS) | <ul style="list-style-type: none"> Malawi – 47.4% (2010 DHS) Rwanda – 52% (2010 Preliminary DHS) Zimbabwe – 58.5% (2010 Preliminary DHS) | <ul style="list-style-type: none"> Ethiopia – 28.6% (2011 Preliminary DHS) Nepal – 49.7% (2011 Preliminary DHS) | N/A |

³² 2006 Rapid CATCH indicator definition: Percentage of children age 0–23 months who received a postnatal visit from an appropriately trained health worker within 3 days after birth.

³³ Percentage of mothers of infants 0–5 months who received neonatal care within 2 days of delivery.

| INDICATOR | DEFINITION AND DISAGGREGATION | BASELINE DATA (2008 OR EARLIER) | FY2009/PY1 DATA | FY2010/PY2 DATA | FY2011/PY3 DATA | FY2012/PY4 DATA |
|--|---|---|---|---|-----------------|---|
| | | DHS) <ul style="list-style-type: none"> ▪ Nigeria – 14.6% (2008 DHS) ▪ Rwanda – 36.4% (2007–08 Interim DHS) ▪ Zimbabwe – 60.2% (2005–06 DHS) Note: Data for MCHIP countries with population-based surveys and family planning activities. | | | | |
| 16. Percentage of women who received iron/folate during their last pregnancy | Numerator: Number of women who received iron/folate during their last pregnancy that led to a live birth Denominator: Total number of women surveyed who delivered a live baby within the last 2 years | <ul style="list-style-type: none"> ▪ Bangladesh – 57.2% (2007 DHS) ▪ Burkina Faso – 70.3% (2003 DHS) ▪ India – 64.8%; UP – 58.2%; Jharkhand – 49.5% (2005–06 DHS) ▪ Indonesia – 77.8% (2007 DHS) ▪ Kenya – 46.8% (2003 DHS) ▪ Lesotho – 37.8% (2004 DHS) ▪ Liberia – 87.4% (2007 DHS) ▪ Madagascar – 32.3% (2003–04 DHS) ▪ Malawi – 79.7% (2004 DHS) ▪ Mozambique – 59.7% (2003 DHS) ▪ Nepal – 62.8% (2006 DHS) ▪ Nigeria – 54.1%; North West Region – 30.6% (5yrs) (2008 DHS) ▪ Paraguay – n/a (2008 RHS) ▪ Rwanda – 41.7% (2007–08 Interim DHS) ▪ Zimbabwe – 41.4% | <ul style="list-style-type: none"> ▪ Lesotho – 46.5% (2009 DHS) ▪ Kenya – 69.6% (2008–09 DHS) ▪ Madagascar – 58.0% (2008–09 DHS) | <ul style="list-style-type: none"> ▪ Malawi – 91.2% (2010 DHS) | N/A | Nepal – 79.5% (2010 DHS) Rwanda – 73% (2010 DHS) Zimbabwe – 49.5% (2010–11 DHS) Ethiopia – 35.1% (CSHGP, GOAL 2007–2011) Nepal – 82.3% (CSHGP, Plan 2007–2011) * % of mothers of children aged 0–5 months receiving iron foliate tablets/caps at least for 6 months during their pregnancy |

| INDICATOR | DEFINITION AND DISAGGREGATION | BASELINE DATA (2008 OR EARLIER) | FY2009/PY1 DATA | FY2010/PY2 DATA | FY2011/PY3 DATA | FY2012/PY4 DATA |
|--|--|--|--|--|---|---|
| | | (2005–06 DHS) Note: Data for MCHIP countries with population-based surveys and maternal health activities. | | | | |
| 17. Number of (national) policies drafted with USG support* | This refers to the number of national laws, policies ³⁴ , regulations, strategy documents, including national service delivery guidelines and performance standards, developed or revised with MCHIP support to improve access to and use of high- impact MNCH services, including FP. The list of policies will be provided and disaggregated by country and technical area. | 0 | 4 | 29 | 49 (See list of policies by country at the end of this matrix.) | 43 (See list of policies by country and technical area at the end of this matrix) |
| 18. Number of MCHIP countries that have introduced innovative health financing schemes/incentive mechanisms with MCHIP support | This includes performance-based incentive (PBI) schemes, pay for performance, client incentive mechanisms, franchising, vouchers, and insurance schemes at a national or sub-national level. | 0 | 0 | 2 | 3 (Zimbabwe, Nigeria, India) | 1 (Kenya) |
| 19. Number of people trained through USG-supported programs* | This indicator will be disaggregated by training topic and for CSHGP and MCP contributions as | 0 | 1935 (Note: These are training participants and not unique individuals.) | 23,348 (Note: These are training participants and not unique individuals.) | 69,273 MNH:29,680 (core: 3,843, field: 25,837) CH/N:3,843 (core: 261, field: 2,822) | 69,148 MNH: 34, 609 (core: 1,695, field: 32,914, HBB 12,766) CH/N:13,207 (core: |

³⁴ This includes national-level policies supporting: 1) notification of maternal deaths; 2) enactment of the International Code of Marketing of Breast milk Substitutes; 3) ratification of Maternity Protection Convention 183; 4) authorization of midwives to deliver lifesaving interventions; 5) authorization of community health workers to identify and manage pneumonia; and 6) incorporation into policy of promotion of low-osmolarity oral rehydration salts and zinc for management of diarrhea. This indicator will be extended and improved as one activity under sub-objective 2 of MCHIP.

| INDICATOR | DEFINITION AND DISAGGREGATION | BASELINE DATA (2008 OR EARLIER) | FY2009/PY1 DATA | FY2010/PY2 DATA | FY2011/PY3 DATA | FY2012/PY4 DATA |
|--|---|---------------------------------|--------------------------|--|--|---|
| | needed. Training topics include: MNH, child health and nutrition, malaria, FP/RH, HIV/AIDS (PMTCT, male circumcision), and M&E/operations research. | | | | Malaria:9,083 (all field) FP/RH:25,779 (all field) HIV/AIDS:985 (all field) MER: 544 (core: 13, field: 531) Other:119 (Note: These are training participants and not unique individuals.) | 445, field: 12,762) Malaria:7,409 (core: 215, field: 7,194) FP/RH:11,476 (core: 296, field: 11,180) HIV/AIDS:1,048 (core: 310, field: 738) MER: 1399 (core: 350, field: 1049) (Note: These are training participants and not unique individuals) |
| 20. Percentage of facilities that offer delivery services with MgSO ₄ available in the delivery room | Number of facilities that offer delivery services with MgSO ₄ available in the delivery room/Total number of facilities that offer delivery services | 0 | New indicator for Year 3 | New indicator for Year 3 | Guinea - 87% | 94% - India |
| 21. Number of countries with pre-service education strengthened to improve skilled birth attendance** | This includes updating curricula and improving the skills of tutors. This indicator will be disaggregated by type of curriculum/cadre of provider, e.g., midwife, nurse, clinical officer, etc. | 0 | 2 (Malawi, Ghana) | 5 (DRC, India, Liberia, Malawi, Mozambique) | 10 (DRC, Ethiopia, Ghana, Guinea, India, Malawi, Mozambique, Nigeria, Rwanda, Zimbabwe) | 7 (Bangladesh, Ethiopia, Ghana, Guinea, India, Mozambique, Rwanda) |
| 22. Number of MCHIP-supported health facilities demonstrating increased compliance with clinical standards over baseline | Number of MCHIP-supported facilities that are implementing a quality improvement approach, such as Standards-Based Management and Recognition that demonstrate increased compliance with standards over | 0 | 0 | 117 | 1990 (Bolivia, Burkina Faso, DRC, DR, Guinea, India, Indonesia, Kenya, Malawi, Mozambique, Nigeria) | 1,718 (Bolivia, Burkina Faso, Guinea, India, Kenya, Liberia, Malawi, Mali, Mozambique, Paraguay, Zambia, Zimbabwe) |

| INDICATOR | DEFINITION AND DISAGGREGATION | BASELINE DATA (2008 OR EARLIER) | FY2009/PY1 DATA | FY2010/PY2 DATA | FY2011/PY3 DATA | FY2012/PY4 DATA |
|--|--|---------------------------------|--|---|--|---|
| | baseline. This will be disaggregated by country and type of facility (e.g., dispensary/health post, health center, hospital). | | | | | |
| 23. Number of countries with introduction of high-impact MNCH interventions through MCHIP-supported activities and CSHGP grants in MCHIP-supported countries** | <p>This includes:</p> <ul style="list-style-type: none"> ▪ Maternal anemia control ▪ PPH prevention (at least 25% of facilities that offer delivery services in one district)** ▪ PPH treatment (at least 25% of facilities that offer delivery services in one district)** ▪ Pre-eclampsia/ Eclampsia programs (program model developed for prevention, detection, and treatment)** ▪ Postnatal and essential newborn care (less than three districts)** ▪ Kangaroo Mother Care (facility-based KMC services in less than three districts)** ▪ Community Kangaroo Mother Care ▪ Newborn handwashing promoted ▪ Management of asphyxia in the newborn (home and | 0 | Mat. anemia - 0 PPH/P - 2 PPH/T - 2 PE/E - 0 PNC/ENC - 0 KMC - 0 CKMC - 1 NB HW - 0 Asphyxia - 1 NB infect - 0 ORT/Zinc - 1 CCM/Pneu. - 2 New vaccines - 0 | Mat. anemia - 1 PPH/P - 7 PPH/T - 7 PE/E - 2 PNC/ENC - 5 KMC - 7 (introduced/expanded) CKMC - 2 NB HW - 3 Asphyxia - 2 NB infect - 3 ORT/Zinc - 1 CCM/Pneu. - 0 New vaccines - 1 | Mat. anemia - 1 PPH/P - 2 PPH/T - 2 PE/E - 2 PNC/ENC - 3 KMC - 8 (into./exp) CKMC - 2 NB HW - 1 Asphyxia - 14 NB infect. - 1 ORT/Zinc - 1 CCM/Pneu. - 0 New vaccines - 5 | Mat. anemia - 2 PPH/T - 2 PE/E - 5 PNC/ENC - 3 KMC - 0 CKMC - 0 NB HW - 0 Asphyxia - 4 NB infect. - 0 ORT/Zinc - 3 CCM/Pneu. - 1 New vaccines - 3 (see the table following this matrix for the list of countries) |

| INDICATOR | DEFINITION AND DISAGGREGATION | BASELINE DATA (2008 OR EARLIER) | FY2009/PY1 DATA | FY2010/PY2 DATA | FY2011/PY3 DATA | FY2012/PY4 DATA |
|---|---|---------------------------------|--|--|---|---|
| | facility settings)** <ul style="list-style-type: none"> ▪ Newborn infection management ▪ Oral rehydration therapy/zinc ▪ Community case management/pneumonia control ▪ New vaccines/innovative technologies | | | | | |
| 24. Number of countries with expansion of high-impact MNCH interventions through MCHIP-supported activities and CSHGP grants in MCHIP-supported countries** | This includes: <ul style="list-style-type: none"> ▪ Skilled birth attendance/ Essential obstetric care** ▪ PPH prevention** (at least 20% of facilities in the country that offer delivery services)** ▪ Postnatal and essential newborn care (three or more districts) ▪ Kangaroo Mother Care (facility-based KMC services in three or more districts)** ▪ Oral rehydration therapy/zinc ▪ Community case management/pneumonia control | 0 (with MCHIP support) | SBA/EOC - 2 PPH/P - 2 PNC/ENC – 0 KMC -8 (into./exp) ORT/Zinc - 0 CCM/Pneu. – 1 | SBA/EOC - 8 PPH/P - 7 PNC/ENC – 2 KMC -8 (into./exp) ORT/Zinc - 1 CCM/Pneu. – 1 | SBA/EOC -1 PPH/P - 7 PNC/ENC – 9 KMC -8 (into./exp) ORT/Zinc - 2 CCM/Pneu. – 1 | SBA/EOC -4 PPH/P -9 PNC/ENC – 0 KMC -0 ORT/Zinc - 3 CCM/Pneu. – 2 (see the table following this matrix for the list of countries) |
| 25. Number of countries with strategies to revitalize oral rehydration therapy (ORT) use** | ORT/CDD revitalization strategy indicating explicit intent of MOH and partners to increase use of ORT | 0 | 2 | 3 | 5 (DRC, Kenya, Malawi, Rwanda, Zimbabwe) | 4 (Kenya, Mali, Rwanda, Zimbabwe) |

| INDICATOR | DEFINITION AND DISAGGREGATION | BASELINE DATA (2008 OR EARLIER) | FY2009/PY1 DATA | FY2010/PY2 DATA | FY2011/PY3 DATA | FY2012/PY4 DATA |
|---|---|---------------------------------|---|-----------------|---|--|
| 26. Number of clients attending essential MNCH services with integrated FP at MCHIP-supported facilities who received FP counseling | Essential MNCH services include ANC, postabortion care, postpartum care, well-baby/immunization services. Data will be disaggregated by country. | 0 | April–Sept. in Nigeria 105,953 ANC clients and 25,527 postpartum care | 1,077,640 | 1,049,817 (Bangladesh, DRC, Guinea, India, Malawi, Mozambique, Nigeria, Rwanda) | 701,422 (Ethiopia, Guinea, India, Mali, Mozambique, Rwanda) |
| 27. Couple years of protection | CYP is the estimated protection provided by contraceptive methods during a 1-year period, based upon the volume of all contraceptives sold or distributed free of charge to clients during that period. CYP is calculated by multiplying the quantity of each method distributed to clients by a conversion factor, to yield an estimate of the duration of contraceptive protection provided per unit of that method. The CYP for each method is then summed for all methods to obtain a total CYP figure. ³⁵ | 0 | New for Year 3 | New for Year 3 | 404,807 (Bangladesh, Guinea, India, Malawi, Mozambique, Nigeria) | 572,783 (Bangladesh, Guinea, India, Mali, Mozambique) |
| 28. Number of deliveries with a skilled birth attendant (SBA) in USG-assisted programs* | Number of deliveries with a skilled birth attendant (SBA). SBA includes: <ul style="list-style-type: none"> ▪ Medically trained doctor, nurse, or midwife. It does | N/A | Nigeria total from April–Sept was 28,336 | 228,307 | 544,622 (Bangladesh, Bolivia, DRC, DR, India, Indonesia, Malawi, Mozambique, Nigeria, Paraguay, Rwanda, Zimbabwe) | 344,865 (Bangladesh, Bolivia, DR, Ethiopia, Guinea, India, Indonesia, Kenya, Mali, Mozambique, Paraguay, Rwanda, |

³⁵ CYP conversion factors are based on how a method is used, failure rates, wastage, and how many units of the method are typically needed to provide one year of contraceptive protection for a couple. The calculation takes into account that some methods, like condoms and oral contraceptives, for example, may be used incorrectly and then discarded, or that IUDs and implants may be removed before their life span is realized.

| INDICATOR | DEFINITION AND DISAGGREGATION | BASELINE DATA (2008 OR EARLIER) | FY2009/PY1 DATA | FY2010/PY2 DATA | FY2011/PY3 DATA | FY2012/PY4 DATA |
|---|--|---|------------------|-----------------|--|---|
| | NOT include traditional birth attendants (TBAs). Data will be disaggregated by country. | | | | | Zimbabwe) |
| 29. Number of women receiving active management of the third stage of labor (AMTSL) through USG-supported programs* | Number of women giving birth who received Active Management of the Third Stage of Labor (AMTSL) through USG-supported programs. Data will be disaggregated by country. | N/A (data not captured prior to program implementation) | 15,688 (Nigeria) | 108,873 | 469,654 (Bolivia, DRC, Guinea, Indonesia, Malawi, Mozambique, Nigeria, Paraguay, Rwanda) | 118,775 (Bolivia, Guinea, Madagascar, Mali, Mozambique, Zambia, Paraguay) |
| 30. Percentage of women receiving a uterotonic immediately after birth | | Baseline data not available | New for Year 3 | New for Year 3 | Bangladesh – 85% Guinea – 81% India – 81% Zimbabwe – 87% | India - 100%, Kenya - 94%, Mali - 94%, Mozambique - 74%, Zimbabwe - 89% |
| 31. Number of newborns receiving antibiotic treatment for infection from appropriate health workers through USG-supported programs* | Number of newborn infants (identified as having possible infection) who receive antibiotic treatment from appropriate trained facility, outreach or community health workers through USG-supported programs. | 0 with MCHIP support | 2,668 | 3,737 | 252,982 (DRC, Nigeria) | N/A |
| 32. Percentage of babies not breathing/crying at birth who were successfully resuscitated | This is one of the Helping Babies Breathe indicators. | Baseline data not available | New for Year 3 | New for Year 3 | | 92% - Zimbabwe, 95% - Mali |

| INDICATOR | DEFINITION AND DISAGGREGATION | BASELINE DATA (2008 OR EARLIER) | FY2009/PY1 DATA | FY2010/PY2 DATA | FY2011/PY3 DATA | FY2012/PY4 DATA |
|--|--|---------------------------------|---|---|--|--|
| 33. Number of children less than 12 months of age who received DPT3 from USG-supported programs* | Number of children less than 12 months who received DPT3 in a given year from USG-supported programs | 0 | N/A | 10,024,409 | 25,786,000 (DRC, India, Rwanda, Zimbabwe) | 22,379,692 (India, Kenya, Malawi, Timor-Leste, Zimbabwe) |
| 34. Number of cases of child diarrhea treated in USAID-assisted programs* | Number of cases of child diarrhea treated through USG-supported programs with oral rehydration therapy (ORT) or zinc supplements | 0 | DRC: 1,595 children <5 received zinc or ORS | 55,742 <ul style="list-style-type: none"> ▪ Newborn cases: 1,889 ▪ Child cases: 49,854 ▪ Under-five cases: 3,999 | 521,105 (DRC, Malawi, Rwanda, Zimbabwe) | 22,712 (Ethiopia, Guinea, Mali, Zimbabwe) |
| 35. Number of cases of child pneumonia treated with antibiotics by trained facility or community health workers in USG-supported programs* | Number of cases of child pneumonia treated with antibiotics by trained facility or community health workers in USAID-supported programs | 0 | DRC- 1167 | 4,864 | 46,461 (DRC, Rwanda, Zimbabwe) | 45,204 (Guinea, Mali, Zimbabwe) |
| 36. Number of countries accepting new MNCH indicators for national collection and routine reporting | This includes service use and quality of care indicators related to maternity services, postpartum care, community case management, etc. | 0 | New for Year 3 | New for Year 3 | 5 (Bangladesh, DRC, Kenya, Malawi, Rwanda) | 3 (Mali, Mozambique, Rwanda) |
| 37. Number of countries piloting new MNCH indicators | This includes service use and quality of care indicators related to maternity services, postpartum care, community case management, etc. | 0 | New indicator for Year 3 | New indicator for Year 3 | 4 (Bangladesh, DRC, Kenya, Malawi) | 4 (Bangladesh, Kenya, Rwanda, Zimbabwe) |

| INDICATOR | DEFINITION AND DISAGGREGATION | BASELINE DATA (2008 OR EARLIER) | FY2009/PY1 DATA | FY2010/PY2 DATA | FY2011/PY3 DATA | FY2012/PY4 DATA |
|-------------------------------------|--|---------------------------------|-----------------|---|---|---|
| 38. Number of studies ³⁶ | This includes special studies, baseline and feasibility studies and evaluations conducted with both core (SO2 and SO3) and field funds (under SO1). Special studies are analyses undertaken to gather information relevant for a particular program or activity in order to improve knowledge or understanding about the study subject. Special studies examine unique circumstances as opposed to an entire activity or program. A baseline study records the context of the host country working environment at that time. Such studies are generally carried out before program activities begin or during program start-up. A feasibility study examines the context in which an anticipated activity would be implemented as well as the viability and practicality or implementing the particular activity. This includes midterm and endline evaluations conducted by CSHGP grantees. | 0 | 34 | 48 <ul style="list-style-type: none"> ▪ 22 CSHPG ▪ 10 Malaria Communities Program ▪ 16 MCHIP | 46 <ul style="list-style-type: none"> ▪ 21 MCHIP ▪ 25 CSHPG (see the table following this matrix for a list of studies) | 50 <ul style="list-style-type: none"> ▪ 33 MCHIP (see the table following this matrix for a list of studies) <ul style="list-style-type: none"> ▪ 17 CSHPG (8 midterm evaluations 9 final evaluations) |

³⁶ Planned studies from the Results pathways include the global PE/E survey, PE/E country evaluations (2 countries), an evaluation of community-based KMC (2–3 countries), and mid-term and endline evaluations by the CSHGP grantees.

| INDICATOR | DEFINITION AND DISAGGREGATION | BASELINE DATA (2008 OR EARLIER) | FY2009/PY1 DATA | FY2010/PY2 DATA | FY2011/PY3 DATA | FY2012/PY4 DATA |
|---|--|---------------------------------|-----------------|-----------------|---|--|
| 39. Number of innovations or promising practices of CSHGP grants documented and supported by SO3 | Demonstration of innovations and promising practices includes: <ul style="list-style-type: none"> ▪ CSHGP Operations Research Studies supported through TA from MCHIP SO3 ▪ Special analyses conducted across the portfolio of CSHGP grants by MCHIP SO3, such as innovation tracking, Lives Saved calculations, and including possible themes of integration/integrated packages, cost, effective delivery modalities, analysis for scalable components, equity ▪ Documentation of successful projects | 0 | 5 | 11 | 6 (6 innovation grants started in YR3) | 23 active Innovation awards |
| 40. Number of CSHGP grantee innovations or promising practices incorporated into MCHIP country programs | Demonstration of innovations and promising practices includes: <ul style="list-style-type: none"> ▪ CSHGP Operations Research Studies supported through TA from MCHIP SO3 ▪ Special analyses conducted across the portfolio of CSHGP grants by MCHIP SO3, such as innovation tracking, Lives Saved calculations, and including possible themes of integration/ | 0 | 0 | 0 | None | Total of 3 <ol style="list-style-type: none"> 1. Barrier Analysis Tool (developed by Food for the Hungry, sponsored by CORE Group and USAID) was used in Rwanda to develop a national BCC plan. MCHIP participated in development and implementation of plan. 2. During the final evaluation of Concern Worldwide's |

| INDICATOR | DEFINITION AND DISAGGREGATION | BASELINE DATA (2008 OR EARLIER) | FY2009/PY1 DATA | FY2010/PY2 DATA | FY2011/PY3 DATA | FY2012/PY4 DATA |
|---|--|---------------------------------|-----------------|-----------------|--|---|
| | <p>integrated packages, cost, effective delivery modalities, analysis for scalable components, equity; SO3 organized TAG, for example on equity</p> <ul style="list-style-type: none"> ▪ Documentation of successful projects | | | | | <p>program in Rwanda, the ICM scorecard that was developed as part of this project was presented to MCHIP staff who participated in the final evaluation. MCHIP personnel were interested in using the tool in the future, but this has not been followed up.</p> <p>3. World Renew (formerly CRWRC) and MCHIP have a strong ongoing relationship with both groups sharing information and experience in Bangladesh and India. In Bangladesh, World Renew's Susoma project uses MNH material from MCHIP MaMoni; participated in and helped organize MCHIP's HBB workshop in Netrokona District (Susoma project area).</p> |
| 4. Number of CSHGP-developed tools, reference materials and guides utilized to inform | Disaggregated by specific tool, reference material and guide. Examples are: KPC survey, including Rapid CATCH indicators; KPC TOAST curriculum | 0 | 1 | 1 | 1 (Equity guidance use for start-up of MCHIP Zimbabwe) | <p>Total of 3</p> <p>1. Barrier Analysis Tool (developed by Food for the Hungry, sponsored by CORE Group and USAID) was</p> |

| INDICATOR | DEFINITION AND DISAGGREGATION | BASELINE DATA (2008 OR EARLIER) | FY2009/PY1 DATA | FY2010/PY2 DATA | FY2011/PY3 DATA | FY2012/PY4 DATA |
|--------------------------------|--|---------------------------------|-----------------|-----------------|-----------------|--|
| MCHIP country-level activities | (Training of Survey Trainers); Lives Saved calculator; Technical Reference Materials; MAMAN package; Sustainability framework; Program Design Monitoring and Evaluation course (PDME). | | | | | <p>used in Rwanda to develop a national BCC plan.</p> <ol style="list-style-type: none"> 2. During the final evaluation of Concern Worldwide's program in Rwanda, the ICM scorecard that was developed as part of this project was presented to MCHIP staff who participated in the final evaluation. 3. World Renew (formerly CRWRC) and MCHIP have a strong ongoing relationship with both groups sharing information and experience in Bangladesh and India. In Bangladesh, World Renew's Susoma project uses MNH material from MCHIP MaMoni; participated in and helped organize MCHIP's HBB workshop in Netrokona District. |

CSHGP LIST ANALYSIS NOTES:

- Only indicators that demonstrated a statistically significant increase ($p < 0.05$) in CSHGP grantees' final evaluation reports were modeled in LiST. All other indicators, including HIV/AIDS indicators, were modeled as unchanging.
- Some CSHGP indicator definitions did not exactly match those that CSHGP grantees reported, in which case the CSHGP indicators were used as proxies. For instance, infant and young child feeding (IYCF) was entered as the LiST complementary feeding education and supplementation indicator. Iron and folic acid (IFA) supplementation during pregnancy was entered as the LiST multiple micronutrient supplementation indicator. Immediate drying and warming was entered as the LiST Kangaroo Mother Care (KMC) indicator. Point-of-use (POU) water treatment was entered as the LiST improved water source indicator.
- The health facility (HF) delivery indicator point estimate in LiST cannot be greater than SBA; therefore for Save/Malawi and Relief/Niger, SBA was entered as the SBA and HF delivery indicators in LiST. (In both cases, the point estimate of HF delivery was slightly higher than SBA but within the confidence interval.)
- EBF coverage was assumed to be the same for children less than 1 month old and for those 1–5 months old although LiST allows users to enter different rates for the two age groups.
- All grantees conducted their baseline surveys within the first 3 months of the year following the year in which the grant was awarded (e.g., grants funded in 2006 conducted their baseline sometime between January and March of 2007.) Therefore, each project's baseline year was considered to be the year in which the baseline knowledge, practice, coverage (KPC) survey was conducted. This is notable in that LiST assumes that no additional lives were saved in the baseline year.
- All LiST analyses are performed using national population data in LiST's demographic files and then scaled down to the project level using the project area population provided by the grantee in the CSHGP web-based database.
- Analysis results (additional lives saved, or ALS) are rounded to the nearest 100 for each intervention before being totaled for an overall project ALS estimate.

CSHGP PROJECT-SPECIFIC INFORMATION:

Concern Worldwide/Rwanda was implemented in six districts (Gisagara, Kirehe, Ngoma, Nyamagabe, Nyamasheke and Nyaraguru). Indicators modeled in LiST include: child ITN use, soap at place of handwashing (soap), appropriate fever treatment, ORT use, POU water treatment (POU), pneumonia care-seeking, zinc for diarrhea treatment, child vitamin A supplementation. National five-year under-5, infant and neonatal mortality rates were used from Rwanda's 2005 DHS as baseline mortality rates.

Save /Malawi was implemented nationwide, but the KPC survey was only implemented in Mzimba district. Exclusive breastfeeding (EBF) and newborn postnatal visit (NPV) within 3 days of delivery indicators were included in the KPC LiST analysis. An additional household survey was conducted in the three community-based maternal and newborn care (CBMNC) focus districts (Dowa, Chitipa and Thyolo districts). Increases in skilled birth attendance (SBA), HF deliveries, NPV within 2 days, and EBF were modeled for the CBMNC districts. The ALS estimated through the two LiST analyses were added together, and the total was entered into the PMP table; however, it must be noted that this ALS value is for only four districts although the project covered the whole country. For the KPC analysis, Mzimba district 10-year under-5, infant and neonatal mortality rates were used from Malawi's 2004 DHS as baseline mortality rates. For the CBMNC analysis, national 5-year rates were used.

Wellshare International/Tanzania was implemented in Karatu district. Indicators modeled in LiST include: EBF, child ITN use, soap, NPV within 3 days, pneumonia care-seeking, ORT use, SBA, intermittent presumptive malaria treatment during pregnancy, child vitamin A supplementation, and 4+ antenatal care visits (4+ANC). Northern Zone 20-year under-5, infant and neonatal mortality rates were used from Tanzania's 2004-05 DHS as baseline mortality rates.

CARE/Nepal was implemented in Doti and Kailali districts. Indicators modeled in LiST include: SBA, IYCF, soap, PNV within 3 days, DPT3, HF deliveries, and 4+ANC. Far Western Region 1-year under-5, infant and neonatal mortality rates were used from Nepal's 2006 DHS as baseline mortality rates.

Plan/Nepal was implemented in Parsa and Sunsari districts. Indicators modeled in LiST include: SBA, PNV within 3 days, IFA supplementation (6+ months), immediate newborn drying and warming, HF delivery, and 4+ANC. National 5-year under-5, infant and neonatal mortality rates were used from Nepal's 2006 DHS as baseline mortality rates because the project districts were located in two different regions.

GOAL/Ethiopia was implemented in Awassa Zuria and Boricha Woredas. Indicators modeled in LiST include: EBF, IYCF, POU, IFA supplementation, and 2+ maternal tetanus toxoid vaccinations (MTT). Southern Nations, Nationalities and People's Region (SNNPR) 10-year under-5, infant and neonatal mortality rates were used from Ethiopia's 2005 DHS as baseline mortality rates.

Relief International/Niger was implemented in Konni district. Indicators modeled in LiST include: SBA, MTT, EBF, IYCF, child ITN use, soap, appropriate fever treatment, ORT use, POU, and HF deliveries. Tahoua Region 10-year under-5, infant and neonatal mortality rates were used from Niger's 2006 DHS as baseline mortality rates.

Table 6. Details for Indicators 23 and 24 (Number of Countries and Country Names)

| | YEAR 1 RESULTS | YEAR 2 RESULTS | YEAR 3 RESULTS | YEAR 4 RESULTS | YEAR 5 TARGET | LOP TARGET |
|--|-----------------------------|--|--|--|---|------------|
| High Impact Maternal Health Interventions | | | | | | |
| Maternal Anemia Control | | 1 Bangladesh or Indonesia | 1 Rwanda | 2 Zimbabwe, Kenya | 5 TBD | 5 |
| Skilled Attendance at Birth (Essential Obstetric Care) | 2 Mozambique, Nigeria | 8 Malawi, Kenya, Madagascar, India, Liberia, Mali, Lesotho, DRC | 1 Zimbabwe | 4 Ghana, Bangladesh, Afghanistan, Ethiopia | 1 South Sudan | 10 |
| PE/E Prev./Treatment Introduced | | 2 Nepal Mozambique | 2 Tanzania Zimbabwe | 5 Bangladesh, Ethiopia, Indonesia, Bolivia, Paraguay | 7 Guinea, India, Madagascar, Pakistan, South Sudan, Yemen, Zambia | 7 |
| PPH Prevention Expanded | 2 Mali, DRC | 7 Kenya, Mozambique, Madagascar, Liberia, India, Nigeria, Malawi | 7 Zimbabwe, Nepal, Rwanda, Paraguay, Indonesia, Ethiopia, Bangladesh | 9 Guinea, South Sudan, Angola, Peru, Nicaragua, Guatemala, Honduras, Tanzania, Afghanistan | 2 Pakistan, Zambia | 20 |
| PPH Treatment Introduced | 2 Nigeria, DRC | 7 Mali, Kenya, Malawi, Mozambique, Madagascar, Liberia, India, | 2 Zimbabwe, Nepal | 2 Paraguay, Bolivia | 2 Yemen, Philippines | 15 |
| High Impact Newborn Health Interventions | | | | | | |
| Management of asphyxia introduced | 1 Nigeria | 2 Kenya, Bangladesh | 14 Azerbaijan, India, Ethiopia, Nigeria, Zimbabwe, Ghana, Dominican Republic, Nicaragua, Guatemala, El Salvador, Honduras, Panama, Belize, Bolivia | 4 Malawi* , Tanzania* , Mozambique, Zambia | 5 Pakistan S Sudan Uganda* Francophone Africa (2 TBD) | 8 |
| Newborn handwashing promoted | | 3 Indonesia, Bangladesh, India | 1 Kenya | | | 8 |

* Through TA and support to regional ENC/HBB pre-service curriculum development in collaboration with RCOHC and ECSACON.

| | YEAR 1 RESULTS | YEAR 2 RESULTS | YEAR 3 RESULTS | YEAR 4 RESULTS | YEAR 5 TARGET | LOP TARGET |
|---|------------------------|--|--|--|---|------------|
| Newborn infection management introduced | | 3 Bangladesh, Nigeria, Dominican Republic | 1 Paraguay | 0 | 3 <i>Liberia- TBD +2 CHX introduction, TBD</i> | 8 |
| Community KMC | 1 Bangladesh | 2 Malawi Indonesia | 2 Ethiopia, Mozambique, | 0 | 0 | 8 |
| KMC introduced/expanded | | 7 Malawi, Bangladesh, Nigeria, DRC, Mali, Dominican Republic, Nicaragua | 8 Rwanda, Indonesia, Guatemala, Honduras, El Salvador, Paraguay, Zimbabwe Mozambique | 0 | 1 South Sudan | 15 |
| PNC/ENC expanded | | 2 Bangladesh, DRC | 9 India, Nigeria, Malawi, Ethiopia, Zimbabwe, Mozambique, Mali, Guinea Rwanda | 0 | 2 Pakistan South Sudan | 10 |
| PNC/ENC introduced | | 5 India, Malawi, Mali, Nigeria, Dominican Republic | 3 Azerbaijan, Indonesia, Paraguay | 3 Kenya, Tanzania, Colombia, Mozambique | 1 Uganda* | 15 |
| High Impact Child Health Interventions | | | | | | |
| Expansion of ORT/Zinc | 1 Senegal | | 2 DRC, Rwanda | 3 Kenya, Mali, Zimbabwe | | 6 |
| Introduction of ORT/Zinc | 2 Kenya, Mali | | 1 Zimbabwe | 3 DRC, Rwanda, Senegal | 2 Zambia, Guinea | 8 |
| Expansion of CCM or Pneumonia Control | 2 DRC, Senegal | | 1 Rwanda | 2 Mali, Zambia | 1 Guinea | 7 |
| Intro. of CCM or Pneumonia Control | 2 Kenya, Mali | | 0 | 1 Guinea | | 5 |
| Immunization Interventions | | | | | | |
| RI and Polio | 3 DRC, India, Kenya | | 3 Nigeria Afghanistan, Pakistan | 3 Ukraine, Kyrgyzstan, Tajikistan | 1 Uganda | 7 |
| New vaccines/Innovative technologies | 1 Rwanda | | 5 DRC, Kenya, Benin, Zimbabwe, Tanzania | 4 Senegal, Malawi, India, Timor-Leste | 2 Uganda, Yemen | 7 |

| | YEAR 1 RESULTS | YEAR 2 RESULTS | YEAR 3 RESULTS | YEAR 4 RESULTS | YEAR 5 TARGET | LOP TARGET |
|--|---|----------------|-------------------------------|---|--------------------------------------|------------|
| RED+ (RED plus MNCH/FP) | 1 Liberia | | 3 Kenya,India, Zimbabwe | 0 | 0 | 3 |
| District RI planning/Management capacity | 5 DRC, India, Kenya, Nigeria, Southern Sudan | | 2 Rwanda, Zimbabwe | 5 Senegal, Malawi, Uganda, Tanzania, Timor-Leste | 2 Pakistan (?),Yemen (?) | 8 |
| Resources leveraged for RI | 8 DRC, India, Kenya, Timor-Leste, Zimbabwe, Madagascar, Nigeria, Southern Sudan | | 1 Tanzania | 4 Senegal, Malawi, Rwanda, Uganda | 1 Pakistan | 6 |
| One Year RI Coverage Increased | 6 (Years 1 and 2: Rwanda, Southern Sudan, India, Madagascar, Nigeria, East Timor) | | 1 Kenya | 5 DRC, Malawi, Tanzania, Timor-Leste, Zimbabwe | 3 Pakistan, Senegal, Uganda | 7 |

Table 7. Details for Indicators 38 and 17

| Indicator 38: Number of Studies | | |
|---------------------------------|-----------|--|
| Geographic Area | Number | Additional Notes |
| Bangladesh | 3 | 1. MaMoni midline survey in Habiganj 2. MaMoni endline survey in Sylhet 3. Evaluation of HBB post training skill retention among service providers |
| Ethiopia | 1 | Baseline assessment for feasibility of community based kangaroo mother care in Ethiopia |
| Honduras | 1 | Evaluation of a Pilot introduction of OiU for use during AMTSL in Honduras |
| India | 2 | 1. Evaluation of Postpartum systematic screening tool in Jharkhand India 2. Assessment of Post partum intrauterine contraceptive device services in India |
| Kenya | 3 | BFCI QQ assessment, Igembe baseline, PMTCT intervention in Bondo |
| Malawi | 2 | 1. An Evaluation of Facility-based Scale-up of HBB Initiative in Malawi; 2. PCV13 post-introduction evaluation |
| Mali | 1 | Matron Assessment |
| Mozambique | 3 | Health Facility Survey for Quality and Humanization of Care in Mozambique's Model Maternity Facilities; Mozambique: Validation of New Maternal and Neonatal Care Indicators; Avaliacao da qualidade dos dados de SMI; Implementation of Integrated Service Packages for Reproductive, Maternal, Newborn, Child and Adolescent Health |
| Nepal | 1 | Assessment of the community based newborn care package in Nepal |
| Nicaragua | 2 | 1. Evaluation of a pilot introduction of OiU for use during AMTSL in Nicaragua 2. CAMBIO (Changing AMTSL Behavior in Obstetrics) assessment in Nicaragua |
| Paraguay | 2 | 1. IEC Clients' knowledge baseline 2. Community forum assessment |
| Rwanda | 3 | Malaria prevalence among pregnant women in Rwanda, PPH study and Malaria impact evaluation in Rwanda |
| Tanzania | 1 | R2P study on HTC in VMMC |
| Timor Leste | 1 | Understanding the socio-cultural dynamics of urban communities and health system factors influencing childhood immunization in Dili, Timor-Leste |
| Zimbabwe | 7 | 1.NIHFA/EQOC study. 2. IYCF Formative Research study. 3.National EPI review 4.Breastfeeding KAB study. 5.IYCF Program Review. 6.VHW PQI baseline assessment. 7.National baseline assessment of newborn corners |
| Total | 33 | |

| Indicator 17: Number of National Policies, Guidelines and Strategies Developed Using USG Funds. ³⁸ | | | |
|---|--------|---|---|
| Geographic Area | Number | Technical Area(s) | Additional Notes |
| Burkina Faso | 1 | Malaria treatment/prevention | Integrated communication plan for Malaria |
| Guinea | 4 | Child health and nutrition (2) Malaria (1) FP/RH (1) | Document de politique de Santé communautaire. 2. Guide mise en oeuvre de la PCIMNE Communautaire. 3. Document de politique de prise en charge du paludisme. 4. Politique nationale SR/PF. |
| India | 2 | Child health and nutrition (1) FP/RH (1) | Multi dose Open vial policy. 2. National Plan and road map for scale up of PPIUCD services developed by Gol with TA from MCHIP. |
| Kenya | 14 | Maternal and newborn health (2) Child health and nutrition (9) Monitoring and evaluation (3) | Maternal module on community MNH guidelines MNH service delivery standards iCCM implementation guidelines ORT corner operational guidelines and standards IFA plan of action 2012–2015 Micronutrient strategy Nutrition surveillance protocol CODE of breast milk substitute regulations implementation plan Nutrition Action Plan MIYCN Guidelines & Orientation Package CODE of breast milk substitute regulations—new,Zinc reclassification by PPB to OTC DON— M&E framework DVI—M&E framework DCAH—M&E framework |
| Lesotho | 3 | HIV/AIDS | Lesotho Nursing Council (LNC) 5-year strategic plan. 2.LNC 2-year Operational Plan. 3. National five-year VMMC Operational Plan |
| Liberia | 3 | Maternal and newborn health (1) FP/RH (2) | 1. Rapid Model 2. WHO Home-Based Maternal and newborn Home Care Curriculum |
| Mali | 2 | Child health and nutrition FP/RH | National Strategy for Essential Community Care (Soins Essential Comunaitaire) Guidelines |
| Mozambique | 8 | Maternal and newborn health (1) Child health and nutrition (1) Malaria treatment/prevention (3) HIV/AIDS (1) FP/RH (1) M&E (1) | National standards for Model Maternities, including IPTp for malaria, PMTCT, and nutrition Clinical protocols for the management of various illnesses in childhood, adulthood, and pregnancy Guidelines for Distribution of Long-Lasting Insecticide Treated Mosquito Nets to pregnant women through the National Health System National Strategic Plan for Malaria Control 2012–2016 |

³⁸ This refers to the number of national laws, policies, regulations, strategy documents, including national service delivery guidelines and performance standards, developed or revised with MCHIP support to improve access to and use of high impact MNCH services, including FP. The list of policies will be provided and disaggregated by country and technical area.

Indicator 17: Number of National Policies, Guidelines and Strategies Developed Using USG Funds.³⁸

| Geographic Area | Number | Technical Area(s) | Additional Notes |
|------------------------|---------------|--|---|
| | | | National Policy of the Malaria Control Program National strategic plan for elimination of mother-to-children transmission of HIV National performance standards for CECAP/FP Monitoring and Evaluation Plan 2012–2016—National Malaria Control Program |
| Rwanda | 2 | Maternal and newborn health (1) FP/RH (1) | 1. Family Planning Policy (2012–2016) 2. The National Social and Behavior Change Communication Sub-strategy for Maternal and Child Health |
| South Sudan | 1 | FP/RH (1) | RH/FP Policy Strategy Plan for South Sudan |
| Tanzania | 1 | Child Health and nutrition | Routine Immunization Policy |
| Vietnam | 1 | HIV/AIDS | National Guidelines for the Care of Newborns and Children Exposed to and Infected by HIV |
| Zimbabwe | 1 | Child health and nutrition | Immunization Policy |
| Total | 43 | | |

