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MCHIP Maternal and Child Health Integrated Program

MCHIP YEAR FIVE ANNUAL REPORT

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Abbreviations and Acronyms

AA	Associate Award
AAP	American Academy of Pediatrics
ACNM	American College of Nurse-Midwives
ACOG	American Congress of Obstetricians and Gynecologists
ACS	Antenatal corticosteroids
AFRO	World Health Organization Africa Regional Office
AIDS	Acquired immune deficiency syndrome
AMTSL	Active management of the third stage of labor
ANC	Antenatal care
APR	A Promised Renewed
ARI	Acute respiratory infection
BCC	Behavior change communication
BEmONC	Basic emergency obstetric and newborn care
BMGF	Bill & Melinda Gates Foundation
BTS	Born Too Soon
CCM	Community case management
CDC	U.S. Centers for Disease Control and Prevention
CHEW	Community Health Extension Worker
CHNRI	Child Health and Nutrition Research Initiative
CHW	Community health worker
CHX	Chlorhexidene
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
CSO	Civil society organization
CYP	Couple years of protection
DCC	Delayed cord clamping
DGAP	Diarrhea Global Action Plan
DHS	Demographic and Health Survey
DoD	Department of Defense
DoV	Decade of Vaccine
DRC	Democratic Republic of Congo
ECSACON	East Central and Southern Africa College of Nursing
EML	Essential Medicines List
EmONC	Emergency obstetric and newborn care

ENA	Essential Nutrition Action
ENAP	Every Newborn Action Plan
ENC	Essential newborn care
EPI	Expanded Program on Immunization
FANTA	Food and Nutrition Technical Assistance
FIGO	International Federation of Gynecology and Obstetrics
FMOH	Federal Ministry of Health
FP	Family planning
GAPPD	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
GMHC	Global maternal health conference
GNHC	Global newborn health care
GPEI	Global Polio Eradication Initiative
GVAP	Global Vaccine Action Plan
HBB	Helping Babies Breathe
HBS	Helping Babies Survive
HCT	HIV counseling and testing
HFS	Healthy Fertility Study
HIDN	Health, Infectious Disease and Nutrition
HIP	High-impact practices
HIV	Human immunodeficiency virus
HKI	Helen Keller International
HMIS	Health management information system
HTC	HIV testing and counseling
ICC	Inter-agency Coordination Committee
iCCM	Integrated community case management
ICDDR	International Center for Diarrheal Disease Research
ICM	International Confederation of Midwives
IEC	Information, education and communication
IFA	Iron-folic acid
IIP	Immunization in Practice
IMCI	Integrated management of childhood illness
IMNCI	Integrated management of neonatal and childhood illness
IOM	Institute of Medicine
IP	Infection prevention
IPAC	Immunization Practices Advisory Committee
IPC	Interpersonal communication
IPNC	Integrated postnatal care
IPTp	Intermittent preventive treatment during pregnancy

IPV	Inactivated polio vaccine
IRB	Institutional Review Board
ITN	Insecticide-treated net
IYCN	Infant and young child nutrition
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
KPC	Knowledge, practice, coverage
LAC	Latin America and the Caribbean
LAM	Lactational amenorrhea method
LARC	Long-acting reversible contraception
LiST	Lives Saved Tool
LQAS	Lot quality assurance sampling
M&E	Monitoring and evaluation
MAMA	Mobile Alliance for Maternal Action
MaMoni	Integrated Safe Motherhood, Newborn Care and Family Planning Project
MAPC	Maternal anemia prevention and control
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
MHTF	Maternal Health Task Force
MICS	Multiple Indicator Cluster Survey
MIP	Malaria in pregnancy
MIYCN	Maternal, infant and young child nutrition
MLM	Mid-Level Managers
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
MTR	Mid-term review

NGO	Nongovernmental organization
NNMR	Neonatal Mortality Rate
NUVI	New and Under-Utilized Vaccines Introduction
NVI	New vaccine introduction
OGAC	Office of the Global AIDS Coordinator
OiU	Oxytocin in Uniject
OR	Operations research
ORS	Oral rehydration salts
ORT	Oral rehydration therapy
OSCE	Objective structured clinical examination
PAC	Postabortion care
PAHO	Pan American Health Organization
PBI	Performance-Based Incentive
PE/E	Pre-eclampsia/eclampsia
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PIE	Post-introduction evaluation
PL	Program learning
PMI	U.S. President's Malaria Initiative
PMNCH	Partnership for Maternal, Newborn & Child Health
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
PY	Program Year
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
RI	Routine immunization
RMC	Respectful maternity care
RMNCH	Reproductive, Maternal, Newborn, and Child Health
SBA	Skilled birth attendant

SBCC	Social and behavior change communication
SBM-R®	Standards-Based Management and Recognition
SC	Save the Children
SCM	Supply chain management
SEC	Soins Essentiels Communautaires
SIA	Supplementary immunization activity
SMRH	Safe motherhood and reproductive health
SNL	Saving Newborn Lives
SOP	Standard operating procedures
SP	Sulfadoxine-pyrimethamine
TA	Technical assistance
TAG	Technical advisory group
TBA	Traditional birth attendant
TF	Task force
TOR	Terms of Reference
TOT	Training of trainers
TWG	Technical working group
U5MR	Under-five mortality rate
UHEP	Urban Health Extension Program
UIP	Universal Immunization Programme
UN	United Nations
UNCoLSC	UN Commission on Life Saving Commodities
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
USSD	Unstructured Supplementary Service Data
UUTSL	Use of uterotonic in the third stage of labor
VCT	Voluntary counseling and testing
VMMC	Voluntary medical male circumcision
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), has contributed to reductions in maternal, newborn, and child mortality through increased coverage of key, high-impact interventions in over 45 countries from its inception in October 2008. Over the course of five years, MCHIP has established strong working relationships and dissemination channels with global and regional partners and, perhaps most important, worked directly with country programs worldwide. MCHIP has influenced a number of policies that support improved health outcomes and has supported countries in achieving their goals and in scaling up evidence-based maternal, newborn, and child health/family planning (MNCH/FP) approaches. MCHIP's country reach also allows its contributions at the regional and global levels to be grounded in current field realities and provides a strong platform for multi-directional program learning (PL).

At the start of Program Year (PY) 5, MCHIP had 37 active country programs. Early in the year, three new field support-funded programs got under way in Yemen, Namibia, and Uganda, as did one new Associate Award for Sindh and Punjab provinces in Pakistan, and a new Survive and Thrive Global Development Alliance activity in Burma. Several of MCHIP's ongoing country programs also expanded during the year. At USAID's request, after serving as Secretariat for the Government of India's Child Survival Call to Action Summit, MCHIP/India was asked to assist the Ministry of Health and Family Welfare (MOHFW) in rolling out its new Reproductive, Maternal, Newborn, and Child Health plus Adolescent strategy (RMNCH+A) in six USAID-supported states—four where the project had never worked before. MCHIP/Kenya also expanded during the year, taking its integrated package of RMNCH support from Western into Eastern and Rift Valley provinces, and MCHIP/Mali doubled its geographic scope by adding the region of Sikasso to the project's ongoing work in the region of Kaye. Finally, MCHIP Malawi added a new voluntary medical male circumcision (VMMC) activity and MCHIP Tanzania added two new regions—Njombe and Tabora—to its already highly successful program in Iringa. Several USAID Missions expressed interest during the year in issuing Associate Awards (AAs) that would have extended the project's support beyond September 2014, when the current MCHIP Leader Award ends. Although MCHIP's funding ceiling would not permit all of the interested Missions to pursue an AA, two new AAs were awarded prior to the end of PY5—one for work through 2018 in Bangladesh and the other through 2017 in Malawi—and two additional AAs are expected in early PY6 for the continuation of programs in Zimbabwe and Yemen. Going into MCHIP's final year, there are still 29 country programs and 36 distinct country workplans at some stage of implementation. Seven country programs closed in PY5—Bolivia, Burkina Faso, Democratic Republic of Congo, Guyana, Paraguay, Indonesia, and Tajikistan—and others will be phasing out in Quarter 1 of PY6. All of MCHIP's country activities are scheduled to end on or before June 30, 2014.

A financial summary for the program is provided in Annex A.

[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 International; Program for Appropriate Technology in Health (PATH); Broad Branch Associates; and Population Services International (PSI).

GLOBAL LEADERSHIP HIGHLIGHTS

Global/Regional Events

MCHIP held the sixth annual postpartum family planning (PPFP) technical meeting on May 27, 2013, in Kuala Lumpur, Malaysia, as a satellite event at the Women Deliver Conference. Approximately 100 experts and leaders in reproductive health and MNCH from over 40 global health organizations, government agencies, donors, universities, and other groups participated. The meeting provided a forum for participants to share best practices and experiences with PPFP programming and featured the announcement of the new WHO resource, "Programming Strategies for Postpartum Family Planning."

MCHIP also contributed to advancing global thinking and country-level uptake of strategies focused on improving quality of care. The "Improving Measurement of Maternal and Newborn Health Service Coverage and Quality" satellite, one-day event at the *2013 Global Maternal Health Conference*, held in Arusha, Tanzania, in January 2013, provided an opportunity to discuss current and potential indicators and data collection strategies to measure the quality and coverage of key maternal and newborn health (MNH) interventions. Three methods of national data collection were discussed and several key recommendations, including the need to measure equity and the importance of interagency collaboration and harmonization of surveys, approaches, and partner efforts, were put forward.

In collaboration with USAID, the United Nations Children's Fund (UNICEF), the Bill & Melinda Gates Foundation (BMGF), and Saving Newborn Lives (SNL) the *Newborn 2013: Global Newborn Health Conference* was held in Johannesburg, South Africa, in April. More than 450 researchers, health officials, policymakers, health experts, and advocates from over 50 countries came together to review the progress that had been made toward reducing newborn deaths and review what can be done to address this challenge in countries where the needs are greatest. The conference leveraged technology to reach a much larger audience than the 450 individuals in attendance. The conference was live cast over the Internet, drawing a large international audience with over 16,000 views of the webcast in 90 countries. In addition, satellite viewing parties were held in countries such as Bangladesh, India, Nepal, and Madagascar. With over 28,000 contributors on Twitter, the online conversations reached 48 million people across the world.

MCHIP's global leadership role in immunization continued, with the program serving as a liaison among global, regional, and country levels in collaboration with key partners (e.g., GAVI Alliance, USAID, U.S. Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO), UNICEF, and USAID bilaterals). For example, MCHIP participated in the 5th GAVI Partners Forum, conducted in Dar es Salam, Tanzania, with about 650 participants from all over the world in attendance. The focus of the forum was on engaging civil society organizations (CSOs).

Global Tools and Resources

MCHIP published three briefs—on active management of the third stage of labor (AMTSL), postpartum hemorrhage (PPH), and delayed cord clamping (DCC)—that highlight key recommendations from the recently updated WHO guidelines. These briefs have been widely disseminated at global events and at the country level, which has resulted in governments and stakeholders in South Sudan, Pakistan, India, and Yemen institutionalizing and operationalizing these recommendations. In Yemen, the Ministry of Public Health and Population was provided with technical assistance from MCHIP to incorporate the guidelines into the MOPHP's Accelerated MNH Action Plan toward Millennium Development Goals (MDGs) 4 and 5. In South Sudan, MCHIP provided technical assistance to the development of national guidelines on PPH prevention and use of misoprostol. In Pakistan, MCHIP provided technical assistance (TA) to develop guidelines for improved use of uterotonics including proper maintenance and storage of oxytocin.

The Maternal Health team developed a new Program Implementation Guide, *Advance Distribution of Misoprostol for Self-Administration: Expanding Coverage for the Prevention of Postpartum Hemorrhage,* which was included in an update to the K4Health PPH toolkit. The toolkit now includes a new section for resources for the Advance Distribution of Misoprostol including the implementation guide and other materials to help programs initiate or scale up PPH programming with advance distribution of misoprostol for self-administration. The Program Implementation Guide was used during the first of three 3-day workshops held by MCHIP for program implementers working in PPH. At the first workshop in Washington, D.C. in September 2013, 32 participants from 20 international NGOs were trained using the draft implementation guide materials. Two additional regional workshops will be conducted in New Delhi, India (Quarter 1 [Q1], PY6) and Maputo, Mozambique (Q2, PY6).

MCHIP continued to lead global efforts to implement VMMC programs in PY5. In addition to supporting many countries in their implementation and scale-up, emphasis has been placed on strengthening VMMC communication strategies and dissemination of key VMMC materials. MCHIP supported the VMMC U.S. President's Emergency Plan for AIDS Relief (PEPFAR) technical working group (TWG) in the development of PEPFAR's *Best Practices for Site Operations: A service guide for site operations.* The document was launched at the MCHIP offices on March 20, 2013, and the launch was attended by PEPFAR's TWG with representatives from CDC, USAID, Office of the Global AIDS Coordinator (OGAC), Department of Defense (DoD), and implementing partners. Participants from the field joined through a live video feed. Distribution of the document took place in Quarters 3 and 4 with hard copies and CD-ROMs delivered to all VMMC programs in the 14 priority countries; the document and related tools have also been posted on WHO's male circumcision website.

Technical assistance for the Lives Saved Tool (LiST) was provided by MCHIP during training workshops hosted in Zambia, Senegal, and Malawi. The LiST meetings drew together participants from the Ministry of Health (MOH) regional and national offices, nongovernmental organization (NGO) partners, and USAID Mission staff to learn about the structure and functions of the integrated modeling tool for MNCH-FP. By estimating changes in mortality or risk factors based upon current levels of coverage for high-impact interventions and health status at baseline, LiST results are valuable to guide scale-up activities and support was requested as part of national planning for the Child Survival Call to Action | A Promise Renewed efforts.

The LiST seminars were well-attended by a collection of local stakeholders and the diverse audience included technical experts, potential end-users, strategic planning authorities, and policymakers who will use LiST analyses to promote evidence-based MNCH-FP decision-making at the national and subnational level. Findings highlighted the importance of scaling up key interventions such as the Helping Babies Breathe initiative, for example, which aims to reduce the number of neonatal deaths in Malawi. A focus on LiST analyses at the regional level in Senegal promoted accountability and the ability to adapt the universal set of national targets to more contextually appropriate levels based upon varying profiles of coverage at baseline. Use of LiST in these countries contributed critical insight to advance an informed approach to planning and allocation in settings where resources remain limited.

MCHIP conducted a systematic review of national malaria in pregnancy (MIP) documents from six countries to help to better understand how well countries aligned with WHO guidance and how national malaria control and reproductive health (RH) programs aligned in terms of providing consistent and clear guidance. A summary report on the antenatal care (ANC) and MIP components of the analysis, which presented comparative information for six countries, was shared with the President's Malaria Initiative (PMI).

Policy and Guidelines

Building on work at the country level, MCHIP has continued to make valuable contributions to advancing work in RMNCH, and measurement through its global leadership efforts. As part of MCHIP's work with the UN Commission for Life-Saving Commodities, MCHIP and its consortium partners have directly participated in working groups for 10 of the 13 prioritized commodities, as well as participating in two of the cross-cutting groups. Through its participation in the Maternal Health Technical Reference Team for the UN Commission, MCHIP initiated the development of an advocacy tool targeted at high-level policymakers and MOH Department Heads to introduce them to the Commission's work and enable them to effect change in their countries and become engaged at the global level.

The *Newborn 2013: Global Newborn Health Conference* provided an opportunity to introduce and solicit feedback on the newly renamed Every Newborn Action Plan (ENAP)—a roadmap and joint action platform for the prevention of preventable newborn mortality. Situated within the framework of Every Woman Every Child movement, the ENAP builds on the recommendations of the UN Commission on Life-Saving Commodities (UNCoLSC) for Women and Children, A Promise Renewed, and the objectives of the Family Planning 2020 effort. The plan involves USAID, MCHIP, Save the Children, the Partnership for Maternal, Newborn & Child Health (PMNCH), and UNICEF, as well as partners and representatives of health ministries in some 20 low-income countries. MCHIP Newborn Health Team members serve on the global ENAP Core Team and the global ENAP Advisory Group. As of 30 September 2013, consultations had been held in 11 countries and through regional consultations in West Africa (for eight countries) and Asia (for nine countries) to sharpen national newborn health plans and accelerate scale-up of newborn programs.

The Child Health Team provided technical input for the Integrated Global Action Plan for the Prevention and Control of Pneumonia and Diarrhea, which was launched in April in Geneva, London, and Washington D.C., along with a related *Lancet* series on Childhood Diarrhea and Pneumonia. After the launch of the Diarrhea Global Action Plan (DGAP) seven country case studies in 2011, as a parallel process to GAPP (Global Action Plan for the Prevention of Pneumonia), MCHIP/USAID specifically engaged WHO to advocate for an integrated plan citing country examples where coordinated approaches have produced better results. Over time, more partners joined to build consensus. The launch of this global plan is a reflection of the joint advocacy and coordination efforts between key child health agencies, of which MCHIP has been an active player.

The Child Survival Call to Action and resulting "A Promise Renewed" (APR), as well as the Community Case Management (CCM) Task Force and the Diarrhea and Pneumonia Working Group have received substantive support from MCHIP and been effective mechanisms to disseminate key MCHIP learning on integrated community case management (iCCM), care-seeking behaviors, and more. As the CCM Task Force Secretariat, MCHIP ensured that consolidated iCCM implementation tools, such as the CCM Indicators Book and revised supply chain management resource guides, were available to country implementers through the CCM Task Force (TF) website, CCMCentral.com. MCHIP also supported a Child Health and Nutrition Research Initiative (CHNRI) process on iCCM, which provided a revised iCCM research agenda, both as identified by global researchers, but more important by iCCM program managers and academics at the country level. MCHIP worked with USAID and UNICEF and partners to bring attention to the Child Survival Call to Action at the congressional level as a one-year mark of this important event.

GLOBAL DEVELOPMENT ALLIANCES

Survive and Thrive

In Year 5, MCHIP provided support to Survive and Thrive, a partnership including USAID, professional associations, private sector, and civil society seeking to improve survival rates for women and children around the world. Survive and Thrive aims to connect U.S. health care professionals with their counterparts in low- and middle-income countries to share insights and strengthen skills in caring for mothers, newborns, and young children to reduce preventable maternal, newborn, and child deaths. More specifically, the partnership will expand clinical competencies among health professionals who care for women, newborns, and children; scale up quality improvement processes and approaches; bring affordable technologies and innovative educational materials and products to health professionals and their clients; accelerate efforts to monitor and evaluate the effectiveness of these programs so that they can be scaled accordingly; and create learning opportunities for emerging global health leaders. The Global Development Alliance (GDA) is a three-year program and MCHIP will continue to provide support in Year 6.

- MCHIP established and continues to manage subagreements with each of the three professional association Survive and Thrive GDA members: American College of Nurse-Midwives (ACNM), American Congress of Obstetricians and Gynecologists (ACOG), and American Academy of Pediatrics (AAP). Portions of these funds were used in Year 5 for assessment visits by the GDA team to Tanzania, Malawi, Mozambique, Bangladesh, Nepal, India, and Burma to orient USAID Missions and other local and regional stakeholders to mobilize support for the GDA. MCHIP is also in the final stages of completing the Survive and Thrive website, a source for background information and updates about the GDA.

- Following an MCHIP-organized program planning visit for Survive and Thrive GDA members to Burma in Q2 to assess maternal and newborn care (MNC) practices, meet with the USAID Mission, MOH, and local partners, MCHIP/Survive and Thrive began implementation of a program in Burma for working with the MOH to improve maternal and newborn health outcomes.

- The Mobile Alliance for Maternal Action (MAMA) has launched two country programs in Bangladesh and South Africa and is expected to launch a third program in India in late 2013. MAMA Bangladesh launched in December 2012 and currently reaches over 210,000 subscribers. Results of a preliminary phone survey show that 63% of MAMA Bangladesh subscribers attended four ANC visits (national average 32%), 45% had a facility-based birth (national average 29%), and 83% exclusively breastfed for six months (national average 64%). MAMA SA has more than 20,000 unique users, which translates into more than 67,000 unique page views, hundreds of mobi-site comments, and more than 110,000 SMSs and 8,500 Unstructured Supplementary Service Data (USSD) messages being sent thus far. Most registered mobi-site users (73.01%) have already delivered and are looking for information to care forthe baby, while the rest (26.99%) have yet to deliver. A large portion of SMS users (21.88%) opted to receive HIV-related messages; this is lower than the national HIV rate, which currently stands at 29.5%. Focus groups and user testing have shown that users of the service have found MAMA SA valuable. The mPowering Frontline Health Workers (mPowering) partnership Global Director and Program Officer were hired in August 2013. This partnership provides targeted technical assistance, capacity building, and evaluation support to contribute to the elimination of preventable child and maternal deaths. It aims to do this through accelerating the use of mobile technology to improve the skills and performance of frontline health workers.

GLOBAL PROGRAM LEARNING

MCHIP finalized its scope and strategy for Program Learning (PL) in PY5. It has aligned its PL with the concept of Implementation Science (i.e., answering real-world questions about the *how* and *why* of increasing coverage and quality of key interventions). The PL strategy centers on the five learning themes identified in PY3 (scale-up, quality improvement, community activities, service integration, and equity). After a series of meetings between each MCHIP technical team and its USAID counterparts to finalize the Year 5 PL questions, each of the technical teams' PL questions were systematized, including specifying the justification, audiences, products, and dissemination plans. A similar process was followed with the 11 countries with the bulk of the field-funded PL questions.. Portfolio-wide PL synthesis products are planned for all five learning themes, with the most emphasis to be given to the themes of scale-up, quality improvement, and community activities. Additional details are provided in the Program Learning section of this report.

Detailed Year 5 Achievements by Results Pathways and Program Areas

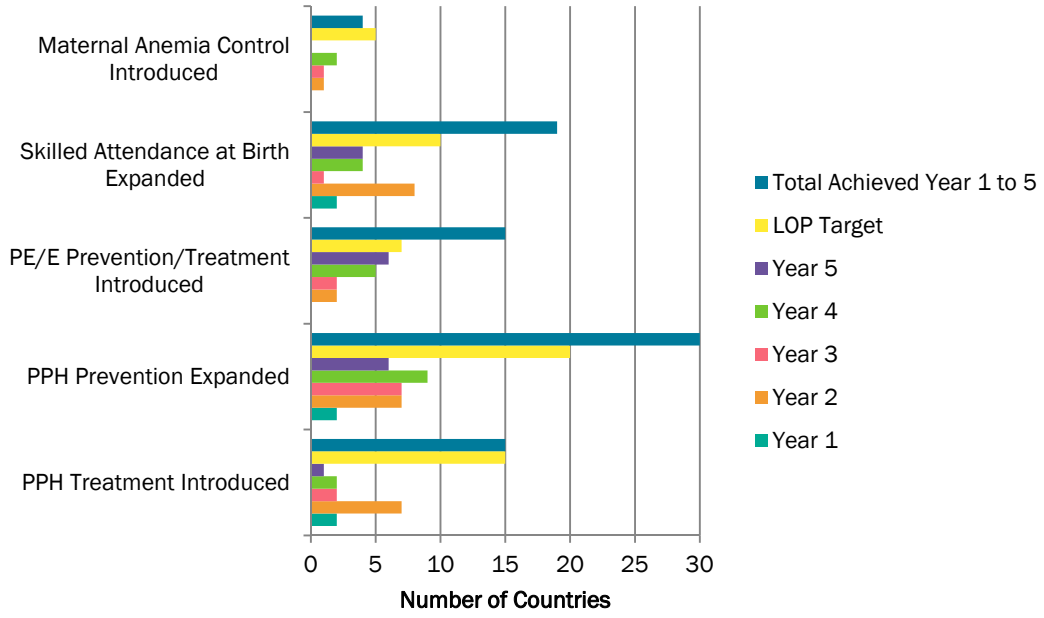
MATERNAL HEALTH

In Year 5, MCHIP continued to provide global leadership in maternal health and to support the scale-up of high-impact interventions to reduce maternal and neonatal mortality in more than 20 countries. During Year 5, MCHIP continued to analyze and learn from the results of the multi-country survey on PPH and pre-eclampsia/eclampsia (PE/E) conducted in Year 4 and has identified 14 countries on which to to focus in order to highlight gaps identified and determine what changes have been made to address them. MCHIP has made strides in the learning phase PPH studies and has applied learning from those studies to a Program Implementation Guide to assist other NGO implementers to introduce and scale up PPH programming with community- based distribution of misoprostol.

MCHIP successfully piloted an innovative methodology for estimating coverage of the use of a uterotonic in the third stage of labor (UUTSL), which has been a key information gap in measuring progress in scaling up AMTSL for prevention of PPH. MCHIP contributed substantially to global maternal health forums this year, participating and presenting technical and program learning at the Global Maternal Health Conference (GMHC), the Global Newborn Health Conference, Women Deliver, the Nutrition and Nurture meeting, the International Congress of Nutrition, and other forums. At these events, MCHIP shared technical updates and program learning on implementation of comprehensive PPH programs including community-based distribution of misoprostol, evidence supporting the use of magnesium sulfate ($MgSO_4$) for management of PE/E, management of preterm birth using antenatal corticosteroids, intrapartum practices to prevent newborn infection and improved labor care to prevent newborn deaths, and nutrition interventions for maternal anemia control, calcium supplementation for prevention of PE/E, and innovative approaches to MIYCN incorporating FP.

Progress made in introducing and expanding high-impact maternal health interventions at the country level is illustrated in Figure 1 below.

Figure 1. Progress in introducing and expanding high-impact maternal health interventions



Global Leadership for Maternal Health

MCHIP helped define and drive the global agenda in maternal health by serving on the scientific/steering committees to set the agendas and themes for global forums during Year 5, including the GMHC conference in Tanzania in January, the Global Newborn meeting in South Africa, and the Women Deliver conference in Malaysia. At each of these events, the Maternal Health Team presented key program learning on best practices in maternal health and contributed to development of panels, symposia, skill sessions, and side events. These global forums allow MCHIP to disseminate program learning and technical updates to program implementers, USAID and other funding agencies, global stakeholders, and MOH representatives from attending countries, broadening the audience to benefit from MCHIP technical expertise and key messages. At the GMHC conference in Tanzania, MCHIP shared research on use of $MgSO_4$ for management of PE/E and on implementation modalities for use of misoprostol in comprehensive PPH programming, along with technical briefers on the updated WHO recommendations for PPH, updated guidelines on AMTSL, and DCC. At the Global Newborn Meeting, the Maternal Health Team focused attention on the importance of a perinatal approach and led sessions on maternal interventions for improved newborn health outcomes. The Global Newborn Meeting was an opportunity for MCHIP to share information, presentations, and briefers with a broad audience of MNCH leaders and implementers. At the Women Deliver conference in Malaysia (attended by program implementers, high-level representatives from MOHs, and global technical leaders), the MCHIP Maternal Health Team highlighted maternal health commodities and the work of the Maternal Health Supplies Working Group of the UN Commission on Life Saving Commodities. With PRE-EMPT and Accelovate, MCHIP organized and led a well-attended technical and advocacy seminar on $MgSO_4$ for PE/E at Women Deliver. MCHIP introduced the new respectful maternity care (RMC) toolkit on K4Health at a Jhpiego-led "Building Capacity for Quality of Care and Respectful Maternity Care" event to introduce RMC implementation materials to a broad audience.

- MCHIP continued to engage with WHO to advance progress on key maternal health issues including preterm birth, PE/E, and AMTSL. MCHIP was invited to participate in the technical consultation meeting in Geneva in April at which global leaders in maternal, newborn, and perinatal health provided insights into the scope and content of planned WHO Guidelines for preterm birth. MCHIP also participated in a WHO global consultation on producing and developing an appropriate midwifery workforce for low- and middle-income countries. With WHO, MCHIP produced briefers to summarize new guidelines on management of PPH and PE/E, and disseminated guidelines at global meetings during the year.

- MCHIP continued to collaborate with the International Federation of Gynecology and Obstetrics (FIGO) to support efforts to expand the use of PPH and PE/E interventions with national professional associations in six countries (Nigeria, Uganda, Mozambique, Ethiopia, India, and Nepal). FIGO remains committed, believing that the program will be able to realize modest gains in strengthening participating national professional associations, especially with an advocacy event planned at the FIGO Africa Regional Meeting in Addis Ababa October 2013.

- The third meetings of the Africa MNH Champions from 10 countries took place in Conakry, Guinea, (for Francophones) and Lilongwe, Malawi, (for Anglophones), focusing on acquiring skills in advocacy to garner country-level commitments to attaining MDGs 4 and 5. Champions also attended technical updates in the prevention of mother-to-child transmission of HIV (PMTCT) and MIP. In Year 5, champions have led trainings in BEmONC, PMTCT, and long-acting, reversible contraception (LARC) and participated in evaluations of postabortion care (PAC) programs and integration of FP and cervical cancer screenings in their respective countries. Representatives of five of the 10 champions teams submitted and received acceptance of abstracts for presentations at the June 2014 International Confederation of Midwives Triennial Congress.

- During this program year, MCHIP made advances in program learning as detailed below and in Annexes C and D for the Africa and the Latin America and the Caribbean (LAC) Bureau program learning questions. Lessons from program learning questions on PPH and community-based distribution of misoprostol, quality of care (including results of LAC studies on routine episiotomies and rates of cesarean sections), maternal anemia, pre-service education and South-to-South engagement, among others, will inform the provision of technical assistance to country programs as well as MCHIP's work in global and regional leadership efforts.
- In the LAC region, successful MCHIP efforts to facilitate South-to-South learning and strengthen regional professional associations fostered progress in introducing and institutionalizing competency- based curricula in public and private pre-service midwifery educational institutions. MCHIP also completed and disseminated the results from successful interventions that led to sustained reductions in episiotomies and maintenance of high rates of AMTSL in Nicaragua.

Prevention and Treatment of Postpartum Hemorrhage

- MCHIP published three briefs—active management of the third stage of labor (AMTSL), postpartum hemorrhage (PPH), and delayed cord clamping (DCC)—that highlight key recommendations from WHO guidelines. Aimed at program managers and staff working at all levels of the health system, these briefs explain in simple, user-friendly terms the latest best practices from WHO in maternal health. They have been translated into Spanish and French and were widely disseminated at the country level as well as at key health conferences, including the GMCH conferences, the International Confederation of Midwives (ICM) conference in Ecuador, and the Women Deliver Conference.
- MCHIP continued to provide technical support to learning phase studies of advancing PPH prevention programs using community-based distribution of misoprostol in Madagascar, South Sudan, Liberia, Rwanda, and Guinea. The studies will contribute to the global knowledge base and document results from a variety of implementation models for distribution of misoprostol as part of a comprehensive PPH program. Study results were disseminated in Liberia, South Sudan, and Madagascar.
- MCHIP continued to increase capacity for misoprostol expansion by developing and disseminating new materials on program implementation of PPH with misoprostol. The Maternal Health Team developed a new Program Implementation Guide, *Advance Distribution of Misoprostol for Self-Administration: Expanding Coverage for the Prevention of Postpartum Hemorrhage*, which was included in an update to the K4Health PPH toolkit. The toolkit now includes new section for resources for Advance Distribution of Misoprostol, including the implementation guide and other materials to help programs initiate or scale up PPH programming with advance distribution of misoprostol for self-administration. (http://www.k4health.org/toolkits/postpartumhemorrhage/advance-distribution-misoprostol-program-resources). The Program Implementation Guide was used during the first of three 3-day workshops held by MCHIP for program implementers working in PPH. At the first workshop in Washington, D.C. in September 2013, 32 participants from 20 NGOs were trained using the draft implementation guide materials. Two additional regional workshops will be conducted in New Delhi, India, (Q1 PY6) and Maputo, Mozambique (Q2 PY6). The PPH toolkit continues to be an effective means of sharing program materials related to PPH, and was visited by 1,141 unique users in 106 countries during Program Year 5.
- A global database to capture key indicators from programs using misoprostol for PPH prevention was developed to form a central data clearinghouse of 15 global indicators from all programs using misoprostol at the community level. This database is expected to fill a critical information gap to assist in global advocacy efforts to solidify support by WHO for

advance distribution of misoprostol for use at home birth. It is designed to answer the following questions:

1. What coverage of home births was achieved with misoprostol?
2. Was misoprostol administered with quality (e.g., women counseled correctly, took it at correct time)?
3. If not done with ideal quality, what were the reasons (e.g., training, stock-outs)?
4. Did misoprostol administration interfere with women giving birth in a facility (i.e., coverage of institutional delivery, coverage of use of a uterotonic)?
5. What were the positive and negative outcomes (pregnant women's satisfaction, side effects, adverse events, PPH incidence)?

- The database has been populated with data from the completed pilot studies and was shared at the PPH implementation workshop (described above) with other organizations. Based on input received, the Maternal Health Team will make adjustments to the database and roll it out for external use in PY6. In consultation with a technical expert panel, the Maternal Health Team developed a rapid estimation method to measure coverage of Use of Uterotonic in the Third Stage of Labor (UUTSL). The UUTSL estimation methodology seeks to fill an information gap in measuring coverage with uterotonic in the third stage. A guidance document was developed and the methodology was field-tested in three countries: **Tanzania; Mozambique,** and **India** (the state of Jharkhand). The approach and application of the methodology were adapted as needed to each country context (e.g., availability of data, availability of local stakeholders). Initial findings from the three country pilots were shared with the expert panel in July 2013. Based on the pilot experiences and expert recommendations, the guide will be revised and finalized, a two-page technical brief produced, and a manuscript prepared for journal submission in Q1 of PY6. As a result of the findings in Jharkhand, the government is planning on initiating a program for advanced distribution of misoprostol to increase coverage of a uterotonic for women delivering at home.
- An article presenting the results of a review of program implementation strategies for the use of misoprostol for the prevention of PPH at home birth was published in *BMC Pregnancy and Childbirth*. "**Misoprostol for postpartum hemorrhage prevention at home birth: an integrative review of global implementation experience to date"** by Jeffrey Smith et al. examines the outcomes of various implementation strategies and concludes that advanced distribution of misoprostol by community health agents during home visits late in pregnancy achieved the greatest distribution and coverage rates. The paper's findings were shared at GMHC Arusha 2013 and the CORE Group spring meeting. A research summary briefer was also produced and disseminated.
- MCHIP continued to provide technical assistance to country program efforts toward prevention of PPH, beginning work in six new countries during Year 5. MCHIP also continued provision of technical assistance to country programs to improve management of PPH, beginning work with South Sudan in Year 5. The use of uterine balloon tamponade was integrated with training materials for managing PPH in South Sudan, and approved by the MOH for use in clinical protocols.

Pre-Eclampsia/Eclampsia

- MCHIP's efforts in PE/E during Year 5 focused on responding to country needs and engaging with local partners, and supporting countries to strengthen their management of PE/E with technical assistance and through the dissemination of the PE/E toolkit on K4Health. In Year 5, MCHIP provided technical assistance to Bangladesh, Ethiopia, Pakistan, South Sudan, Guinea, and Tanzania for improving screening and management of PE/E with a focus on the use of $MgS0_4$. Technical assistance continues to include the

promotion of technical understanding and use of the 2011 WHO global PE/E guidelines; MCHIP supported the translation of the guidelines into three languages and also adapted the guidelines into a summary briefer. In addition to promoting the use of the guidelines and country-led advocacy for updating national standards to reflect them, MCHIP collaborated with PRE-EMPT and Accelovate to begin advocacy for a standardized $MgS0_4$ solution. MCHIP also collaborated with Accelovate's work on market assessments for $MgSO_4$ use in Nepal and Kenya. The collaboration with PRE-EMPT continued in Year 5, with MCHIP serving as an advisor for PRE-EMPT activities in multiple countries and serving on the technical advisory group (TAG).

- An article presenting the results of a review of the global literature to document the known occurrences of side effects resulting from $MgSO_4$ use **was published by MCHIP in *BMC Pregnancy and Childbirth***. *"An integrative review of the side effects related to the use of magnesium sulfate for pre-eclampsia and eclampsia management"* by Jeffrey Smith J et al. summarizes the low rates of side effects when $MgSO_4$ was used. The findings of the paper were shared at global events during the year including GMHC in Tanzania, the CORE Group spring meeting, and Women Deliver. A short briefer was developed and shared with country programs. This paper consolidates research showing that $MgSO_4$ is a safe and effective drug for management of PE/E and is being used to advocate to providers who continue to hesitate to use the drugs for fear of toxicity and side effects. The PE/E toolkit on K4Health continues to be a useful resource for program implementers with 1,000 unique visits from users in 98 countries during MCHIP Program Year 5.

Skilled Attendance at Birth

- In Year 5, MCHIP continued to promote skilled attendance at birth and midwifery models of care by advocating for the professionalization of midwife cadres in country contexts. For example, MCHIP worked closely with Pakistan colleagues to continue development of a Midwife-Led Birthing Center Model of Care for Sindh Province and initiated the first Midwife-Led Birthing Centers.

- Technical briefs on maternal interventions to reduce newborn complications were updated and presented at the Global Newborn Meeting in Johannesburg, South Africa, in April 2013. Briefers on "Intrapartum Practices to Reduce Newborn Infection" and "Improved Labor Care to Reduce Intrapartum Newborn Deaths" were disseminated at the meeting as well as to individual MCHIP field programs. Further, at the Global Newborn Meeting, the MCHIP Maternal Health Team led several skills-based sessions for an international audience to support evidence-based policy and program decision-making. Follow-up efforts from the Global Newborn Meeting continued throughout the rest of the year. MCHIP has contributed to the country-level and regional meetings to finalize the Global Newborn Action Plan, and ensured that maternal interventions to reduce newborn complications were well and accurately represented and that best practice guidance was incorporated.

- MCHIP continued to collaborate with ICM and support dissemination of key ICM tools by developing communication materials on essential midwife competencies (Poster) and briefers on: standards in midwifery education, midwifery regulation and the Member Association Capacity Assessment Tool (MACAT) tool for professional associations. Communication and outreach materials were prepared and shared by ICM at Women Deliver, and at ICM Africa regional and LAC meetings (produced in English, French, and Spanish). The focus of ERA—Education, Regulation, and Association—was used; materials included a poster, a pregnancy wheel, a tri-fold, and briefing papers and were well received.

- MCHIP participated in the Second Midwifery Symposium May 26–27, 2013, preceding Women Deliver, which culminated in the Midwifery Declaration of Commitment to which MCHIP is a signatory. This declaration strives to champion the provision of widely

available, accessible, acceptable, and high-quality midwifery services, which is key to MCHIP's work in skilled birth attendance.

- MCHIP continued to make advances in implementation of program interventions and global leadership on the prevention of disrespectful and abusive care and promotion of RMC in childbirth. During this program year, MCHIP developed and disseminated a toolkit of RMC implementation materials on K4Health. The toolkit is intended to provide resources and guidance to program implementers and others looking to strengthen RMC in their countries and programs. Since its launch in April 2013, the toolkit received 861 unique visits from users in 83 countries. MCHIP convened a meeting in Washington, D.C., to review current methods of measuring progress in RMC and to begin development of routine measures of RMC and disrespectful and abusive care. MCHIP began work to develop a logical framework for the measurement of RMC. An initial logical framework was prepared for presentation at the FIGO conference (Q1 of PY6) and will be shared and refined with partners working on RMC including the White Ribbon Alliance (WRA), Maternal Health Task Force (MHTF), and the USAID Traction project.

Maternal Nutrition

- In Year 5, at the country level, MCHIP brought maternal anemia prevention and control (MAPC) onto the agenda through country-level stakeholder meetings in Kenya and Rwanda. These meetings stimulated dialogue for the development of a multisectoral task force in Kenya and a roadmap to address anemia in Rwanda. Recommendations from the Rwanda meeting are being incorporated into a Nutrition Action Plan, which is being updated. Efforts continue in Kenya under the global Anemia Task Force, with the assessment workshop conducted in Year 3 informing discussions on the multisectoral task force and ATF plans in Year 6. Additionally, during Year 5 MCHIP worked to develop a protocol for a study to improve compliance with iron-folic acid (IFA) supplementation in Kenya.

- In Egypt, MCHIP is working on MAPC through private pharmacies and Community Development Agencies to provide greater availability to IFA supplements and ensure that messages about taking IFA are incorporated into health delivery systems. Tablets are provided through other donor funding secured by Save the Children. Coverage of IFA is extremely low as are other components of an integrated package to control anemia (e.g., deworming) in antenatal care. In other countries, MCHIP worked in Year 5 to advocate and strive for improvements in the supplies and logistics of MAPC and the demand for essential commodities for the MAPC. This effort was successful in Kenya, as IFA is back onto the Essential Drugs List and procurement of IFA is being included in the World Bank-financed health sector support project. Innovative use of mHealth technologies for IFA messages are planned for Kenya in PY6.

- Building on the momentum of the Asia and Middle East Regional Nutrition Meeting held in Dhaka in 2012, a regional meeting in Africa (Johannesburg, April 2013) on MAPC and calcium supplementation provided another opportunity for continued discussion to examine facilitating factors and barriers to MAPC based on shared country experiences. The meeting provided a forum for stimulating dialogue on how our experiences with MAPC can guide the operationalization of calcium supplementation guidelines and future programming in this area. MCHIP organized the Africa meeting that took place the day before the "main meeting," examining newborn health interventions and partnered with USAID (SPRING), international partners (and the Micronutrient Initiative), international experts from academic institutions in the U.S. and South Africa to provide technical assistance, and country experiences from Kenya and Nepal.

- At the global level, MCHIP completed and disseminated a report on the Africa Regional Nutrition meeting, as an annex to the Main Newborn Meeting report. Year 5 also saw

construction and completion of a K4H website on anemia prevention and control, which houses information on global evidence, trends, and consequences of anemia. The website offers practical program guidance for designing integrated approaches to addressing maternal and child anemia, within the context of disease control (malaria and helminth control) and nutrition (micronutrient supplementation). The K4H website was launched at the International Congress of Nutrition in Spain and will be launched at the fall Core Group Meeting, at the Anemia Task Force Meeting, and General Core Group Session Power Breakfast in Washington, D.C.

- At the International Congress of Nutrition in Granada, Spain, MCHIP featured work on maternal nutrition and maternal anemia via several presentations, as follows: 1) an oral presentation on global and regional anemia trends and how effective programs are at reducing the burden of anemia; 2) an e-poster on maternal nutrition and obstetric outcomes; 3) an e-poster on integrated approaches to address maternal nutrition with infant and young child feeding and family planning from Kenya; and 4) an e-poster on anemia prevalence and trends in Rwanda In addition, four presentations featured innovative infant and young child nutrition (IYCN) approaches to address stunting through triangulation of qualitative, dietary, and quantitative operations research data, and the MCHIP/Smart program use of positive deviance from Egypt. MCHIP also sponsored a panel with international experts conducting research on giving iron to children. The panel members presented the benefits and risks of giving iron to young children in developing countries where infection rates are high.
- MCHIP provided significant contributions to the Anemia Task Force, as a member of the Secretariat in Year 5. MCHIP prepared for presentations on practical guidance for designing programs with an integrated package to address anemia using the MCHIP Decision Tree at the USAID and CORE Group-led Anemia Task Force Meeting in Q1 of PY6. MCHIP will also feature country program work from Rwanda/Kenya, including the assessments conducted in Year 5.
- The MCHIP website was updated to include specific tabs on integrated anemia prevention and control programs, innovative infant and young child nutrition to prevent stunting, and prevention of pre-eclampsia, as well as global leadership. The global leadership content provides "voices from the field" through blogs, webinars (from ICN and Brown Bag series), and reports from experiences in improving and implementing anemia prevention and control programs, and infant and young child nutrition to prevent stunting and prevention of pre-eclampsia. A Brown Bag series was held at MCHIP headquarters for Washington, D.C.-based organizations, as a forum to also address hot issues in MAPC and IYCN. These activities were coordinated with other USAID-funded programs—in particular CORE Group and SPRING, which have, with MCHIP, participated and provided a technical role on the Secretariat for the Multi-Sectoral Anemia Prevention and Control Task Force.
- MCHIP initiated and led the development of an operations research study examining MIYCN and FP practices in Yemen, where over 50% of children are stunted and contraceptive prevalence was 19% in 2006. This work builds on existing operations research examining infant and young child feeding practices within the context of a rise in stunting in Egypt and adds FP as a topic under investigation.
- CORE Group continued to increase PVO/NGO interest and engagement to facilitate use and scale-up of community-focused, high-impact interventions including Essential Nutrition Actions; linking with TOPS and the FSN Network; participating with SUN; and promoting NACS. CORE Group facilitated consensus-building and building of a community of practice for anemia through participation in the Anemia Task Force with MCHIP, USAID, Food and Nutrition Technical Assistance (FANTA) and SPRING. For the Task Force, CORE Group surveyed its members to assess where they presently had anemia-related work and fed this

into a process to identify target countries where the Task Force can support collaboration and further refine its goals and objectives. The countries identified by USAID include Ghana, Uganda, and Kenya. CORE Group participated in several meetings and took the lead in creating an Anemia listserv and in engaging partners for an expanded community of practice and developing and linking a Multisectoral Anemia Partners Meeting to the CORE Group Fall Meeting 2013. Earlier contributions laid the foundation for and evolution of partners' activities including MCHIP's completion of a toolkit, jointly updated frameworks, and greater collaboration among partners and across USAID. CORE Group also continued to diffuse and increase use of *Essential Nutrition Actions Framework* (ENA), including through hosting an Essential Nutrition Actions Orientation linked to the CORE Group Fall Meeting in 2012.

Program Learning for Maternal Health

- **In misoprostol programs for PPH prevention with distribution though ANC/community for self-administration, can quality be maintained in realistic programmatic settings likely to be encountered during scale-up? (Theme: Scale, Quality, Community)**

  MCHIP completed PPH Prevention at Homebirth pilots and supported planning for scale-up/expansion in additional countries. The pilot in South Sudan was completed and findings were disseminated in-country in May 2013. Based on the program success, the MOH is expanding the combined facility- and community-based PPH program. The Maternal Health Team has prepared a manuscript for submission to Lancet Global Health, to be submitted in Q1 of PY6. The pilot in Liberia was completed and findings were disseminated in-country in August 2013. Based on results, the MOH is revising the community-based component to improve uterotonic coverage of home births and expanding the PPH program. The Maternal Health Team has prepared a manuscript to be submitted in Q1 of PY6. The Rwanda pilot was completed and preliminary findings were shared with the MOH in September 2013. The MOH will disseminated findings in-country in Q1 of PY6 and determine program expansion. The Maternal Health Team will prepare a manuscript, to be submitted in Q1 of PY6. Madagascar completed the pilot in one district and, in consultation with the USAID Mission, decided to expand the pilot to another district. A mid-term dissemination meeting is planned for Q1 of PY6. The Guinea Institutional Review Board (IRB) protocol was developed and submitted for review, and training is planned for Q1 of PY6.

- **Which indicators best measure quality of maternal and newborn (MNH) care?** *(Theme: Quality, Measurement)*

  MCHIP has been working on developing a subset of more sensitive quality indicators from the quality of care (QoC) studies. In PY6, the framework, development process, and preliminary results were presented at the GMHC in Tanzania to representatives of numerous funding and implementing agencies. A pilot research plan and data collection instruments were developed and approved by the Johns Hopkins Bloomberg School of Public Health (JHSPH) IRB. Further validation analysis conducted for nine potential revised informative indicator subsets were generated following expanded expert surveys, including evaluating performance in the 2012 Tanzania QoC survey dataset, which became available in August 2013. These results were presented to USAID and MCHIP in September 2013. Draft outlines for a literature review on QoC measurement, a journal article on the development of the indicator subset, and an article on the indicator subset pilot have been completed with plans for publication in PY6.

- **Will a simple intervention, consisting of training and an audit/feedback cycle, increase appropriate provision of antenatal corticosteroids (ACS) to pregnant women with conditions that increase the likelihood of pre-term birth?** *(Theme: Quality)*

MCHIP made advances in development of program materials and operations research on perinatal interventions to reduce morbidity and mortality from prematurity. A technical briefer, advocacy briefer, and job aid for ACS were developed and disseminated during Year 5 at the GMHC conference in Tanzania, the Global Newborn Health meeting, Women Deliver, and other forums. In collaboration with the Survive and Thrive GDA, MCHIP began development of training materials for preterm birth with a focus on a perinatal approach, appropriate administration of ACS, and immediate preterm newborn care. An operations research study began in **Cambodia, Indonesia,** and the **Philippines** to improve the administration of ACS through a technical update and audit/feedback cycle. Training materials and study instruments were developed; a technical advisory group provided feedback and inputs to study development; and data collection will begin in the first quarter of Program Year 6.

- **Does a pilot calcium supplementation successfully increase coverage of calcium supplements in Nepal?** *(Theme: Scale, Equity)*

  In Nepal, the calcium pilot has completed calcium distribution with 9,246 women having received calcium when distribution ended in August 2013. The household survey was conducted in August and 1,230 women were interviewed. Data entry and cleaning continue. Also, in August, USAID and the MOHP/Family Health Division Director visited Dailek district for the pilot close-out meeting. In-country national dissemination of results will take place in December.

- **What are countries' successes and challenges in anemia prevention and control programs in Africa and Asia?**

  MCHIP conducted a follow-up with participants from both the Johannesburg and Dhaka meetings via Survey Monkey and is compiling and analyzing results about how these meetings were useful in guiding country-level programming.

- **Are tailored messages on infant and young child feeding delivered at the household level a feasible strategy to improve infant and young child feeding practices and related behaviors?** *(Theme: Community)*

  In Year 5, MCHIP led a mixed-methods, four-part operations research study examining factors associated with stunting in Egypt.
  The study includes collection of information on maternal dietary practices and weight gain during pregnancy, breastfeeding practices, the lactational amenorrhea method (LAM), and FP use among postpartum (lactating and non-lactating) women. Three parts of the four-part study have completed data collection, with analyses under way, while the fourth part of the study, longitudinal follow-up of children's growth, will be completed in Year 6. Result from the first three parts of the study are being analyzed now, with completion of several peer-reviewed journal articles expected in December 2013. Preliminary findings show that infant and young child feeding practices are not optimal in Egypt. with children under six months not being exclusively breastfed and the late introduction and poor quality of complementary foods. Feeding children non-nutritive "junk foods" is a growing concern in the country.

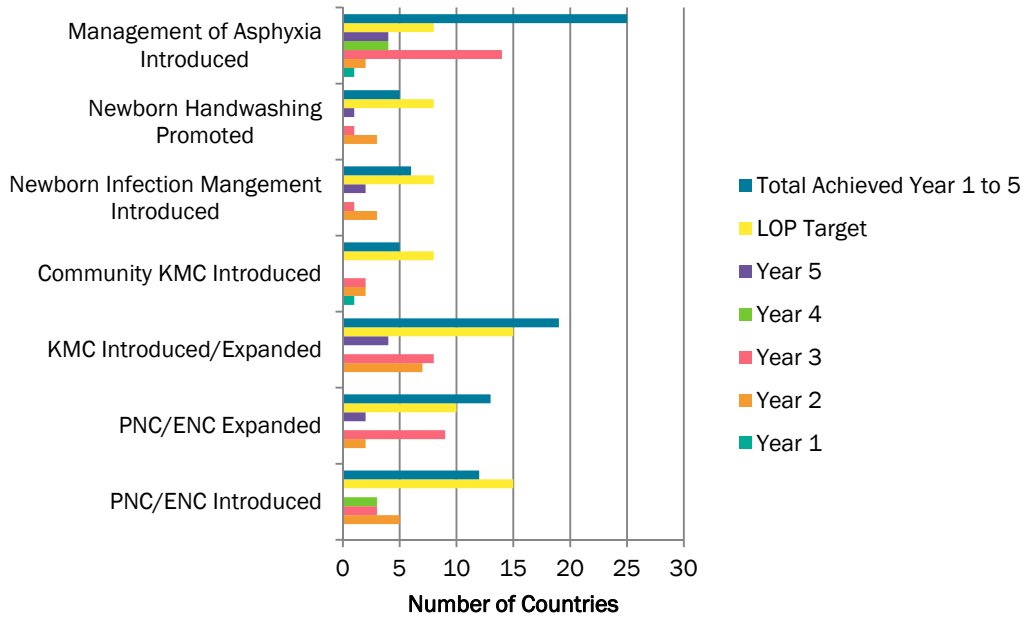
NEWBORN HEALTH

MCHIP's newborn health strategy focuses on the introduction and expansion of access to evidence-based newborn interventions that address the three main causes of newborn mortality: birth asphyxia, preterm births, and newborn infection. In Year 5, MCHIP continued to provide technical leadership to global newborn health advocacy and policy efforts while also providing targeted technical assistance at regional and country levels to introduce and expand newborn interventions. Major accomplishments included: MCHIP's leadership in planning the first-ever Global Newborn Health Conference, which was well received by participants and catalyzed

follow-on action in numerous countries; support to the development of the Every Newborn Action Plan; Liberia's adoption of chlorhexidine for umbilical cord care and endorsement of Kangaroo Mother Care (KMC) for care of preterm babies; renewed global attention to and interest in KMC, resulting in part from MCHIP's global, regional, and country-level KMC efforts throughout Year 5; expansion of Helping Babies Breathe (HBB) into Francophone West Africa; development of a draft Helping Babies Survive essential newborn care (ENC) curriculum to complement Helping Babies Breathe, which will be piloted in Year 6; and increased country interest in four critical newborn health commodities as a result of MCHIP's participation in the UNCoLSC working groups on resuscitation, simplified injectable antibiotics, ACS, and, notably, chlorhexidine (CHX)—Mozambique, Pakistan, and South Sudan would like to explore or introduce CHX for cord care through their respective MCHIP Associate Awards in 2014.

Progress made in introducing and expanding high-impact newborn health interventions in PY5 is presented in Figure 2 below.

Figure 2. High-impact interventions in newborn health



Global Leadership for Newborn Health

- **Global Newborn Health Conference:** The Global Newborn Health Conference brought together more than 450 researchers, health officials, policymakers, health experts, and advocates from more than 50 countries. They reviewed the progress that had been made toward reducing newborn deaths and discussed what can be done to address this challenge in countries where the needs are greatest. The participants, including 70 officials representing health ministries from around the world, agreed to support the development of a new global action plan aimed at reducing the annual global death toll of nearly 3 million babies during the first month of life. The conference leveraged technology to reach a much larger audience than the 450 individuals in attendance. The conference was live cast over the Internet, drawing a large international audience with over 16,000 views of the webcast in

Photo credit: Rachel Taylor/MCHIP

Global Newborn Health Conference: hands-on HBB skills session, April 2013.

90 countries. In addition, satellite viewing parties were held in countries such as Bangladesh, India, Nepal, and Madagascar. With more than 28,000 contributors on Twitter, the online conversations reached 48 million people across the world.

- **The Global Newborn Health Conference** was followed by a one-day planning session in which multi-organization teams from MCHIP, SNL, USAID, BMGF, and UNICEF countries began discussions of national strategies for scale-up of priority newborn health interventions. These discussions continued and, in many cases, connected newborn health programming with resources and political commitment associated with the UN Secretary General's global Every Woman/Every Child strategy, the "Promise Renewed" Call to Action to eliminate preventable child deaths, and the UN Commission on Life-Saving Commodities. Specific country follow-on actions resulting from the Global Newborn Health Conference (GNHC) included:

India:

Strengthen ENC at the community and facility levels; re-emphasize appropriate resuscitation for asphyxia and skilled birth attendance; focus on preterm newborns through prevention and care (ACS, KMC, maternal nutrition, and maternal infection), newborn infection prevention and management (chlorhexidine, antibiotics, clean delivery), and congenital abnormalities; conduct policy mapping and analysis for policy formulation for new chlorhexidine and ACS`1; apply a contextualized LiST tool to calculate impact of modern interventions and packages with realistic targets; determine mode of operationalization; focus on rural and urban poor; engage corporate and private sectors in service provision; determine role of civil society and faith-based organizations and engage communities.

Tanzania:

Strengthen coordination and leadership through Safe Motherhood Initiative and Newborn & Child Health to harmonize strategies; form a task force to look into continuum of care and identify issues surrounding newborn care (conduct midterm review [MTR] of an existing plan and incorporate MNH care); conduct MTR of Maternal and Newborn Health Road Map: convene a core planning team, review MTR tools to ensure newborn issues are addressed, and plan for roadmap costing and target setting; review and harmonize MNCH quality of care standards; review District Health Information System to ensure that all indicators are captured; support rollout of DHIS; and conduct maternal, perinatal, and child death reviews (MPDRs). MPDR guidelines exist, so plan to form a functional national committee on MPDR.

Zambia:

Map the status of newborn health care interventions in guidelines and implementation and focus on strengthening KMC, HBB-newborn resuscitation, and infection management. Further dialogue is needed to have ACS in the essential kit at lower-level facilities. There are several entry points for integrating newborn care: IMCI, newborn health framework—articulates content for different interventions, MNH scale-up plan, and MNCH roadmap; review will be done for the following: newborn health framework and basic health care package. A national newborn health focal point person to be identified, coordination strengthened, and process undertaken to complete/strengthen and finalize the Road Map (April/May 2013); Newborn Health Framework to be disseminated (May 2013); Newborn Health Guidelines to be updated for a more comprehensive package of interventions.

Liberia:

Develop a newborn health strategy that encompasses: ENC, HBB, KMC, CHX, ACS (review/revise guidelines) and integrated management of neonatal and childhood illness (IMNCI), and standardize incentives for Community Health Volunteers.

Senegal:
Provide feedback to the MOH and other stakeholders toward a newborn health plan/policy; strengthen child survival plan (includes FP and maternal health) and commodities plan (ongoing process); clinic levels: advocate for the integration of HBB into emergency obstetric and newborn care (EmONC)/ENC; community: advocate for integration of newborn care into iCCM guidelines and training materials; Implement and scale up HBB and integrated newborn and iCCM.

Nigeria:
Share report of deliberations/outputs with the Health Ministry and debrief the National CTC; advocate for newborn health scale-up to subnational level (April 2013); hold national roundtable on NBH (May 2013) and national launch of State of the World's Mothers report; include topics and respective interventions for maternal health, FP, preterm birth, asphyxia, infection prevention/treatment. ACS is listed as an essential drug and the supply is to be available through government procurement.

- **Every Newborn Action Plan:** The Global Newborn Health Conference served as a launch pad for the global Every Newborn Action plan, which takes forward the UN Global Strategy for Women's and Children's Health by focusing specific attention on newborn health. The plan involves USAID, MCHIP, Save the Children, BMGF, WHO, PMNCH, and UNICEF, as well as partners and representatives of health ministries in some 20 low-income countries. MCHIP Newborn Health Team members serve on the global ENAP Core Team and the global ENAP Advisory Group. As of September 30, 2013, consultations had been held in 11 countries and through regional consultations in West Africa (for eight countries) and Nepal (for nine countries) to sharpen national newborn health plans and accelerate scale-up of newborn programs. Two members of the MCHIP Newborn Health technical team participated in the Senegal meeting and MCHIP country newborn staff participated in the Nepal meeting. These consultations have included review of bottleneck analysis results, helped catalyze country action to advance newborn health, and have also informed the global ENAP that will be officially launched at the World Health Assembly in Geneva in May 2014.
- **UN Commission on Lifesaving Commodities (UNCoLSC):** Throughout Year 5, the MCHIP Newborn Health Team participated in the UNCoLSC resuscitation, chlorhexidine, injectable antibiotics, and ACS working groups through regular conference calls, document review, and in-person attendance to selected Commission meetings. The latter notably included MCHIP's participation in a meeting of eight countries in Dakar, Senegal, in July 2013, which served as a follow-up to the UNCoLSC 2012 recommendations that had been adopted in Abuja. As referenced in the Dakar meeting description, "experiences from countries suggest, in addition to overarching health systems and financial challenges, three main types of barriers that prevent women and children from accessing and using appropriate commodities:
    - the insufficient supply of high quality health commodities;
    - the inability to effectively regulate these quality commodities; and,
    - the lack of awareness of how, why and when to use them, resulting in limited demand."
- The Dakar meeting provided a platform for countries to report back on progress made to date against these challenges and resulted in:
    - Identification of global and country-level next steps to ensure rapid implementation
    - Agreement on effective monitoring and reporting mechanisms/channels, at and between global and national levels
    - Sharing of best practices in advocacy to galvanize country action

- In an effort to increase PVO/NGO interest and engagement with newborn health issues and to facilitate use and scale-up of community-focused, high-impact interventions, CORE Group conducted an online survey of its 59 Member and 16 Associate Organizations on their newborn health activities, assets, and needs to better facilitate program learning, collaboration, and scale-up. A summary report and presentation includes a quick overview of the responses from a total of 24 different organizations. In April 2013, preliminary findings were presented at the Global Newborn Health Conference in South Africa and at CORE Group's Spring Meeting by CORE Group's Safe Motherhood and Reproductive Health (SMRH) Working Group Co-Chair, Carolyn Kruger, with PCI, and in June, at the Latin American and Caribbean Neonatal Alliance meeting in El Salvador by CORE Group's Community Child Health Working Group Co-Chair, Alfonso Rosales. Through the survey we were able to identify gaps, challenges, and opportunities, including geographic areas where a large number of partner organizations could be leveraged and coordinated to advance newborn health. India had the most number of organizations, so efforts were made to link to the existing RMNCH A+ CSO network to identify areas for collaboration and to support "A Promised Renewed" efforts.

Prevention of Preterm Births and Care for Pre-Term/Low Birth Weight Newborns

Building upon the *Born Too Soon* publication on preterm births in 2012, MCHIP helped to maintain global momentum for preterm care by working with key partners, including the SNL program of Save the Children, BMGF, WHO, UNICEF, the UNCoLSC and the *Survive and Thrive* GDA in Year 5.

- **Kangaroo Mother Care**: MCHIP shared core-funded KMC program learning from LAC and Africa at the International KMC Conference in Ahmedabad, India (Nov 2012), a conference that MCHIP also helped to support through core funds. Presentations and exchanges at this conference informed development of a concurrent track on prevention of preterm birth and care for preterm babies at the GNHC in Johannesburg, for which the MCHIP Newborn Health Team led the planning. Participation in this concurrent track by the India team contributed to the country's decision to develop national KMC implementation guidelines (using MCHIP field funds and drawing upon core-funded resources, including the *KMC Implementation Guide* published in 2012). In addition, at the conference, MCHIP, SNL, BMGF, and WHO met and agreed to collaborate to harmonize and accelerate actions to scale-up KMC implementation globally, resulting in a "reinvigoration" of the KMC working group. Membership was expanded to include participants from the Born Too Soon (BTS)-initiated preterm care group, and the new KMC working group agreed to hold a global consultation in Turkey in October 2013, for which MCHIP was tasked with undertaking a regional review of KMC implementation in Asia to complement an African regional assessment conducted in 2012. This review was initiated in September 2013; findings will be reported in Year 6.

- Prior to the Fall Meeting 2012, CORE Group hosted a Kangaroo Mother Care (KMC) Orientation with MCHIP. The orientation session allowed participants to learn about the KMC practice, positioning technique and discuss challenges to scaling up this life-saving method of care within health facilities and introduction to community settings.

- MCHIP achieved **country-level KMC advances** using core funds in **Liberia and Zambia**. In the West African nation, MCHIP's influence dates from 2011–2012, when it supported a newborn health situation analysis (published in 2013) and piloted use of SNL's scale-up readiness benchmarks and scale-up maps with newborn stakeholders (September 2012). In response to the situation analysis recommendations, the MOHFW offered a strong endorsement of KMC in 2013/Year 5: *"The Kangaroo Mother Care guideline will be used by the policy makers, planners, implementers and partners to guide the establishment and implementation of Kangaroo Mother Care services at National, Regional, County and health facility levels to ensure survival and optimal development of preterm and low birth weight babies."*

MCHIP is assisting to scale up evidence-based, high-impact MNCH interventions to contribute to reductions in maternal and child mortality and progress toward MDGs 4 and 5. In Zambia, MCHIP with USAID funding received under Saving Mothers Giving Life is collaborating with CDC and DoD, and multiple implementing partners in four target districts in PY5 (Mansa, Lundazi, Nyimba, and Kalomo).MCHIP has provided training and on-site mentorship in EmONC and HBB to health care providers in these districts.

At national level, MCHIP has engaged the Ministry of Community Development, Maternal and Child Health (MCDMCH) and supported a stakeholder meeting to review the Zambia newborn health framework and guidelines for needed updates to ensure that evidence-based interventions including KMC are incorporated and strengthened. Despite the 2010 Zambia "Road Map to Accelerating Maternal and Child Health" having an objective to increase the proportion of districts implementing KMC from 50% to 80%, KMC has been promoted only through behavior change messages at community level through the Safe Motherhood Action Groups. With core funding, MCHIP has supported the development of KMC protocols and guidelines, partly supported a KMC learning visit to Malawi, and identified potential KMC service sites including a center of excellence to serve as a site for training providers and other potential sites for KMC service implementation in PY6.

Newborn Resuscitation and Essential Newborn Care (ENC)

- MCHIP partnered with Save the Children, UNICEF, the WHO/Regional Office for Africa (AFRO) and Laerdal Global Health to organize a **training of trainers (TOT) workshop on ENC/resuscitation (Helping Babies Breathe [HBB]) in Senegal** in Q1 of Year 5. MCHIP believed that conducting a TOT in West Africa was a missed opportunity, as a Francophone TOT had not yet been supported by any organization or project. Additionally, newborn mortality rates in West Africa are high, ranging from 46 deaths per 1,000 live births in Mali (DHS 2006), 38 deaths per 1,000 live births in the Ivory Coast (DHS 2011–12), to 29 deaths per 1,000 live births in Senegal (DHS 2010–11). The goal of the workshop was to improve newborn survival in Francophone West Africa by improving provider capacity in ENC, including neonatal resuscitation. Using a combination of WHO's ENC course and the HBB teaching approach and training materials, the partnership conducted a five-day training for 26 participants from five Francophone countries (Benin, Guinea, Guinea-Bissau, Senegal, and Togo). Country teams were composed of MOH officials, implementing partners, pediatricians or neonatologists affiliated with a teaching institution and available to support training activities back in their own countries, and both country and regional WHO and UNICEF representatives. The training helped to catalyze action in Senegal where, with UNICEF's support, elements of the HBB approach have been integrated into the national technical training service manual on newborn care. As of late September 2013, UNICEF had purchased 250 NeoNatalie mannequins and plans were under way for a national TOT. Cascade training and distribution of equipment to selected districts were slated to begin immediately following the TOT.

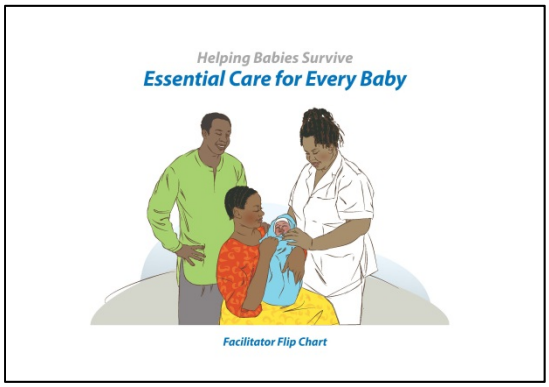
Photo credit: Ida Neuman/ Laerdal Global Health
Francophone HBB Training in Senegal, December 2012.

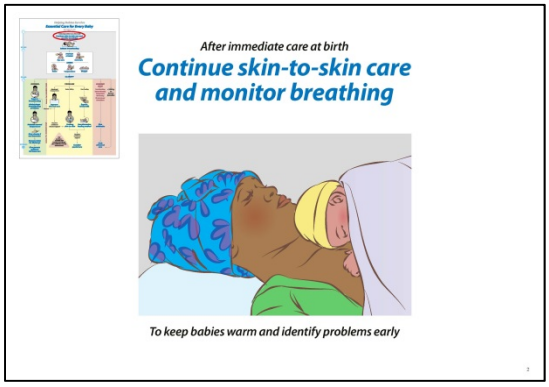
- In Year 5, MCHIP consolidated gains made in the introduction of HBB in 25 MCHIP-supported countries since 2010 and **focused greater attention on using core funds to improve quality and understand how to optimally scale up the intervention**. Core funds underwrote quality assurance visits from AAP mentors to selected country programs, supported an AAP mentor to present at the Global Newborn Health Conference, and were used to initiate a process documentation of HBB introduction and scale-up in Bangladesh

and Malawi to answer a key program learning question: *What conditions have—or have not—helped to achieve high coverage and quality at scale?*

- CORE Group continued to participate in the Helping Babies Breathe GDA, including the dissemination of the "Guide for Implementation of HBB – Strengthening neonatal resuscitation in sustainable programs of essential newborn care" and widely diffuse "Taking Care of a Baby at Home After Birth: What Families Need to Do." CORE Group also created a Resources for Newborn Health handout with the tools and other materials to be disseminated at the Global Newborn Health Conference, CORE Group spring meeting, and other related forums.

- To address an identified gap in ENC elements of the HBB curriculum, MCHIP collaborated with a team of North American pediatricians and the American Academy of Pediatrics to develop the ***Helping Babies Survive*** **(HBS)** curriculum. HBS focuses on the ENC that health workers should provide in the first day of life and necessary preparation of the family for care of the newborn at home. HBS is based extensively on relevant materials from the WHO ENC course, and materials are presented in a format similar to HBB, including a facilitator flip chart, action plan, simulated skill practices, observed structured clinical examinations (OSCEs), and knowledge test, plus a parent guide. MCHIP's contribution included technical facilitation of the entire process, technical review of documents, and financial support to hire the educational designer and to hold several face-to-face meetings to review the draft learning materials. Final drafts of the HBS materials were completed in Year 5 and briefly field-tested in India and Kenya; Laerdal Global Fund supported these pilots. In Year 6, MCHIP will support implementation of HBS in selected countries where the HBB approach is already in use. It is anticipated that HBS will be compatible and easily implemented alongside preterm care curriculum under development through the *Survive and Thrive* GDA.



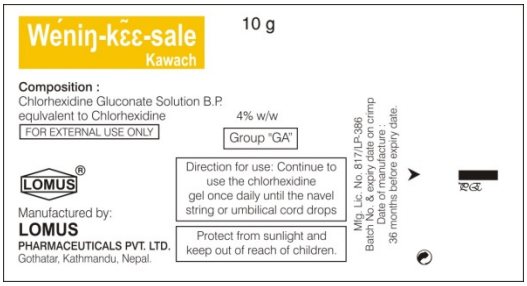


Newborn Infection Prevention and Management

In Year 5, MCHIP continued its participation in a multi-agency technical working group on newborn sepsis management. While MCHIP and partners expected to finalize and disseminate an implementation guide on newborn infection management, this was tabled in order to await—and align guidance with —WHO's updated recommendations resulting from their multi-country study of simplified antibiotic regimens. As of the end of Year 5, WHO had not yet released its recommendations and, as such, the implementation guide remains in draft form. MCHIP expects the guide to be revisited and revised in Year 6, following the release of WHO's recommendations.

At the same time, MCHIP continued to provide global technical assistance and leadership to the UNCoLSC working groups on simplified injectable antibiotics and chlorhexidine for umbilical cord care. On the latter, the MCHIP newborn team facilitated the potential expansion of CHX to interested countries through MCHIP-funded programs. As of the end of Year 5, three new countries began exploring the introduction of CHX: Mozambique (MCHIP Associate Award),

Pakistan (MCHIP/FKHP Associate Award), and South Sudan (MCHIP/ISDP Associate Award). Yemen and Zimbabwe teams have also expressed interest.



MCHIP has also made a catalytic core investment in the introduction of CHX for umbilical cord care in Liberia, where MCHIP's Year 4 core-funded newborn situation analysis recommended, among other actions, that the MoHFW "adapt the use of chlorhexidine [CHX] 4% application to the umbilical stump to replace the current practice of alcohol application or leaving the cord clean and dry." Less than a year later, through a national stakeholder process supported by MCHIP, the Liberia MoHFW did indeed endorse CHX for cord care, stating "chlorhexidine will be applied to the tip of the cord, the stump and around the base of the stump cord of all babies delivered in Liberia immediately after cutting the cord and with repeat application once daily until the cord separates." Liberia's National Essential Medicines List (EML) previously listed chlorhexidine digluconate in different concentrations as general antiseptic; the MoHFW endorsement of CHX for umbilical cord care should help expedite the inclusion of 7.1% chlorhexidine digluconate onto the EML. As local production is not feasible in the near future, MCHIP helped secure funds through Save the Children from the UNCoLSC's CHX working group budget to purchase an initial order of CHX product from a manufacturer in Nepal.

Handwashing with Soap for Newborn Survival

- In Bangladesh, the International Center for Diarrheal Disease Research (ICDDR) concluded formative research on handwashing with soap for newborn survival. MCHIP incorporated relevant newborn handwashing messages into the postnatal package for implementation under the new Bangladesh Associate Award. In Indonesia, GDA materials were adapted, translated, and received MOH approval. Training for MOH staff from three project districts was conducted in Jakarta. MOH action plans for each district were created during training. At the end of Year 5, MCHIP initiated a cross-country review of the *Handwashing with Soap for Newborn Survival* GDA through an external consultant. This activity will be completed and results disseminated in Year 6.

Program Learning for Newborn Health

1. **How have Bangladesh and Malawi introduced and scaled up HBB? What conditions have—or have not—helped to achieve high coverage and quality at scale? *Process documentation of HBB in Bangladesh and Malawi; Themes addressed: scale up***

   In Year 5, MCHIP undertook an in-depth review of Bangladesh and Malawi experiences in introducing and scaling up HBB. This process documentation identified elements of the interventions that did and did not work, recorded lessons learned, and drafted recommendations to inform other countries' efforts to introduce or expand HBB. Findings and recommendations will be written up in Q1 of PY6 and a manuscript drafted for journal submission (target: *Global Health Science and Practice).*

2. **What is the impact of training on immediate professional care of the newborn on provider practices at the time of delivery and in the postnatal period? *Analysis of Bangladesh HBB data;* See Monitoring and Evaluation (M&E) section**

3. **What is necessary to ensure that new midwifery graduates have the appropriate ENC/HBB skills to provide care for newborns? *Analysis/case study of MCHIP experiences in Ghana and Malawi; Themes addressed: training***

In Year 4, MCHIP collaborated with regional colleagues in east and southern Africa to assess and strengthen the ENC/resuscitation elements of pre-service midwifery curricula, with focused support and assistance to Malawi. At the same time, MCHIP undertook similar activities through the MCHIP Ghana team using core funds. In Year 5, MCHIP assessed both efforts; the resulting country case studies will be finalized in Q1 of PY6 and disseminated in each country as well as to global audiences through HBB GDA members and via the HNN and MCHIP websites.

4. **How can postnatal care (PNC) home visits be introduced and scaled up? What conditions are necessary to achieve high coverage and quality at scale?** ***PNC multi-country assessment; Themes addressed: scale up, community***

   While PNC home visits for care of the newborn in the first week of life are now part of policy in many countries, high coverage has yet to be achieved in most. In PY4, WHO administered a multi-country survey with MCHIP and SNL support, while MCHIP and SNL simultaneously undertook a five-country, in-depth review of progress made in adoption and implementation of PNC home visits. In Year 5, MCHIP began adapting the assessment report into a manuscript that will be completed in Q1 of Year 6 and submitted for publication (target: *Bulletin of the WHO*).

5. **What is required to introduce and sustainably scale up KMC services?** ***KMC multi-country assessment; Themes addressed: scale up***

   In Year 5, MCHIP began a multi-country assessment of KMC introduction and scale-up in Asia, similar to the Africa regional assessment conducted in Year 4. Draft country reports are expected from Bangladesh, India, Indonesia, Pakistan, and the Philippines early in Year 6; results will be shared at the KMC acceleration meeting in Turkey, inform the global evidence base on KMC programming, and help to identify future operations research questions.

6. **How effective is universal promotion of KMC at the household level in ensuring high coverage of appropriate care for preterm/LBW babies?** ***Ethiopia community Kangaroo Mother Care [CKMC] study;***

   See M&E section.

7. **How can community-based newborn infection management be introduced at the country level?** ***Country case study; Themes addressed: community***

   Following the Year 4 core-funded situation analysis of newborn health in Liberia, in Year 5 MCHIP used core funds to support introduction of several interventions and approaches, including community-based management of newborn infection and use of CHX for cord care. MCHIP and Save the Children Liberia are looking to identify additional funding that can support onward implementation while MCHIP uses core funds in Year 6 to document and disseminate program learning.

CHILD HEALTH

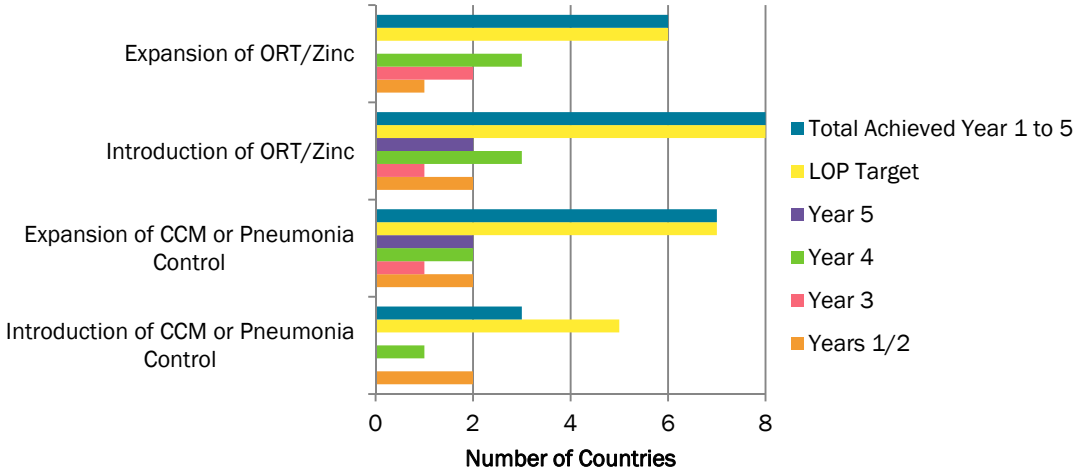
MCHIP continues to support scaling up of key child health interventions that can help to end preventable child deaths, such as iCCM and revitalized low osmolarity oral rehydration salts (ORS) combined with zinc for diarrheal disease. Year Five has continued to see expanding momentum for child health; MCHIP has been contributing to and harnessing the energy of "A Promise Renewed" (APR), the CCM Task Force, and the Diarrhea and Pneumonia Working Group. These forums have been effective mechanisms to disseminate key MCHIP learning on iCCM, care-seeking behaviors and more. As the CCM Task Force Secretariat, MCHIP ensured that consolidated iCCM implementation tools, such as the CCM Indicators Book and revised supply chain management resource guides were available to country implementers through the CCM TF website, CCMCentral.com. MCHIP also supported a CHNRI process on iCCM, which

provided a revised iCCM research agenda, both as identified by global researchers, but more important by iCCM program managers and academics at the country level.

At the country level, MCHIP worked on expanding iCCM in Mali, Guinea, and Zimbabwe (for malaria), while conducting key operations research to help introduce iCCM in Kenya. In Kenya, MCHIP not only assisted in the development of a draft CCM Roadmap and Implementation Plan, but also directly contributed to the change in policy which re-classifies zinc from prescription-only to an over-the-counter drug. In Mali, MCHIP has been working closely with UNICEF and other partners on joint studies (one led by UNICEF, one by MCHIP) that have evaluated the intermediate effect of the integrated community health package (*Soins Essentiels Communautaires* – SEC). In Zambia, MCHIP mapped and analyzed bottlenecks preventing the scale up of ORS and zinc.

Progress made in introducing and expanding high-impact child health interventions is presented in Figure 3 below.

Figure 3. High-impact interventions in child health



Global Leadership for Child Health

- In addition to providing technical assistance and participation in country and regional APR launches, MCHIP is supporting the APR effort by working with MOHs and their implementing partners to develop integrated scorecards that can be used to track progress against key MNCH indicators.
- MCHIP acted as the Secretariat for the India Child Survival and Development Summit held in February 2013. The Summit was a national follow-up to the 2012 Global Child Survival Call to Action and brought together a wide array of key stakeholders. MCHIP facilitated all of the technical committees supporting the Summit and completed a series of related LiST analyses. *Note: this was funded by both core and field funding.*
- MCHIP child health and immunization teams provided technical input into the Integrated Global Action Plan for the Prevention and Control of Pneumonia and Diarrhea (GAPPD), which was launched in April in Geneva, London, and Washington D.C., along with a related *Lancet* series on Childhood Diarrhea and Pneumonia. The launch of this global plan is a reflection of the joint advocacy and coordination efforts between key child health agencies, of which MCHIP has been an active player. The GAPPD is being used as the strategy for re-focused child survival strategies in countries launching the APR and has also been used to

advocate successfully for inclusion of diarrhea and pneumonia in a malaria Global Fund proposal under the New Funding Mechanism.

- As the Secretariat of the CCM Task Force, MCHIP has contributed to stronger iCCM programs that are using state of the art iCCM tools (e.g., supply chain management, M&E, operations research, and, most recently, costing and financing). During the past year, MCHIP organized one Steering Committee teleconference and five TF teleconferences. Because the TF is increasing recognized as a source of the state-of-the-art information and tools on iCCM, participation in CCM TF teleconferences has increased from an average of 30 to over 50 people and now even includes country program managers. More programs are using state-of-the-art tools and therefore providing better quality of iCCM services. Included in Secretariat tasks was the (re)vitalization of four subgroups:
    - **Operations Research Subgroup:** MCHIP supported monthly teleconferences that bring together leaders in CCM to prepare joint panels on iCCM at various academic and programmatic conferences, as well as an ongoing CHNRI process to establish an updated prioritized research agenda for iCCM. MCHIP is supporting this CHNRI process and MCHIP is especially proud to have encouraged this CHNRI process to include a focus on in-country iCCM experts, which has led to key findings highlighting differences between the research priorities of global experts as opposed to in-country experts. Findings will be shared with donors and members of the iCCM Task Force, and will also be presented at the iCCM Evidence Review Symposium in Year 6, which will be attended by between 30–35 country delegations.
    - **Monitoring and Evaluation Subgroup:** MCHIP assisted in finalizing the Benchmark Indicator book, which will assist countries in identifying and adapting appropriate indicators to measure their CCM efforts. The Indicator Book will be available on CCMCentral.com, but more important will be disseminated at a special launching session at the iCCM Evidence Review Symposium.
    - **Supply Chain Management (SCM) Subgroup:** MCHIP supported the subgroup in starting an inventory of available SCM tools for iCCM and in developing a "SCM Tips" resource tool to provide guidance to individuals, organizations, and communities as they begin to plan iCCM programs. MCHIP also supported the subgroup in organizing a webinar series highlighting SCM issues in the context of CCM; two webinars were conducted this year on an "Introduction to Supply Chain for CCM Program Managers" and "mHealth tools for iCCM." There has been great participation in these webinars (over 60 participants each, with multiple in-country representatives as well). As such, the webinar series will continue into Year 6 and will focus on topics identified by participants of previous webinars.
    - **iCCM Costing and Financing subgroup:** MCHIP worked with several different TF members working on costing to establish a subgroup that will review the various iCCM costing tools and develop a training package to go with them. These training materials will educate partners on how to use these tools with MOHs to plan funding. The subgroup has plans to contribute to increasing the number of experts who can do costing of iCCM plans.
- MCHIP continued to refine the CCMCentral.com website as a global resource for iCCM, hosting current global events, tools, documents, and meeting reports. Google Analytics stated a *total of 5,488 visitors* during the reporting cycle with *3,125 unique visitors*. CCMCentral.com is increasing the visibility of iCCM and continues to facilitate the sharing of standardized resources and the latest information on iCCM to a wide community of more than 100 members.

Integrated Community Case Management

- The past year has seen a lot of progress made in Kenya, where MCHIP assisted the Kenyan Department of Adolescent and Child Health in the development of a draft CCM Roadmap and Implementation Plan, along with an accompanying M&E Plan. These documents have not been officially launched yet, but the MOH is allowing partners to move forward with Phase 1. Phase 1 outlines several research projects to be conducted by partners, under which MCHIP is conducting an operations research (OR) study in Bondo District that will address issues around the feasibility of adding a CCM package onto the already existing community health platform. Overall, the CCM Roadmap should greatly impact the status of child health in Kenya by expanding coverage of case management services for childhood illness to areas that have previously been underserved.
- In Mali, MCHIP has helped strengthen the commitment of civil society in reducing child health mortality by working in strong partnership with local and regional federations of community health associations (FELASCOM and FERASCOM) to strengthen and expand CCM programs in selected districts. The child health work this year focused on ensuring that the overall programmatic approach to iCCM throughout the country was harmonized by developing shared tools and one common training curriculum. MCHIP also refined job aids for volunteer health workers (CHWs) (*relais communautaires*) to reinforce case identification and appropriate referral. MCHIP is expanding on initial findings of a lot quality assurance sampling (LQAS) study conducted by UNICEF by organizing a qualitative study to evaluate issues facing implementation of the integrated essential community care (SEC) package.

Diarrheal Disease and Pneumonia

- After substantial advocacy from MCHIP and other partners, the Kenya Ministries of Medical Services and Public Health and Sanitation officially changed the classification of zinc to an over-the-counter drug. This change paves the way for expanded community access to zinc and, when combined with the new iCCM Roadmap, will strengthen the overall package of diarrheal disease treatment interventions.
- In Guinea, MCHIP is actively engaged in the national steering committee for child health, which has coordinated partners implementing CCM in training over 1,000 CHWs in the past year. MCHIP is implementing a comprehensive case management strategy in 18 rural health facilities (integrated management of childhood illness [IMCI] training and supportive supervision) and in 90 villages (CCM linked into support from health facilities). MCHIP also worked closely with the MOH to develop performance improvement standards for child health to improve the quality of child health services at facility level, to encourage the use of data for action, and to strengthen the link between child health activities in the community and facilities.

Program Learning for Child Health

In PY5, MCHIP has contributed to the evidence base in child health that is helping to inform child health programming, focusing primarily on iCCM.

1. **What are the important issues for the introduction and expansion of iCCM? (Data Source: Desk review of project documents; MCHIP theme: Community, Scale)**

   In Kenya, MCHIP is contributing key evidence about the feasibility of adding iCCM into an already existing community health platform, while in Mali MCHIP is identifying factors that are causing low utilization of community health services. Both of these studies will help increase the reach of iCCM, thereby helping to avert avoidable child deaths. At the global level, MCHIP has brought iCCM learning together on factors influencing scaling up iCCM in three countries and also on how countries have adapted global iCCM training and supervision guidelines in six countries.

2. **Multi-country review investigating factors that influence scale-up of ORS coverage (Data Source: Desk review and key informant interviews in six countries--Malawi, Zambia, Liberia, Mali, Mozambique, and Senegal; MCHIP theme: Scale-up)**

   MCHIP contributed to cross-country learning about both supply and demand factors that either facilitate or hinder the wide use of ORS in the management of acute diarrheal disease. The theory is that these factors can be changed to increase the levels of use of ORS and reduce morbidity and mortality associated with diarrheal disease. Once the findings are disseminated in early PY6, the aim is for countries (especially MCHIP-supported) to assess aspects of their own programming that can be altered in order to increase or sustain high use of ORS in diarrheal disease management and contribute to reducing child deaths in these countries.

   This qualitative study is utilizing interviews with key informants from MOHs, NGOs, and academic institutions to identify enabling factors and obstacles to scale-up coverage of ORS in three low- and three high-performing countries, and highlights potential solutions to overcome obstacles. MCHIP completed the Zambia assessment on the status of availability of ORS and zinc and supported the first refresher training of 15 health center managers on the use of ORS and zinc (based on the finding that most health workers are unaware of the recommendation to use low osmolarity ORS and zinc in DD management). The expected result of this work is increased availability of zinc in the public sector and correct management of diarrheal disease cases and over time.

3. **What lessons can we learn about collaboration from the functioning of the CCM Task Force to inform future efforts in adopting and scaling up a new health strategy?**

   In PY5, MCHIP engaged external consultants to conduct a review of the accomplishments of the CCM Task Force and of the role of the TF Secretariat (held by MCHIP). The review included in-depth interviews, an online questionnaire, and a key document review, as well as a cost analysis of the Secretariat function. The review gathered *perceptions* of efficacy and value of both the overall CCM Task Force and the Secretariat role in particular. Overall, the positive contributions to date of the Task Force and the Secretariat role were clear; however, how the TF engages at a country level was found as an issue requiring further strategic discussion. Results of the study will be discussed by the CCM Task Force Steering Committee in Y6 Quarter 1 to make strategic decisions about how the TF and Secretariat role could be changed.

4. **What are care-seeking practices for childhood illnesses? (Data source: Secondary analysis of Demographic and Health Survey [DHS] data)**

   To further help the global child health community understand care-seeking patterns, MCHIP conducted a multi-country analysis of care-seeking for childhood illnesses using data from over 40 DHSs. Although many countries have made significant progress in increasing diarrheal disease treatment, many countries are still lagging behind.

5. **Special supplement to the American Journal of Tropical Medicine and Hygiene on iCCM (Data source: series of special studies; MCHIP theme: Community)**

   MCHIP assisted the Operations Research subgroup of the CCM TF in publishing an iCCM journal supplement in the *American Journal of Tropical Medicine and Hygiene* in October 2012. MCHIP arranged for the supplement to be "online open access" and then hosted a launch for the supplement at the American Society of Tropical Medicine and Health's conference held in Atlanta in November 2012. As a result, the supplement has been distributed widely among CCM stakeholders, including those at country levels.

IMMUNIZATION

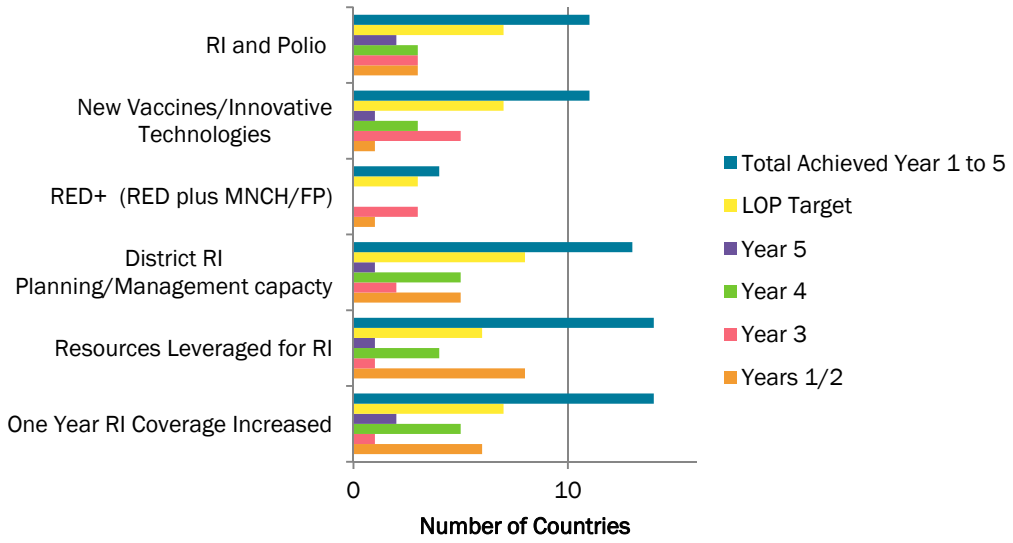
MCHIP provided technical assistance for strengthening country-level capability to manage the delivery of routine immunization (RI) and new vaccines, while promoting their acceptance and utilization. MCHIP's work in immunization centered on four strategies: 1) increasing capacity to achieve and sustain high and equitable immunization coverage with all appropriate vaccines, to reach the unreached and reduce child mortality; 2) supporting the effective and sustainable introduction of safe, high-quality, lifesaving new vaccines; 3) engaging in priority programs for disease control with a focus on strengthening the RI platform, and 4) influencing the global and regional levels with the results of program learning from the field.

As a member of many working groups and advisory bodies, MCHIP supported the immunization investments of United States Government (USG) and USAID at the global and regional levels in several broad areas: 1) shaping strategies and approaches to sustainably increase the reach of vaccines, close the equity gap, and strengthen local management of routine immunization; 2) helped ensure that all vaccines, both new and "traditional," are used safely; 3) promoted practices for effective and efficient handling of vaccines; 4) helped design vaccine products that are appropriate for use in low-resource settings; 5) promoted understanding, acceptance, and utilization of vaccines; and 6) contributed to accelerated disease control initiatives, including the Global Polio Eradication Initiative (GPEI).

In this Decade of Vaccine (DoV), MCHIP staff were in high demand, with both established partners and new players requesting their expertise and experience in many areas of the immunization enterprise. MCHIP's Program Year 5 country-level technical assistance supported immunization work in 14 countries (seven co-funded with field support): DRC, India, Kyrgyzstan, Kenya, Malawi, Senegal, South Sudan, Tajikistan, Tanzania, Timor-Leste, Uganda, Ukraine, Yemen, and Zimbabwe. MCHIP also provided short-term technical assistance to Ethiopia, Mozambique, Nigeria, and Pakistan. During this implementation period, MCHIP assisted eight countries (DRC, India, Kenya, Malawi, Senegal, Tanzania, Uganda, and Zimbabwe) with the introduction of new lifesaving vaccines (e.g., pneumococcal, rotavirus, measles second dose, measles-rubella, and meningitis A) through technical support to ministries of health for timely planning and smooth introduction into the routine immunization system.

Country progress in advancing high-impact immunization interventions in PY5 is presented in Figure 4 below.

Figure 4. High-impact interventions in immunization



Global Leadership for Immunization

While most of MCHIP's technical resources support country-level activity to strengthen local capacity to manage RI and ensure the successful introduction of new vaccines, the project's design enables it to share its country-level experiences through regional and global-level mechanisms. MCHIP's strategic participation in selected working groups and committees serves to amplify the project's learning while infusing the policies, strategies, and operational plans of key partners with pragmatic, operational considerations. Because MCHIP uniquely operates in a wide variety of field circumstances and focuses on strengthening RI program management, its input is valued and requested by a range of partners who set the global agenda for immunization.

MCHIP is a key player in many formal mechanisms dedicated to formulating global immunization policies and strategies. In many cases, there is no direct one-to-one correlation tying our interventions with identifiable, concrete outcomes. In some cases, we are one of several voices and assigning attribution to MCHIP for a specific change in policy or strategy is neither possible nor desirable. Even when MCHIP is a major mover behind a new policy, strategy, or training manual, efforts to claim primary attribution would be counter-productive as the result would be less willingness on the part of those partners, whose mandate is to be in charge of the process, to invite further inputs from MCHIP. Furthermore, influencing the direction of multilateral agencies and creating policies and tools that find their way into country programming take time, usually measured beyond the time span of an individual project's annual workplan, because MCHIP depends on the architecture and pathways used globally by better-funded multilateral agencies. In other words, this is a rolling process, which unfolds at its own pace. MCHIP can and does push but in most cases it is not within our project's control to affect what happens on the ground in individual countries where the same multilateral implementing agencies operate.

In some cases (e.g., the Institute of Medicine [IOM] panel on which MCHIP served and produced in September 2013 SMART Vaccines 1.0 and the report *Ranking Vaccines: A Prioritization Software Tool*), it is simply too early to judge whether this IOM decision support tool will be used by the intended audiences (e.g., vaccine manufacturers, researchers, funding agencies, immunization program advisors, and managers). It is also too early to know what effect MCHIP's participation in an external evaluation, along with that of USAID, has had on WHO/AFRO's five-year immunization program. MCHIP continues to provide technical support to a small group convened by WHO on developing a roadmap for updating guidance on the design of home-based immunization records, but we do not yet know what the outcome of this focus on a neglected component of immunization programs will be. Similarly, MCHIP regularly provides detailed technical input to USAID on documents to be presented to the GAVI Program and Policy Committee and to the GAVI Board; however, the direct result of this is never clear.

MCHIP usually plays an active role at meetings or on committees it chooses to attend (e.g., GAVI Partners Forum, NUVI meeting, WHO's ad hoc Working Group on Immunization Implementation Research Prioritization). MCHIP is invited to present its global perspectives, lessons learned, and country experiences and, by so doing, we influence the global agenda. On committees that directly advise the WHO immunization unit on policy (e.g., the Immunization Practices Advisory Committee [IPAC]), MCHIP has been key in 2013 in re-directing attention to immunization supply chain and logistics. Our interventions directly led to a successful effort by WHO's Department of Immunization, Vaccines and Biologicals (IVB) to gain endorsement by WHO's Strategic Advisory Group of Experts (SAGE), which directly advises the WHO Director General, to increase focus and investment on this neglected component of all country immunization programs. Parallel to this,

MCHIP technically supported WHO/PATH on its Project Optimize advisory panel, resulting in a detailed global vision for supply chain and innovative country-specific programming. Along the same lines serving on WHO's IPAC, MCHIP co-led with WHO the revision of WHO's multi-dose vial policy, which has been finalized and will affect all countries, so that the policy addresses characteristics of newer vaccines to assure their safe administration. And MCHIP successfully presented a detailed rationale for additionally presenting IPV (inactivated polio vaccine) in five-dose vials, which has been accepted by the global community and will affect IPV introduction in more than 100 countries.

MCHIP was on a small, active committee that planned the agenda for the annual NUVI meeting and, besides presenting a working session on innovative ways to reach the unreached to close the equity gap, seized the opportunity to initiate a wider discussion on the need to re-design instruments and improve the entire WHO process of new vaccine post-introduction evaluation (PIE). The subsequent PIE in Tanzania incorporated most of MCHIP's proposed improvements.

MCHIP provided technical input into the GAPPD, which will be used to guide country programming, the WHO checklist for new vaccine introduction used in all developing countries, and WHO modules used to train frontline health staff in all countries. In the latter case, MCHIP played a major role in drafting some of the WHO manuals and tools. MCHIP gathered the evidence and successfully advocated for two of the final four indicators on system performance for the Decade of Vaccine's Global Vaccine Action Plan. These indicators are now tracked in all countries in a formal annual review process.

MCHIP's experience in Liberia in integrating delivery of family planning and immunization has been evaluated, documented, and disseminated, including to the CORE Group of PVOs, but it is too early to say whether it will have a broad effect on country programming. However, as a result, Liberia has already decided to implement the approach nationwide. MCHIP has also revised the immunization Knowledge, Practice, Coverage (KPC) module, which will be used by recipients of the USAID Child Survival and Health Grants Program (CSHGP) to measure immunization coverage at the beginning and end of a grant cycle.

MCHIP provided the principal technical support on other tools such as the WHO/EURO Guide to Tailoring Immunization Programmes (TIP) tool kit (as a member of the Communication Technical Advisory Group for WHO/EURO), the WHO Immunization in Practice (IIP) module on partnering with communities, and the WHO tool to identify health worker-related root causes of children remaining unvaccinated. Some of these materials are still in the process of finalization by WHO, and others have already been introduced in some countries.

MCHIP also contributes technically to accelerated disease control initiatives for the Communications Initiative, USAID and its contractors, WHO, UNICEF, BMGF, and CDC in a network of partner organizations on communications in support of the GPEI. We provided TA to USAID on the Global Polio Emergency Plan and to UNICEF on quarterly communication updates presented to the Polio Eradication Initiative Independent Monitoring Board. We also chaired the Program Advisory Committee on maternal neonatal tetanus elimination at UNICEF.

Routine Immunization and New Vaccines

- MCHIP provided TA for the introduction and post-introduction of lifesaving vaccines for some forms of pneumonia and diarrhea in eight GAVI-eligible countries (DR Congo, India, Kenya, Malawi, Senegal, Tanzania, Uganda, and Zimbabwe). This technical support complements USAID's major financial commitments to GAVI for vaccine procurement.

Table 1: Progress toward new vaccine introduction with MCHIP/Immunization technical assistance

COUNTRY		PNEUMOCOCCAL VACCINE	ROTAVIRUS VACCINE	OTHER
1	DR Congo[2]	Met GAVI conditions; completed phased introduction of PCV13 in **2013**	N/A	**Measles** follow-up campaign proposal submitted and approved by GAVI
2	India	N/A	N/A	Phased rollout of **pentavalent** vaccine in USAID focus states in **2012–2013**
3	Kenya	Introduced in **2011** and conducted PIE in **2012**	Introduction planned for **2014**	Introduced measles second dose in **July 2013**
4	Malawi	Introduced in **November 2011;** PIE in **June 2012**	Introduction in **October 2012;** PIE in **July 2013**	Assisted with **measles 2nd dose** GAVI proposal development and preparation for introduction (estimated in **2015**)
5	Rwanda[3]	N/A	Introduced in **May 2012;** PIE in **2013**	Assisted with **measles 2nd dose** GAVI proposal development and introduction preparation in **2013**
6	Senegal	Introduction in **November 2013**	Assist with rotavirus vaccine GAVI proposal development in **2014**	▪ Supported introduction of **MenA** in **November 2012** ▪ Supported MR campaign in **November 2013** ▪ Assisted with **measles 2nd dose** GAVI proposal development in **2013**
7	Tanzania	Supported introduction in **January 2013,** participating in PIE in **November 2013**	Supported introduction in **January 2013,** participating in PIE in **November 2013**	▪ Supported introduction of measles second dose introduction in **January 2013** ▪ Assisted with GAVI application for MR introduction, planned for **2015**
8	Timor-Leste[4]	N/A	N/A	Coordinated with partners to support introduction of **pentavalent** vaccine in **October 2012**
9	Uganda	Launched in **April 2013**	Introduction planned for **2016**	N/A
10	Zimbabwe	▪ Supported introduction in **June 2012** ▪ Supported PIE in **2013**	Satisfied GAVI conditions and supported introduction preparations (introduction planned for **2014**)	N/A

[2] MCHIP program closed September 30, 2013.
[3] MCHIP program closed October 2012.
[4] MCHIP program closing December 2013.

- MCHIP contributed to the following global and regional immunization policy efforts:
  - To address a significant lack of attention to cold chain and supply chain, despite the global focus on new vaccines, MCHIP revised WHO's "Maintaining Vaccines at the Correct Temperature at Country Level" module, contributed to a draft Immunization Practices Advisory Committee (IPAC) Call to Action and presentations to WHO's SAGE for increased investment in immunization supply chain and logistics, provided technical support to WHO/PATH Optimize as a member of its Program Advisory Group, and served as the IPAC lead on the revision of WHO's multi-dose vial policy. In addition, MCHIP created a decision support tool for the Institute of Medicine to help identify and prioritize new preventive vaccines to be produced and introduced. The IOM's SMART Vaccines 1.0 and its report, *Ranking Vaccines: A Prioritization Software Tool,* was released in September 2013. Information is available on the National Academies Press website, at: www.nap.edu/smartvaccines
    - MCHIP made significant immunization-related contributions to the Global Action Plan for Pneumonia and Diarrhea (GAPPD), which was disseminated in April 2013.
    - To help guide GAVI's future investments, MCHIP provided technical input on strategies to strengthen service delivery of new vaccines and mechanisms to strengthen health systems for RI, including engaging civil society organizations.
    - MCHIP gathered the evidence and successfully advocated for two of the final four indicators on system performance for the DoV Global Vaccine Action Plan (GVAP).
    - Along with USAID, MCHIP participated in an external evaluation, feeding into WHO/AFRO's five-year immunization program.
    - MCHIP provided technical input to WHO's new Vaccine Introduction Plan and Checklist documents. MCHIP successfully presented a detailed rationale for making IPV (inactivated polio vaccine) available in five-dose vials, which was accepted by the global community.
- MCHIP continues country-level TA to improve data quality, quarterly supportive supervision, and effective implementation of RED/REC (Reaching Every District/Reaching Every Child) 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 Kenya, DRC, Tanzania, Senegal, Zimbabwe, Uganda, and Malawi, MCHIP supported the functionality and partner participation and collaboration in the Expanded Program on Immunization (EPI) Technical Inter-agency Coordination Committees (ICCs) to keep routine immunization strengthening on the agenda, while ensuring sufficient partner collaboration in new vaccine introduction planning.
- **CORE Group presentations:** At the April 2013 CORE Group meeting in Baltimore, MCHIP staff shared experiences on how to measure and determine the extent to which integrated programming improves health outcomes. This presentation included MCHIP's preliminary findings of a pilot program integrating family planning services with vaccination sessions at health facilities in Liberia. At the October 2012 CORE Group meeting in Washington, DC, MCHIP provided a technical update entitled "What's New in Immunization and Where Do PVOs Fit In?" and led a discussion on potential roles for PVOs in immunization.
- MCHIP collaborated with partners to develop and adapt country-level immunization tools:
  - Substantial contributions to the revision of the immunization KPC module used by recipients of grants from the Child Survival Grants Health Program (CSGHP) to measure immunization coverage at the beginning and end of a grant cycle
  - The WHO/EURO Guide to Tailoring Immunization Programmes (TIP) tool kit

- Drafted the Immunization in Practice (IIP) module on partnering with communities, in addition to reviewing and providing technical input on other IIP modules that will be field-tested and published by WHO as the new edition of IIP
- Contributed to WHO's revised "Cascade Plus" approach to immunization pre-service, in-service, and post-training strategies
- Contributed to WHO's "Informal Meeting on Developing a Roadmap for Updating Guidance on the Design of Home-Based Immunization Records"
- Collaborated with partners to review and update the post-introduction evaluation tool

Polio Eradication

- MCHIP provided input to the Independent Monitoring Board (IMB) on ways to improve global polio efforts and provided comments to the WHO/headquarters focal point on the revision of the Global Polio Eradication Initiative strategy. The Communications Initiative, an MCHIP sub-contractor, also provided expertise on polio communication indicators in the GPEI reports and participated in the IMB meeting for the GPEI in London.
- MCHIP supported polio eradication efforts in DRC, India, and Kenya for National Immunization Days (NID). MCHIP implemented innovative approaches on newborn and infant tracking and vaccination (including oral polio vaccine birth dose [OPV0] using community tracking sheets ["My Village, My Home" in India]) and mobile text reminders (in Kenya). MCHIP is also providing technical support to polio-related activities in Kenya and Tanzania in response to the recent polio outbreak in the Horn of Africa.
- Communications Initiative (CI) contributed to polio eradication communication efforts in priority polio countries, by participating in the meeting of the Technical Advisory Group for Polio Eradication and providing guidance on communication strategies in Pakistan; providing communication input during the National Polio Communications Review (hosted by UNICEF/India) for emergency response strategies and sustaining eradication in India; and contributing to the follow-up review of the Afghanistan Technical Advisory Group (TAG) to guide communication efforts, particularly in high-risk areas.
- MCHIP and CI contributed to global polio communication efforts, including providing technical input to the Polio Communication Partnership (which includes BMGF, WHO, UNICEF, Rotary, and CDC) and technical input/feedback on the GPEI strategy, and to GAVI for their role and strategy document on GAVI's polio eradication effort.
- MCHIP also participated in a Polio Outbreak Simulation Exercise (POSE) hosted by WHO in Ukraine in May 2013. This was the second POSE in Eastern Europe, and it provided key insights into the feasibility of offering similar workshops in other USAID-assisted countries.

Program Learning for Immunization

MCHIP/Immunization disseminated program learning through three key mechanisms: papers published in peer reviewed journals, presentations at meetings and conferences, and products documenting project lessons learned (to be completed in Program Year 6).

During this reporting period, the MCHIP/Immunization team had seven papers published and one manuscript accepted for publication, all in peer-reviewed journals.

MCHIP/Immunization's work during this reporting period addressed three main program learning questions, shown below.

1. **How can new vaccines be introduced in ways that optimize their use and favorably affect routine immunization and health systems?**

a. **What is the impact of new vaccine introduction (NVI) on immunization and health systems?**

A WHO *ad hoc* working group, composed of global immunization partners (including MCHIP), was tasked to examine the positive or negative impact of new vaccine introductions on immunization and health systems in countries through a review of both published and grey literature.[5] Strengths of NVI identified included: reduction of disease burden, and improved surveillance, training, cold chain and logistics; however, opportunities for broader health system strengthening were found to fall short. Weaknesses identified included the need for improved human resource and financial planning. It appeared that when technical assistance or tools were available, there was a positive outcome in planning and implementation.[6] MCHIP's contributions to this work resulted in a manuscript published in the journal *Vaccine* and also contributed to updated WHO guidance for countries on NVI.

b. **What vaccines are needed or need to be adapted to resource-poor settings?**

MCHIP chaired and moderated the vaccination panel and presented to over 300 participants at "Lives in the Balance: Delivering medical innovations for neglected patients and populations" (at Médecins Sans Frontières, DNDi [Drugs for Neglected Diseases Initiative], and Mount Sinai School of Medicine) in New York City. Key questions included: What's been learned from the experience of using field-adapted products that haven't been ultimately introduced on a wide scale? What is the intersection between adapted products and their broader use? What's in the pipeline for more "programmatically suitable" vaccine products? What measures are being put in place already to plan for their use? What "incentives" and policy environment need to be established to fulfill the promise of better adapted vaccines in terms of content, cold chain, and presentation? What delivery strategies are possible with more adapted products? What is contributing to increased prices and are there ways to address the increases?

c. **Is the pneumococcal conjugate vaccine cost-effective?**

MCHIP staff in Kenya contributed to an assessment analyzing the cost-effectiveness of PCV10 and PCV13 in Kenya. Findings concluded that while both vaccines are cost-effective when considering the reduction in burden of disease, and lives saved, PCV13 was found to have an increased cost-effectiveness compared to PCV10. A manuscript was published in *PLOS ONE*.[7]

2. **What strategies can be implemented to address challenges and strengthen routine immunization in order to realize the full benefits of vaccines for all eligible groups?**

a. **Why are children unvaccinated?**

MCHIP collaborated with WHO to analyze 126 documents from global grey literature to understand and identify reasons why eligible children had incomplete or no vaccinations. Findings from this analysis identified the main reasons for under-vaccination most commonly related to immunization services and parental knowledge

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[5] Hyde T, Dentz H, Wang S, Burchett H, Mounier-Jack S, Mantel C, The New Vaccine Introduction Impact Published Literature Working Group. "The impact of new vaccine introduction on immunization and health systems: A review of the published literature." *Vaccine*, October 2012.

[6] Wang SA, Hyde TB, Mounier-Jack S, Brenzel L, Favin M, Gordon WS, Shearer JC, Mantel C, Arora N Durrheim D. New vaccine introductions: Assessing the impact and the opportunities for immunization and health systems strengthening. *Vaccine*, volume 31, supplement 2. April 18, 2013.

[7] Ayieko P, Griffiths UK, Ndiritu M, Moisi J, Mugoya IK, Kamau T, English M, Scott JAG. Assessment of health benefits and cost-effectiveness of 10-Valent and 13-Valent pneumococcal conjugate vaccination in Kenyan children. *PLOS ONE*. 24 June 2013.

and attitudes. Frequently cited factors included: access to services, health staff attitudes and practices, reliability of services, false contraindications, parents' practical knowledge of vaccination, fear of side effects, conflicting priorities, and parental beliefs. A manuscript was published in the journal of *International Health* during this reporting period.[8] As follow-on to this collaboration, WHO coordinated the "UnVacc" initiative to develop procedures and tools for district or sub-district health staff to use and analyze underlying causes of children remaining unvaccinated. MCHIP has been a member of the UnVacc working group since October 2012 and is responsible for drafting the procedures and tools to enable local health staff to investigate health workers' practices and how they impact vaccination coverage. MCHIP was invited to present at the **WHO/Geneva Unvacc Initiative Workshop** on "Tools to identify root causes of children remaining unvaccinated: health worker factors." MCHIP will continue its engagement as the tool is developed.

b. How can routine immunization be strengthened through supplementary immunization activities (i.e., mass vaccination campaigns)?

MCHIP's work on supporting WHO to strengthen routine immunization through campaigns was published in a manuscript in the journal of *Vaccine*. The manuscript described an analysis of using supplementary immunization activities (SIAs) to strengthen routine immunization.[9] MCHIP presented this work at the **Global Measles Rubella Management Meeting** in Geneva in February 2013 on "Using Measles Supplementary Immunization Activities [campaigns] to strengthen the routine immunization system," in addition to helping organize a six-hour session on the topic during the meeting. This work is currently being fed into GAVI's efforts to redesign its support to campaigns.

c. What are innovative strategies to reach the unreached to close the equity gap?

MCHIP made significant contributions to the development of the Global Vaccine Action Plan (GVAP), which is the operational plan and M&E framework for the Decade of Vaccines (DoV). The GVAP was disseminated during this reporting period. In a paper published in a special supplement to the journal *Vaccine* on GVAP, MCHIP staff advocated for reaching the children who remain unreached with vaccination and other health services. The paper cited the importance of countries developing tailored, evidence-based and context-specific strategies to promote equity and system strengthening for effective vaccine delivery and uptake.[10]

Continuing MCHIP's dissemination on strategies to reach the unreached, MCHIP organized and moderated a half-day breakout session and presented on "Innovative Ways to Reach the Unreached" during the **Global Annual NUVI Meeting** in the Dominican Republic in June 2013. As a member of a WHO *ad hoc* working group, MCHIP provided extensive input to the overall design of this annual meeting. At this meeting, MCHIP also initiated a discussion on the need to re-design the tools used for the NVI post-introduction evaluation, and has continued to contribute in its re-design.

d. What are factors limiting immunization coverage in urban Dili, Timor-Leste?

MCHIP staff in Timor-Leste conducted a study to understand the service-related and user-related factors that were contributing to low immunization coverage, despite

[8] **Favin M, Steinglass S, Fields F**, Banerjee K, Sawhney M. Why children are not vaccinated: A review of the grey literature. *International Health*. 2012: 229–238.
[9] **Fields R**, Dabbagh A, **Jain M, Sagar KS**. Moving forward with strengthening routine immunization delivery as part of measles and rubella elimination activities. *Vaccine,* volume 31, supplement 2. April 18, 2013.
[10] Brearley L, Vandelaer J, Eggers R, **Steinglass R**. Applying an equity lens in the Decade of Vaccines. *Vaccine*, volume 31, supplement 2. April 18, 2013.

relatively good access to immunization services. Findings contributed to the MOH strategy on managing and implementing the national immunization program. The manuscript was accepted for publication in *Global Health: Science and Practice* during this reporting period.[11]

e. What are opportunities and challenges for the 2012–13 Year of Intensification of Routine Immunization in India?

The MCHIP/India team conducted a retrospective analysis of the Universal Immunization Programme (UIP) to understand key challenges and opportunities since its inception in 1985 in the context of initiatives being undertaken for the 2012–13 "Year of Intensification of Routine Immunization." This analysis was published as a manuscript in the *Indian Journal of Community Health*.[12]

3. **What are the opportunities for civil society organizations (CSOs) to participate in routine immunization to improve its delivery and uptake?**

The **5th GAVI Partners Forum** was conducted in Dar es Salaam, Tanzania, in December 2012, with about 650 participants from all over the world. The focus was on engaging CSOs. MCHIP staff have more than 20 years of experience in engaging communities and collaborating with CSOs to capitalize on their community involvement to reach the hard-to-reach population with immunization. MCHIP headquarters and field staff provided technical guidance on NVI at country levels, forging public-private partnerships, partnering with civil society organizations, exploring new strategies for financial and programmatic sustainability, improving equity for hard-to-reach populations, and identifying good practices and innovations in vaccine delivery and cold chain logistics. MCHIP also facilitated a session on "Innovative approaches to immunization and health delivery," which included a presentation from MCHIP/India on "Regular Appraisal of Program Implementation in District (RAPID): Innovation for improving quality of immunization services through supportive supervision." **MCHIP prepared a blog for the British newspaper *The Guardian* titled "Innovation can increase the impact of immunization programmes." (accessible at http://www.theguardian.com/global-development-professionals-network/2012/dec/10/immunisation-vaccination-innovative-interventions)**

MCHIP also presented to the **MNCH United States Committee for Child Survival Meeting** on "What's new in immunization and where do PVOs fit in?" on April 23, 2013.

In addition, MCHIP led a workshop at the October 2012 **CORE Group meeting in Washington, D.C.**, discussing technical capacity building for PVO engagement in delivering vaccination services. At the workshop, MCHIP provided a technical update titled "What's new in immunization and where do PVOs fit in?" and led a discussion on potential roles for PVOs in immunization. At the April 2013 **CORE Group meeting in Baltimore**, MCHIP led another workshop on "Integration through an M&E Lens," sharing experiences on how to measure and determine the extent to which integrated programming improves health outcomes. This presentation included the MCHIP preliminary findings from the pilot program integrating family planning services with vaccination sessions at health facilities in Liberia.

[11] Amin R, Real de Oliveira TJ, Da Cunha M, Brown TW, Favin M, Cappelier K. Factors limiting immunization coverage in urban Dili, Timor-Leste." (*Global Health: Science and Practice*, Accepted October 2013)

[12] Taneja G, Sagar KS, Mishra S. Routine immunization in India: A perspective. *Indian Journal of Community Health*, vol 25, no 2. April–June 2013.

MALARIA

MCHIP is working closely with the President's Malaria Initiative (PMI), the Roll Back Malaria (RBM) Partnership community, and key stakeholders in maternal, newborn and child health (MNCH) to reduce malaria morbidity and mortality. MCHIP has provided global leadership in MIP and integrated community case management (iCCM), and has contributed to fostering partnerships between experts in malaria and MNCH through participation in the RBM MIP working group and the Global CCM Task Force (TF). MCHIP has also strengthened the capacity of Malaria Communities Program (MCP) grantees to design and implement community-based malaria programs that build local ownership.

Global Leadership for Malaria

In Program Year 5, MCHIP supported coordinated efforts among RBM partners to quickly disseminate the latest WHO updated policy recommendation on intermittent preventive treatment during pregnancy (IPTp) along with guidance that emphasizes continued support of IPTp-SP at the country level, integrated policymaking and implementation between reproductive health and malaria programs, and effective monitoring and evaluation, all of which are necessary for optimizing the delivery of MIP interventions. MCHIP ensured that consolidated iCCM implementation tools, such as the CCM Indicators Book and revised supply chain management resource guides, were available to country implementers through the CCM TF website (www.CCMCentral.com). MCHIP also supported a CHNRI process on iCCM, which provided a revised iCCM research agenda, as identified by both global researchers and, more importantly, iCCM program managers and academics at the country level. MCHIP finalized four MCP case studies that showcase community-based strategies that have a proven impact on malaria prevention and control.

Malaria in Pregnancy

- Through **continued support to the RBM MIP working group**, MCHIP contributed to: expanding the working group's membership; developing a number of key MIP documents; and reaching MNH colleagues at key global meetings. MCHIP also continued to provide leadership to the MIP working group through its role as Co-Chair and its supporting role with respect to the functioning of the working group.
    - **Expanded Membership:** In collaboration with WHO and PMI, MCHIP engaged a number of new research, program, and technical partners in strengthening the MIP working group's capacity and its ability to achieve its mandate. Expanded membership, combined with the leadership of the MIP working group, has contributed to an increased recognition from the RBM Board for the prioritization of MIP. As a result, a number of workplan priorities have been realized, including supporting WHO in the dissemination of the updated WHO IPTp policy and development of draft communication messages for MIP.
    - **Key Documents**
        - **IPTp Policy Brief:** With partners, MCHIP provided input into the April 2013 WHO MIP policy brief to reinforce and clarify the policy recommendation on IPTp-SP that WHO issued in October 2012. The policy brief has been distributed widely to partners and countries to accelerate country-level adoption of the latest WHO guidance on IPTp-SP.
        - **MIP Consensus Statement:** MCHIP contributed to the development of RBM MIP working group's consensus statement on MIP, which highlights the elements needed to optimize the delivery of MIP interventions and to integrate and harmonize policymaking and program implementation for national reproductive health and malaria programs. The MIP consensus statement is currently under review at WHO. Once it has been cleared for production, it will be disseminated to WHO representatives, PMI teams, and partner organization teams in the Africa region.

- **MIP/Newborn Brief:** Along with PMI, WHO, and other working group members, MCHIP led development of a program brief entitled, "Malaria Protection in Pregnancy: A Lifesaving Intervention for Preventing Neonatal Mortality and Low Birth Weight," which synthesizes two published articles about how the use of insecticide-treated nets (ITNs) and IPTp contribute to reduced maternal and child mortality. The brief was distributed at the GMHC in Arusha, Tanzania (January 15–17, 2013), and shared along with key MIP messages at the GNHC in Johannesburg (April 14–18, 2013) to promote the lifesaving benefits of MIP prevention.

- **Reaching MNH Colleagues:** Also at the in GMHC in Arusha, MCHIP led a panel of presenters, including RBM MIP working group partners, on the topic "Malaria in Pregnancy: What It Takes to Deliver Quality Services as a Component of Comprehensive Maternal and Newborn Health Care." The session provided the opportunity to engage maternal health experts from around the world in recognizing that malaria in pregnancy interventions save the lives of women and their newborns, as well as the opportunity to discuss the importance of repositioning malaria in pregnancy as an integral component of maternal health programs.

- To **support acceleration of country MIP programs**, MCHIP joined a mission conducted jointly by the WHO and PMI to **review Zambia's MIP program** on November 5–9, 2012. The team reviewed national-level MIP documents (policies, guidelines, assessments, reports, and technical tools for training, quality assurance, and supervision) and conducted interviews with national-level stakeholders and managers of two health centers. Building on findings and recommendations from MCHIP's 2009 Zambia MIP case study, the team reviewed Zambia's progress and challenges across the eight key areas of MIP programming and provided updated recommendations to stakeholders to further accelerate programming. MCHIP also worked with country-level staff and PMI colleagues in **Uganda** to conceptualize an approach to updating and rolling out current MIP guidance to health workers. The approach, which will be implemented in PY6, includes bringing together key malaria and reproductive health partners and conducting training and supervision. In **Ghana** MCHIP assisted PMI with developing the first draft of a brief that documents Ghana's success in dramatically increasing uptake of the second dose of IPTp. The brief will be finalized in PY6 and used to highlight Ghana's achievements as well as to share lessons that may be applicable to other country programs.

  - A one-day **MIP technical update** was included in the Africa Bureau MH core-funded **MNH Africa Champions Workshops** held in Guinea and Malawi on February 21–25, 2013 (see the **MH Core** section of this report for an overall activity update). MCHIP designed a pre-course MIP questionnaire delivered via the Internet through Q-stream to prepare the MNH champions for the workshop. The one-day workshop focused on an update of current WHO guidance on MIP prevention and case management, MIP clinical training materials, and a health systems approach to strengthening national MIP programs. A package of MIP resources was developed and disseminated to participants, including the current WHO MIP prevention and treatment guidance. In the action plans that champions developed for their countries, they included ensuring that MIP guidance is consistent across national malaria control and reproductive health program documents and consistent with current WHO MIP guidance, as this directly affects the quality of care provided to pregnant women. The **MIP resources** from the MNH Champions Workshop were repurposed as a self-guided package of current MIP technical and programmatic information so that they would be accessible by a wider audience. The package was disseminated to national malaria control and reproductive health representatives during MIP update sessions at the RBM African sub-regional network meetings (East Africa Roll Back Malaria Network [EARN], Central Africa Roll Back Malaria Network [CARN], South Africa Roll Back Malaria Network [SARN]) that took place in July and August 2013 and will be shared at the West Africa Roll Back Malaria Network (WARN) meeting in November 2013. *For more information on the MNH Africa Champions Workshops, please refer to the Maternal Health section of this report.*

Integrated Community Case Management and Child Illness

- As the Secretariat of the **CCM Task Force,** MCHIP has contributed to stronger iCCM programs that are using state-of-the-art iCCM tools (e.g., supply chain management, M&E, operations research, and costing and financing). During the past year, MCHIP organized one steering committee teleconference and five TF teleconferences. Included in the Secretariat tasks was the (re)vitalization of four subgroups: Operations Research, Monitoring and Evaluation, Supply Chain Management, and iCCM Costing and Financing. MCHIP also continued to refine the www.**CCMCentral.com** website as a global resource on current events, tools, documents, meeting reports, and other materials for iCCM.

For further details about MCHIP's CCM results, refer to the Child Health section of this report.

Malaria Communities Program

- To document results and lessons learned across the MCP portfolio, MCHIP reviewed and provided feedback on final reports for 12 MCP grantees, and summarized the results and lessons learned from 19 grantees in 12 countries in a final portfolio review with PMI. Grantees created and strengthened linkages between communities and facilities through implementation of supervision systems, referral mechanisms, and a range of BCC activities to increase treatment seeking. They also piloted new strategies and tools for ministries of health, including CCM (EQUIP Liberia), rapid diagnostic testing in health facilities (HealthRight Kenya), and supervision checklists (Health Partners Uganda, EQUIP Liberia, and AKF Mozambique).They built local capacity, created local oversight bodies, and developed sustainability plans through which they transitioned project activities to ministries of health and other local partners.

- MCHIP organized and moderated an event highlighting MCP contributions: *Strengthening National Malaria Control Efforts through Community-Based Strategies: The President's Malaria Initiative's Malaria Communities Program*. Rear Admiral Tim Ziemer provided opening remarks. MCP partners from Angola, Ethiopia, Kenya, Liberia, Malawi, Tanzania, and Uganda and representatives from PMI discussed strategies, lessons learned, and unique contributions to local, national, and global malaria control efforts.

Program Learning for Malaria

In PY5, MCHIP expanded its program learning for MIP, iCCM, and community strategies for malaria through the MCP.

Review of MIP-related documents from five PMI countries. (Data source: desk review of policies, guidelines, in-service training materials, clinical supervision materials, and pre-service curricula across malaria and reproductive health (RH) programs; MCHIP learning themes: integration, quality, and scale.)

MCHIP reviewed documents from Kenya, Mali, Mozambique, Tanzania, and Uganda to understand the MIP guidance these countries are promoting for health providers and ascertain whether it is both consistent with WHO's MIP guidance and consistent across country-level documents for reproductive health and malaria control programs. The review found that WHO guidance on MIP is incorporated in country-level documents to varying degrees and guidance tends to be discordant within each country's documents. MCHIP and PMI have collaborated with colleagues in the five countries to identify opportunities to quickly disseminate specific findings and recommendations to national RH and malaria control partners for aligning their documents with current WHO guidance and making it clear and consistent across country-level documents. The report has also been shared more widely with RH and malaria control country representatives from East, Central, and Southern Africa during MIP update sessions at the annual RBM African sub-regional network meetings in July and August 2013 and will be

shared at the network meeting for West Africa in November 2013. MCHIP and PMI collaborated on drafting an article explaining the significance of the review's findings and recommended a way forward to ensure consistent and quality MIP guidance from national reproductive health and malaria control programs. The article will be submitted for publication in PY6. At PMI's request, MCHIP expanded the review of guidance documents to cover all 19 PMI focus countries, and the full review will be completed in the first half of PY6.

Review MIP monitoring at the country level. (Data source: desk review of HMIS data collection formats and reporting guidance and interviews with in-country stakeholders; MCHIP learning themes: integration, quality, HMIS, scale.)

The MCHIP MIP core team collaborated with the MCHIP M&E core team on a review of data collection and reporting systems for MNH indicators, including MIP, in six African countries—Kenya, Malawi, Mali, Mozambique, Tanzania, and Uganda (*refer to the Monitoring, Evaluation and Research Core section of this report for an overall activity update*). Phase one of the review included a review of various health management information system (HMIS) data collection tools and guidance collected from the six countries to determine how information is captured and reported specific to provision of IPTp, ITNs, folic acid and iron supplementation, and testing for and treatment of malaria in pregnancy. While it does not provide a complete picture of reporting systems, the document review gives valuable insight into what information is being collected during service provision and how it is being reported. MCHIP started a second phase of the review involving key informant interviews with MIP stakeholders to clarify information from the desk reviews and provide a deeper understanding of each country's reporting system. An important finding from phase one, which is being explored further, is the need to improve recording and reporting of diagnosis and treatment of malaria among pregnant women. A report on phase one across the six countries has been developed, as have individual country reports on Kenya, Mozambique, and Uganda, where the interviews were conducted. In the first half of PY6, phase two will be completed in the remaining three countries and a final activity report will be produced on the findings and recommendations for priority MIP indicators that should be collected and an ideal system for collection. The report will be prepared for dissemination to countries.

Review of MCHIP's Role as the Secretariat of the CCM TF. (Data source: external review of TF and Secretariat; MCHIP learning theme: quality.)

In PY5, MCHIP hired external consultants to conduct a review of the accomplishments of the CCM Task Force and of the role of the TF Secretariat (held by MCHIP). The review included in-depth interviews, an online questionnaire, and a key document review, as well as a cost analysis of the Secretariat function. The review gathered *perceptions* of efficacy and value of both the overall CCM Task Force and the Secretariat role. The positive contributions to date of the Task Force and the Secretariat role were clear. However, the TF's engagement at the country level was found to be an issue requiring further strategic discussion. Results of the study will be discussed by the CCM Task Force Steering Committee in PY6, Quarter 1, and strategic decisions about how the TF and Secretariat role could be changed will be made at that time.

Assessment of Training and Supervision Tools for Malaria Case Management. (Data source: desk review in PMI countries; MCHIP learning theme: integration, quality, and scale.)

MCHIP finalized an assessment in PMI countries of the current status of 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 the extent to which IMCI training and supervision tools that are currently used at country level include WHO recommendations. A primary finding was that it was difficult even to find training and supervision materials at the country level; out of the 16 countries contacted, the review found training materials for 13 and supervision materials for only seven. Based on the materials reviewed, a few countries had incorporated some of the WHO guidance into their materials, but there are areas in both

training and supervision materials where the WHO guidance is not yet reflected. These findings will help guide further discussion of the role of, and adherence to, global guidance. The research findings were disseminated internally through PMI to their country representatives and will be made available in an online open access journal in PY6.

MCHIP finalized four case studies: 1) Strengthening Platforms for Case Management in Communities, 2) Malaria in Pregnancy – Improving IPTp and ANC, 3) Building Community Capacity in Malaria Control, and 4) Achieving, Tracking, and Maintaining High ITN Coverage.

The case studies provide evidence that community engagement yields improved malaria health outcomes, and highlights implementation strategies for community-based malaria control efforts. The case study on malaria in pregnancy explores successful features of community-based strategies that MCP partners used to increase IPTp uptake and ANC attendance. A primary finding was that MCP partners engaged men to help reduce barriers to women's access to MIP-related services. The case study on community capacity focused on successful models of community outreach and engagement used by MCP grantees to sustain malaria control activities. A primary finding was that close collaboration helped to integrate the community and facility health systems through standardized behavioral messages, services adjusted to need and context, and empowered community members. Community participation in selecting volunteers contributed to a sense of ownership of the process and the health messages that were produced.

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 year, MCHIP-FP has prioritized global and regional advocacy efforts for the promotion of postpartum family planning (PPFP) as a means to reduce unintended and closely spaced births. In collaboration with USAID and WHO/Department of Reproductive Health and Research, the MCHIP-FP team created the document, *Programming Strategies for Postpartum Family Planning*. This document is currently in the final stages of approval at WHO and USAID. 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 organized a well-attended auxiliary event at the 2013 Women Deliver Conference in Kuala Lumpur, Malaysia; provided technical leadership in the area of postpartum IUDs (PPIUCD) by co-chairing a technical working group and holding a regional PPIUCD workshop in Zambia; and continues to provide technical assistance in various facets of PPFP programming to a myriad of countries.

Global Leadership for Postpartum Family Planning

- **Regional Meeting in Africa on PPIUCD:** MCHIP and Population Services International (PSI)/SIFPO convened a four-day regional meeting in Zambia to bring together international and regional experts to advance integration of PPIUCD services into maternal health services. A total of 59 participants from 10 countries (Ethiopia, Kenya, Liberia, Malawi, Mozambique, Rwanda, Tanzania, Uganda, Zambia, and Zimbabwe) actively engaged in South-to-South learning, sharing successes and challenges based on their country experiences. The meeting served as a forum to share successes and discuss challenges to implementing quality PPIUCD services, from initiation to scale-up. Among the 59 participants, 11 were from MOHs, eight were providers or represented professional organizations, 37 were from projects, two were from USAID and one was from the UN. Participants from the meeting created country workplans; a follow-up meeting is planned with them at the International Conference on Family Planning in Ethiopia in November 2013.

- **Technical Meeting at the Women Deliver Conference:** MCHIP held the sixth annual PPFP technical meeting on May 27, 2013, in Kuala Lumpur, Malaysia, as a satellite event at the Women Deliver Conference. Approximately 100 experts and leaders in reproductive health and MNCH from over 40 global health organizations, government agencies, donors, universities, and other groups participated. The meeting provided a forum for participants to share best practices and experiences with PPFP programming and featured the announcement of the new WHO resource, *Programming Strategies for Postpartum Family Planning*. Meeting evaluations indicated that participants appreciated the broad range of studies and programs described in the concurrent sessions, lauding the diversity of experiences presented. To continue to share evidence and best practices to guide PPFP integration, WHO, in partnership with USAID and MCHIP, will officially release the *Programming Strategies for Postpartum Family Planning* at the 2013 International Conference on Family Planning.
- Using the Lives Saved Tool (LiST) to Model PPFP Use, Birth Intervals, and Breastfeeding Impact on Neonatal and Infant Mortality: In this analysis, the Futures Institute projected the impact of increasing either PPFP use or exclusive breastfeeding to nearly universal levels, and the resulting reduction in neonatal, infant and under-five child mortality. Reductions are impacted by contextual factors, but certain countries where either FP use or breastfeeding practices are less than optimal would see a greater benefit in focusing on those two linked interventions. A first presentation of these results will be made at the International Conference on Family Planning in November.
- **Updates to Statement for Collective Action**: While the *Statement for Collective Action for Postpartum Family Planning* was launched in conjunction with the 2012 London Summit on Family Planning, MCHIP continues to publicize it through various channels. Also, endorsements from WHO and UKAID meant revising the public versions of this document to reflect the logos of these important global institutions.
- **Postpartum Family Planning Community of Practice and Postpartum Family Planning Toolkit**: The Postpartum Family Planning Community of Practice on the IBP knowledge gateway platform now has 1,261 members from 88 countries as of September 30. In Program Year 5, MCHIP-FP held the following three online discussion forums:
    - "Return to Fertility and Pregnancy Risk after Delivery." This online forum, held from September 24 to October 5, 2012, featured research findings and program learning around postpartum return to fertility and strategies for strengthening knowledge of pregnancy risk and timely uptake of FP services. The discussion explored women's misconceptions around return to fertility and pregnancy risk, provider attitudes and behaviors, social norms and stigma around PPFP use, and other factors affecting women's use of FP services postpartum.
    - "PPFP demand generation and social and behavior change communication: The role of CHWs." This forum was convened by MCHIP on the CHW Central site during September/October 2012. During the forum, MCHIP shared learning from field programs, including the Healthy Fertility Study in Bangladesh, Kenya, and India.
    - "Monitoring and Evaluation of Postpartum Family Planning Integration." Launched on September 24, 2013 through the PPFP Community of Practice, this forum began with an interactive webinar on M&E of PPFP Integration attended by over 30 participants. Continuing via the PPFP COP website through the end of October, the forum will explore methods of assessing PPFP integration, engaging experts and allowing participants to share field implementation experiences. As of September 30, 128 new members had joined the PPFP Community of Practice to participate in the online discussion.

- **Facilitation of Shared Learning between USAID and Domestic USG Agencies and Partners:** In collaboration with the Evidence to Action (E2A) project, MCHIP continues to support USAID and Health Resource and Services Administration's (HRSA's) Maternal and Child Health (MCH) Bureau to foster experiences and learning in MCH integration, both domestically and internationally. During this past year, a planning meeting took place to discuss continued collaboration, and a panel presentation was organized and presented at the Core Group spring meeting in Baltimore, Maryland. The session brought together domestic and international experts to discuss possible linkages and shared learning in MCH, providing participants with an overview of work in preconception and interconceptional health domestically and globally, presenting a tool for reproductive life planning and offering the opportunity to engage in discussion on opportunities for linkages and shared learning domestically and globally. Approximately 40 people attended this session.

- **FP/Immunization Working Group and Toolkit and Publication of HIP Brief:** During PY5, the Working Group continued to actively engage members to share program learning in this area, and several new products were generated. Working Group meetings were held on November 29 and May 2; meeting agendas included implementation updates and sharing of research findings from various organizations involved in EPI/FP integration activities. MCHIP's Liberia work was also shared and discussed at these meetings. The Working Group agreed to collaboratively develop a K4H toolkit on FP and immunization integration. The toolkit serves as a repository to share global evidence, country experiences, and tools and resources to support program implementation. After the content was gathered, the toolkit was reviewed by a panel of 20 individuals representing a diverse array of country settings and institutions. The toolkit was finalized and made publicly available in September 2013. Dissemination efforts will continue into next year. The Working Group was also involved in authoring and reviewing the *High Impact Practices for Family Planning* brief on FP and immunization integration. This was a long process in the making, involving numerous meetings, writing sessions, and rounds of review. The brief was finalized by USAID in September 2013. Other working group products include two briefs that are part of the new toolkit—one on key considerations for M&E of FP/immunization integration, and another on the key behaviors necessary for successful implementation FP/immunization integration.

- **MIYCN/FP Working Group Leadership:** MCHIP continues to co-chair the Maternal, Infant and Young Child Nutrition and Family Planning (MIYCN-FP) Working Group with the JSI Strengthening Partnerships, Results, and Innovations in Nutrition Globally (SPRING) project. Two of the three planned meetings took place, with the third scheduled for October 2013. During the past year, the working group focused on expanding membership, almost doubling the size of the community of practice from 83 members to 163 current members representing 47 organizations/projects from 11 countries. Also, the working group discussed how to disseminate the K4Health toolkit that was finalized in the previous program year.

- **Contributing to the Global Learning Agenda on PPIUCD:** In addition to the aforementioned Zambia Regional Meeting on PPIUCD, the FP team published an informative MCHIP technical brief on *Program Learning for Postpartum Intrauterine Contraceptive Device (PPIUCD) Integration with Maternal Health Services* early in the year, and distributed it widely, including through a blog on the Gates Foundation's *Impatient Optimist* site. The brief also inspired an effort to collect program data from multiple countries, as part of the development of a manuscript, which will be submitted in the next program year. In an effort to contribute to the global learning agenda on postpartum IUCDs, MCHIP in collaboration with PSI also convened several PPIUCD working group meetings to bring together clinical and program experts to share program learning as well as updated clinical techniques. This program year, the working group expanded the PPIUCD section of the PPFP toolkit on the K4Health site. Training materials, social and behavior change communication (SBCC) and IEC materials as well as program learning and implementation guides are now available for the global audience. These resources underwent a technical

review in order to present the most accurate and up-to-date information. The PPIUCD page is now the most visited section of the PPFP toolkit.

- **PPFP Country Profiles Developed from Reanalysis of DHS Data and Synthesis Paper:** Three of the four planned descriptive country profiles for the extended postpartum period were completed. These profiles were for Ethiopia, Burkina Faso, and Mozambique; the Uganda analysis is pending. These detailed country profiles and technical briefs demonstrate missed opportunities for integration of FP by making use of existing DHS data for women two years postpartum. This work highlights unmet FP need, short birth-to-birth intervals, timing of key factors related to fertility return, the relation of FP use and maternal health care, as well as method mix, and serve as important advocacy documents at the country level. New this year is a composite index of risk of unintended pregnancy over the first two years postpartum among sexually active women, and a graphic to show the magnitude of this risk. The MCHIP FP Team has also completed a first draft of a synthesis paper of a multi-country DHS analysis of survey data on postpartum women from 22 countries, exploring global trends in unmet FP need, short birth-to-birth intervals, timing of key factors related to fertility return, linkages with FP use and other MNCH services, and method mix. This manuscript is expected to provide new estimates of need to inform future programming decisions related to PPFP and will be submitted for publication in PY6.

- **Postpartum Tubal Ligation Highlighted in Revision of Learning Resource Package:** Jhpiego's existing Tubal Ligation learning resource package is in the process of being updated by MCHIP-FP to include a chapter on Postpartum Tubal Ligation. The first draft of the revision is currently undergoing internal review. Next steps include external review by a group of technical experts in the field and then the package will be field tested in the Philippines. The field test is expected to begin February 2014.

- **Postpartum Family Planning Toolkit**: The MCHIP-FP team also maintains the Postpartum Family Planning Toolkit on K4Health. In the last year the PPFP toolkit had 2,508 unique site visits with each user spending an average of five minutes on the site. The top three pages of the toolkit were the toolkit homepage with 992 views, the PPIUD page also with 992 views, and the essential knowledge page with 350 views. The toolkit is a fundamental part of MCHIP-FP's knowledge management strategy

Highlights of Assistance to Countries in Postpartum Family Planning

- **Yemen TIPS:** During PY5, the FP and nutrition teams collaboratively planned for the application a Trials of Improved Practices (TIPS) process in Yemen. TIPs is a formative research technique that allows program planners to pretest the actual practices that a program will promote. In Yemen, the TIPs will focus on MIYCN and FP practices. Findings from TIPs will be used to inform the development of a larger intervention package.

- **Yemen PPFP:** MCHIP led a workshop on PPFP and a contraceptive tech update for 112 providers from seven of Sana'a's busiest maternities. Seventeen among them were chosen to participate in PPFP counseling and clinical practicum.

- **Philippines:** During PY5, the FP team provided technical support to the Mindanao Health project, including providing guidance on the development of a behavior change communication plan for the project, and also to the overall MCHIP Philippines team regarding the preparation of an advocacy strategy and accompanying advocacy materials on the IUCD as a PPFP option. The team shared PPFP resources and tools that had been developed and used by MCHIP within other country settings to help inform project activities and influence key decision-makers.
- **Egypt:** During PY5, the team provided PPFP technical support for the Smart Project, including conducting field visits and making recommendations for opportunities to strengthen the PPFP component of the project, conducting training on SBCC for PPFP for

program staff, and developing PPFP communication materials to be incorporated within Smart home visits and health education sessions. The team also provided technical support for the development of the Smart endline evaluation tools.

- **Tanzania:** During PY5, the team provided technical support for an integrated community and facility MNCH program implemented under the MAISHA Project (in coordination with MOHSW). Support has included regular TA calls with the team to discuss progress, challenges, and brainstorm strategies for addressing challenges. MCHIP staff also participated in a workshop in February to review the progress of JHU's evaluation of program activities, discuss initial findings, and plan for the coming year's evaluation activities. MCHIP staff have been involved in ongoing review and provision of feedback on research tools and manuscripts developed by JHU.
- **Mali (field-funded):** MCHIP trained 15 learners from Kita (10) and Bamako (5) on PPFP/PPIUD, focusing on clinical competency to provide PPIUD services at their sites.

Program Learning for FP

The PY5 workplan included seven key program learning priorities in the area of FP/MNCH integration, although other activities will also generate important learning. This past year, the MCHIP-FP team has continued to implement pilot projects in which PPFP is integrated with nutrition (Kenya), immunization (Liberia, India, Mozambique), an MNH community program (Bangladesh, Mali), and maternal health (scale-up of PPFP 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 PY5 program learning activities and results are described below.

Healthy Fertility Study in Bangladesh

Beyond successful integration of FP with existing community MNH activities in the postpartum period, what are the infant health outcomes attributable to healthy pregnancy spacing? (Theme: Community; Integration).

Selected Health Fertility Study Results

- Despite initial baseline differences in ever use of contraceptives (18% intervention vs. 21% comparison), contraception adoption was consistently higher in intervention area in all seven postpartum surveys compared to comparison area. Among socioeconomic status quintiles, the use of any method was similar across wealth quintiles in the intervention arm at all postpartum surveys. However, in the comparison area any method use was significantly lower among the poorest households (15.7% versus 23.3%, $P<0.05$ at 12 months postpartum survey) during all postpartum surveys.
- In intervention and control arms, high levels of coverage of household visits were achieved by community health workers during pregnancy and postpartum periods, indicating feasibility of the intervention vis-à-vis workload.
- Overall, throughout the 36 months following delivery, results show a >20% increase in the cumulative probability of contraceptive use in the intervention area as compared to the control area ($P<0.001$).
- During the 36 months of postpartum observation, HFS activities were associated with a 21% reduction in the cumulative probability of postpartum pregnancy after the delivery of the index child (Hazards ratio: 0.79; 95% CI: 0.70–0.89). Findings indicate that in the intervention area, 40% women became pregnant by 24 months, compared to 48% in the control area. By 36 months postpartum, 47% of intervention area women became pregnant as compared to 56% in the control area. In addition to significant declines in pregnancy incidence, the hazards of shorter birth intervals reduced by 21% (95% CI: 11.7%–30.4%).
- The odds of a preterm birth outcomes were considerably lower in the intervention area than in the control, though this was only marginally significant (OR: 0.80 [95% CI: 0.63–1.03). However a statistically significant reduction in the incidence of low birth weight was not observed. Birth weight could not be obtained from neonates who died, a significant portion of which were likely premature or low birth weight.

The Healthy Fertility Study (HFS) commenced in 2007. In MCHIP PY5, the 36-month-postpartum survey was conducted and final analysis for the study was completed. The Final HFS Report will be completed in October 2013. Select final findings are included in the text box at right.

Data collection on the sub study of the HFS on cost effectiveness analysis was completed. Analysis will continue in the first quarter of PY6 and will be included in the Final HFS Report. Also in PY5, three manuscripts were submitted to peer-reviewed journals. Of these submitted manuscripts, one has been published in Global Health: Science and Practice 2013 (Volume 1, Number 2). Other manuscripts are currently in development and will be finalized in PY6. HFS also finalized the Report of the Assessment of Return to Fertility Messages and "Asma's Story" within the HFS and a *Program Managers' Guide to Community-Based FP and MNH Integration*. The assessment was designed to assess shifts in knowledge, approval, intention, and action resulting from behavior change activities, which incorporate Asma's story and the return to fertility messages. The guide summarized information and considerations to help managers plan and implement an integrated FP-MNH program, using lessons learned from HFS.

MCHIP continued to disseminate the study's findings and lessons learned. The HFS Program Manager presented HFS results at the APHA Meeting in October 2012 and at a PPFP auxiliary event at Women Deliver in May 2013. Also, a national meeting was conducted in Dhaka on September 26, 2013 and convened stakeholders to disseminate findings and lessons learned.

Application of Postpartum Systematic Screening in India and Mozambique

Does use of the Postpartum Systematic Screening (PPSS) tool increase utilization of FP, immunization, postnatal care, and other relevant services in facility and outreach settings? (Theme: Integration)

Within MCHIP, the application of a systematic screening checklist directed at postpartum women has been tested, first in Nigeria, then in India, and currently in Mozambique. This adaptation for postpartum women was in response to the fact that they often do not perceive themselves to be at risk of pregnancy due to their status as amenorrheic and/or breastfeeding, and therefore may not identify themselves as in need of FP services. In Jharkhand, immunization services are provided in villages on specific village health and nutrition days (VNHDs) by auxiliary nurse midwives who travel out to work in teams with local anganwadi health workers and accredited social health activists (ASHAs). The VHND is organized in each village on a fixed day at least once per month with the objective of bundling different MCH services and making them more accessible to rural/disadvantaged populations. MCHIP trained health workers in PPFP counseling in both control and intervention arms of the study. The PPSS study was undertaken in 18 sub-centers in one of the blocks (a geographical area with population of 100,000 approximately) in Simdega District, Jharkhand State to find the added effect of the use of a PPSS tool in increasing the uptake of FP services, beyond PPFP training alone. Study design issues related to timing of data collection and reliance on service statistics have complicated and delayed the analysis of results. Nevertheless, the results suggest that the screening tool did result in increased acceptance of FP among women with a child less than one year old. The preliminary results also show that the uptake of immunization services was not adversely affected by introducing the tool during the VHNDs that were a part of this study.

Using a different study design, a study is currently under way in large Mozambique urban health centers to assess whether screening leads to referrals for FP. Completion of those referrals will be carefully tracked and assessed. Data are being collected through provider and client exit interviews. Monthly service delivery data for immunization, postnatal care, and FP are also being collected from each of the three current study sites, but there are plans for expansion of this study into additional urban health centers.

Model Development in FP/Immunization Integrated Service Delivery in Liberia

Does integration of FP messages with Immunization increase utilization of both services and what are the key programming elements? (Theme: Integration, Quality)

MCHIP (in collaboration with the MOHSW) completed the implementation of a pilot initiative to integrate EPI and FP services at 10 health facilities located in Bong and Lofa counties. A mid-term assessment was held during July 2012 to identify progress, challenges, and areas where adjustments to the approach may be needed. Assessment findings led to several adjustments, such as the introduction of privacy screens at facilities where EPI services were provided in a public space, in response to concerns that women were reluctant to accept FP referrals from the vaccinator out of fear of being seen and stigmatized by other clients. After nine months of implementation, a final assessment was conducted in December 2012 based on ongoing monitoring data, service statistics, and MOHSW HMIS data. The assessment revealed substantial increases in the number of new contraceptive users at the intervention sites—a 90% increase in Lofa County and 73% in Bong County, comparing the intervention period to the same period of the previous year. FP users who were referred from EPI and accepted a method on the same day represented a large proportion of the total number of new contraceptive users in participating facilities. During the pilot period, 44% and 34% of all new contraceptive users in participating facilities in Bong and Lofa (respectively) were same-day EPI-referral acceptors. Pilot facilities experienced an increase in the number of doses of Penta 1 and Penta 3 administered. In both counties, the increase in Penta 1 doses administered outpaced that of Penta 3 doses, resulting in a net increase in the dropout rate. However, changes in immunization were more likely due to external factors rather than the integrated service delivery itself. Dropout from Penta 1 to Penta 3 is a challenge faced across health facilities. Following the completion of the assessment, a stakeholder meeting was held in March 2013 to share and discuss findings, identify remaining challenges to be addressed, and plan for expansion of the approach. The final assessment report was finalized in August 2013, after MOHSW review. Discussions are currently under way regarding operationalization of expanding the approach, and MCHIP is in the process of developing an implementation guide to support this process at the county level. This effort has contributed greatly to MCHIP's learning on integration of services, ensuring quality of both services through the integration process, and planning for scale-up of an integrated approach. Findings from the work in Liberia have been shared in international forums, such as the PPFP technical meeting at Women Deliver, and a manuscript is currently under development which will be submitted for publication. MCHIP has also been providing technical support to IRC, which has included EPI/FP integration (using the MCHIP/MOHSW model) in its CSHGP workplan.

Model Development in FP/MIYCN in Integrated Service Delivery in Kenya

What are the key program elements in MIYCN/FP integration and how does it affect FP use among postpartum women? (Theme: Integration, Community)

During PY5, implementation of the MIYCN-FP integrated service delivery approach expanded to include a total of six health facilities (Bondo District Hospital; Ogam Dispensary; and Kapiyo, Usigu, Got Matar, and Gobei Health Centers) and adjacent community units (BarKowino, Pala, Bar Chando, Ajigo, Kapiyo, Nyamonye, and Usigu). At the start of the year, implementation had begun only in Bondo District Hospital and its adjacent community units. During November through December, the MCHIP team worked to finalize data collection and supportive supervision tools, and identified additional sites where integrated service delivery would be introduced. During this period, the MCHIP team also conducted a visit to Bondo to field test the MIYCN/FP supplementary registers, conduct exploratory assessments at the new sites where integrated service delivery will be introduced, and review the MIYCN/FP Supportive Supervision tool with the Bondo District Health Management Team (DHMT) and Bondo Hospital Health Management Team (HMT). In February 2013, service providers, community health extension workers (CHEWs) and community health workers (CHWs) working in selected health facilities and adjoining

community units in Bondo were trained in MIYCN-FP integrated service delivery. The training included content on FP, nutrition, MIYCN-FP integration, and data demand and information use. During supervision, MCHIP staff noted gaps in knowledge—about return to fertility, LAM criteria, and cues to transition—among community health workers. As a result, an all-site orientation was held in June 2013 to review this content further with them and to ensure that they felt confident counseling on these topics. A final assessment will be conducted in early 2014 (as part of a larger integration country case study), and meetings will be held with key stakeholders to review findings and discuss potential for expanding the approach.

Implant Task Shifting in Mali

Are lower-level providers such as matrons competent in implant provision, according to recognized international and national standards of service provision? (Theme: Quality)

MCHIP implemented a study to closely follow an initial cohort of auxiliary midwives or matrones trained in implants. Matrones are a widely available cadre with formal training of about six months who attend births. In the first year of programming in the district of Diema, in Kayes region of Mali, health center staff, including matrones, benefitted from a training course that integrated active management of the third stage of labor, essential newborn care, and PPFP, with a strong emphasis on LAM. Thirty matrones were then selected to participate in the first cohort trained in implant insertion skills, following a refresher course of the physicians and nurses who supervise them at the health center level. During both courses, a large number of clients were available for insertions, such that all matrones had many opportunities for practice once they were competent on anatomical models. Competency assessments were then carried out at three repeated follow-up visits at short intervals and then a final time during a supervision visit in July 2013. The following table describes the results of these competency assessments.

Table 2. Results of competency assessments of implant provision in Mali

	# OF MATRONES ASSESSED	AVG OF CORRECT STEPS (OUT OF MAX SCORE OF 45) N (% STEPS)	# OF MATRONES WITH SCORE <80%	RANGE N (%)	DATE
Training	30	11 « Very good » 16 « Good » 3 « Satisfactory »†	0	–	23–27 August 2012
1st follow-up	25	40.5 (90%)	2	29–45 (64–100%)	11–20 October 2012
2nd follow-up	24	42.5 (94%)	0	37–45 (82–100%)	5–14 December 2012
3rd follow-up	27	41.0 (91%)*	0	36–44 (80–98%)	15–23 February 2012
Supervision visit	24	38.9 (86%)*	5	24–45 (53%–100%)	20–25 July 2013

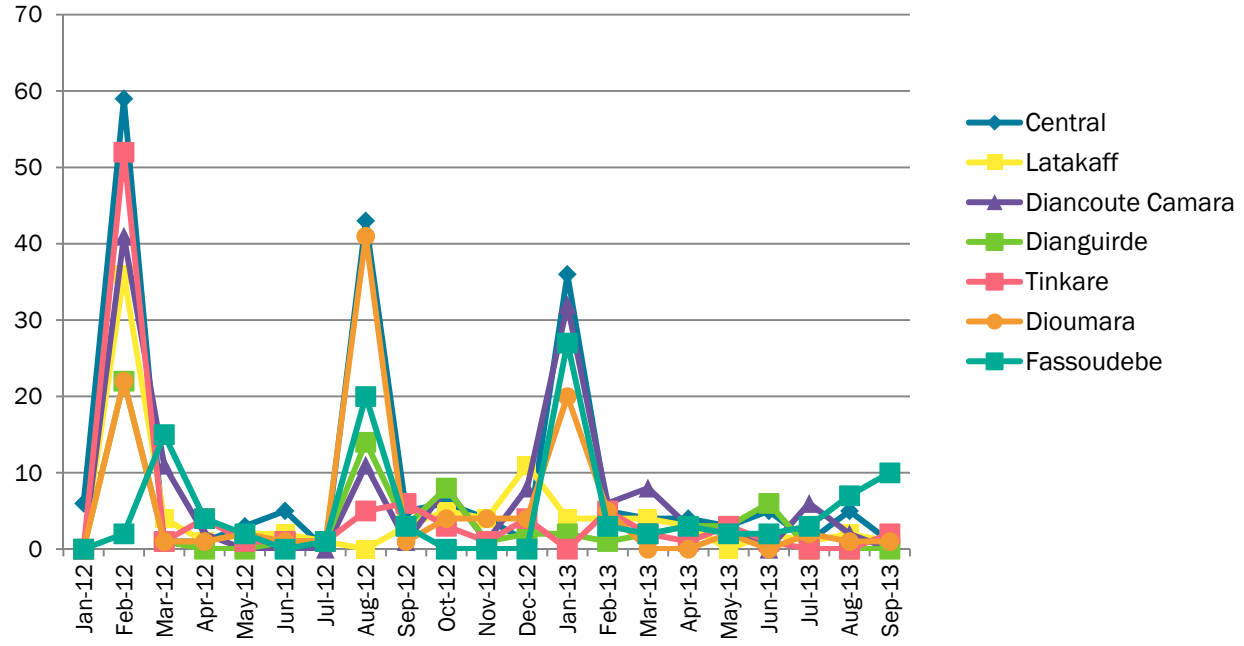
†The assessment forms from the training were no longer retrievable at the time of the analysis, so the trainers' assessment of learners were used in this table.
* The max score was calculated different for these assessments. If a matron skipped one of the steps that was deemed non-essential, the score was calculated with 44 as a denominator.

A closer analysis of the steps missed in the supervision visit revealed that for the most part counseling and infection prevention steps were those that lapsed. While both are regrettable, this is not particularly surprising and might be similar in other cadres. Strategies are needed to improve infection prevention and counseling more generally.

As early as the training, it was clear that there is latent demand for implants even in a remote rural district such as Diema. However, the result of task shifting on uptake of implants is

constrained by other barriers such as the cost of services. Community health centers in Mali are financed through contributions from the community, both in managing the health centers and in applying service fees that finance health center operations. Community health centers have to acquire commodities and pass on the costs to their clients. Costs are waived during training courses. They are also waived during health campaigns as was the case in selected community health centers in Diema during the health and nutrition weeks in January 2013. A chart of implant data in seven community health centers visited as part of a visit to document the implant task shifting study shows how demand spikes when implants are offered free of charge.

Figure 5. Implants inserted monthly in seven community health centers—January 2012 to September 2013 (partial)



Social and Behavior Change Communication e-learning Course

What are best practices for incorporating Social and Behavioral Change Communication (SBCC) messages in PPFP programs?

During PY5, MCHIP began the development of an e-learning course and printed guide on SBCC for PPFP, which synthesize MCHIP's program learning in this area. These resources, which are designed primarily for program managers and technical advisors, build on program efforts conducted under ACCESS-FP, including revisiting and refining content from the PPFP Message Guide published under ACCESS-FP. In the two new resources, an updated list of key PPFP behaviors is presented, along with recommended steps for designing strategic approaches for promoting social and behavior change for PPFP. Case studies also highlight MCHIP's SBCC efforts and processes used in Liberia, Bangladesh, and Kenya. The content of these two resources is still in the review process, and they will be piloted within several field programs in the coming year.

HIV/AIDS

In FY13, MCHIP globally supported and provided technical assistance to a variety of HIV activities. With a focus on "getting to zero" (zero new infections, zero AIDS deaths, and zero stigma and discrimination), MCHIP activities focus on improving knowledge around access and linkage in HIV Testing and Counseling (HTC) and HIV prevention efforts through voluntary medical male circumcision (VMMC). In addition, through its country programs, MCHIP is

supporting HIV activities by implementing and supporting prevention of mother-to-child transmission (PMTCT) interventions in Kenya and Ethiopia, and pre-service education nursing and midwifery programs in Ghana and Lesotho.

Global Leadership for HIV/AIDS

MCHIP remains a global leader in the scale-up and implementation of VMMC programs, supporting many countries in their successful implementation and continuing to advocate and educate in the global arena on its benefits. VMMC programs are performing well, with some programs operating at scale with services that are truly country-owned and integrated with the existing health systems. MCHIP has initiated two research studies that will inform the acceptability and scale-up of the PrePex™ device for VMMC. In addition, MCHIP contributes to provision of expert technical assistance to country programs while also providing global VMMC guidance by participating in key meetings, providing ongoing advocacy, and developing international guidance documents.

Voluntary Medical Male Circumcision

- In PY5, MCHIP supported the VMMC PEPFAR TWG in the development of PEPFAR's *Best Practices for Site Operations: A service guide for site operations*. The document was finalized and MCHIP supported the document's printing and dissemination in Quarter 2. The document was launched at the MCHIP offices on March 20, 2013, and the launch was attended by PEPFAR's TWG with representatives from CDC, USAID, OGAC, DoD, and implementing partners. Participants from the field joined through a live video feed. Distribution of the document took place in Quarters 3 and 4, with hard copies and CD-ROMs delivered to all VMMC programs in the 14 priority countries. The document and related tools have also been posted on WHO's male circumcision website.
- MCHIP hosted a quarterly webinar on VMMC for eastern and southern Africa (ESA) during FY13. This webinar series is designed to bring together experts and program staff who are launching services and provide a forum to discuss best practices, new research, and collaboration in the area of VMMC. Three webinars were hosted by MCHIP this year: the first, on March 19, discussed monitoring, reporting, and quality; the second, on June 6, discussed VMMC communications; and the third, on August 21, discussed devices for VMMC.
- MCHIP provided central technical assistance to Uganda's VMMC programs, at the PEPFAR TWG's request, to develop their internal and external quality assurance program for VMMC. MCHIP also provided TA to the new USAID-funded VMMC program in Mozambique in the form of site readiness assessments and quality assurance.
- MCHIP has been working with partners to coordinate a supplement of USAID-funded VMMC program implementation to be published by *PLOS ONE*. MCHIP papers include a Tanzania and Zimbabwe case study reviewing data on age and service delivery and a study of linkages to care among men testing HIV-positive in VMMC in Lesotho. Papers have undergone initial review and are being peer reviewed by *PLOS ONE*, with expected publication in February 2014.
- MCHIP supported two representatives to present on MCHIP work at the Conference on Retroviruses and Opportunistic Infections in Atlanta, Georgia, in March 2013. MCHIP representatives presented on MCHIP's Tanzania VMMC program and Kenya's PMTCT program. The MCHIP/Tanzania VMMC program also had a poster presentation on task shifting at the International AIDS Society conference in Kuala Lumpur, Malaysia; costs for all three presentations were borne by Jhpiego.

Program Learning for HIV/AIDS

MCHIP has worked on two program learning questions in the area of HIV.

- What is the current role of Voluntary Counseling and Testing (VCT) given that Provider-Initiated Testing and Counseling (PITC) services have become standard of care? What are the current needs for VCT (Desk review of performance of VCT programs in Zimbabwe)?

  HIV counseling and testing (HCT) remains a critical gateway to treatment, care, and prevention interventions. MCHIP is involved in two HCT-related studies to advance program learning. The first study describes the characteristics of clients choosing client-initiated HCT in Zimbabwe and evaluates post-test linkage of clients who received client-initiated HCT to HIV treatment and care, TB treatment, and VMMC. This study is made up of two components: the first is analysis of routine data collected by PSI (February–April 2012) and factors associated with successful referral to VMMC and TB services, and the second is prospective data collection investigating HCT uptake and timing of referral visits among HIV care and treatment clients, VMMC clients, and TB patients. The study received full ethical approvals in March 2013 and initial data analysis of the routine data has been completed. This study will contribute to the overall evidence base that will inform HCT scale-up approaches to support PEPFAR 6-12-12 goals. The second study will evaluate acceptability and feasibility of voluntary partner notification and linked HCT through a pilot intervention and/or assessment in Tanzania. Initial data analysis has been conducted and the team is working on analyzing and writing up the findings.

- In the area of VMMC, MCHIP has worked closely with partners to evaluate the use of PrePex™ devices for VMMC and to develop materials supporting its use in the field. With principal investigators at Johns Hopkins Bloomberg School of Public Health Clinical Trials Division within the Department of Epidemiology, MCHIP has two planned introductory pilot implementation studies in Lesotho and Tanzania. MCHIP contributed to study protocol development for both countries, and initial site visits have been conducted in both countries. USAID is currently developing guidance on the direction of the PrePex™ device studies. MCHIP also worked with designers to develop an animated video describing step-by-step placement and removal of the PrePex™ device, intended for authorized and trained health care workers in the field.

- MCHIP also supported a comprehensive evaluation of an innovative USAID program, Centership model, 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. The draft final report is being circulated to stakeholders with finalization expected in October/November 2013.

URBAN HEALTH

MCHIP has invested core funds to better understand and address urban challenges in Ethiopia and Kenya. Given the Government of Ethiopia's (GOE) leadership in establishing its nationwide Urban Health Extension Program (UHEP), MCHIP support was designed to link Ethiopia's key UHEP champions to the global urban health community of practice and to create opportunities for sharing implementation experiences. These implementation experiences have informed the design of innovative program approaches to improve the quality and/or utilization of evidence-based MNH services in Ethiopia's urban and peri-urban areas. The intended goal of this support was to increase MNH services, particularly institutional delivery at public health facilities. Efforts focused on identifying innovative, cost-effective and locally adaptable interventions that would help improve health outcomes of women and children in the urban community. In Kenya, MCHIP is working side by side with the Tupange Project, funded by the Bill & Melinda Gates Foundation, on a pilot PPH intervention that includes a clinical quality component and a community BCC component.

Ethiopia's Urban Health Extension Program

Previously in PY4, MCHIP Urban Health activities focused on linking Ethiopia's urban health stakeholders to professional communities and creating opportunities to share experiences. MCHIP also focused on building a body of evidence on barriers to urban health service utilization to better inform future project activities. Specific activities included: participation in the 10th International Urban Health conference in Brazil, an urban health study tour in India, a qualitative assessment to understand the barriers to MNCH service utilization in Hawassa, and an EDHS secondary analysis of MNCH data to examine urban and rural differences. In PY5, MCHIP activities focused on designing and testing innovative approaches to improve the quality and/or utilization of evidence-based MNH services in Ethiopia's urban and peri-urban areas. Based on findings from learning and research activities in PY4, the project developed a joint activity plan with the City Health Department to increase institutional deliveries in Hawassa City.

- **Developed and disseminated a referral directory for MNCH services.** A referral directory was assembled to help Urban Health Extension (UHE) professionals refer pregnant mothers to nearby health facilities. The directory was designed to be UHE-professional and client friendly. To ensure all facilities were included, a mapping exercise was undertaken by MCHIP with the support of the City Health Department. The directory was pre-tested and a simple rapid assessment was conducted to ensure it included all appropriate and valid local information. Information on location of service, type of services provided, contact information as well as emergency numbers were included. The user friendly document was then printed and widely disseminated to all UHE professionals as well as many clients as possible.
- **Developed and aired radio messages.** To broadly capture the attention of the population of Hawassa, radio messages promoting the services provided at health facilities were prepared in collaboration with Regional Health Bureau, Regional Mass Media and Communications, and a local radio station, Debub FM. Messages were pre-tested in the community and aired from January through April 2013.
- **Developed interpersonal communication (IPC) skills training.** One of the main barriers for MNH service utilization reported in the qualitative study was poor communications skills of the health care providers with the clients (pregnant mothers). MCHIP developed a training package to address these issues. The principal training objective was to enhance institutional delivery and improve health outcomes by improving health providers' communication skills and refining their IPC. The training also concentrated on improving communication skills in the workplace to strengthen workplace relationships. Using IPC materials, job aids, and data collection tools, MCHIP conducted an IPC skills training adapted to the Ethiopian context from USAID's Quality Assurance Project[13] and provided this to 59 health care professionals from several of Hawassa's hospitals and health centers and a total of 87 UPE professionals. A post-training action plan was also developed to ensure these trained midwives and clinic health care providers in turn trained other staff in their facilities (including directors, management staff, clerks, and security guards) with IPC skills to treat clients, particularly pregnant mothers, with kindness and respect. MCHIP, in collaboration with the City Health Department developed a standard exit interview checklist which is currently being used by health facilities to measure the level of satisfaction of mothers who come to health facility for ANC, deliveries, and immunizations for their children.

[13] *Training Manual. Interpersonal Communication (IPC) Skills for Primary Health Care Providers*, Egypt, January 1995. Quality Assurance Project Center for Human Services in collaboration with The Academy for Educational Development and The Johns Hopkins University.

- **Follow-up and dissemination of lessons learned from Ethiopia's Urban Health Extension Project.** The project staff conducted extensive follow-up to the health facilities that received IPC training, the UHE professionals who received the referral directory and referral slips, as well as the radio station that aired the radio spots. Findings from these follow-up/support visits ensured that the project could simultaneously better support pilot efforts as well as feed back the lessons learned to local stakeholders and MCHIP. As expected, the various pilot interventions and products were reported as helpful to clients and practitioners, but they alone did not ensure service utilization of MNH clients. To gather, synthesize, and reflect on what the Urban Health work pilot activities learned, an end-of-project dissemination workshop was held. The dissemination workshop was conducted in Hawassa city, to share the lessons and promising practices from the implementation of MCHIP activities in Hawassa city. The dissemination work included work done in both FY12 and FY13. A total of 76 participants attended from the regional health bureau, the City Health Department, the municipality, the local administration offices, various health facilities, some UHE-Professionals, and members of the media community. Other nearby FM radio stations *(Sheshamane 100.4 and Debub 97.7 FM radio stations)* was also in attendance to help them share experiences from *Debub FM* 100.9 and to discuss on current challenges and recommendations for the future.

Kenya's Urban Health Achievements

- **PPH study:** The PPH Study baseline data collection was completed and study findings disseminated. This process included the following:
  - A geographical information system (ArcGIS) was used to generate a map indicating where health facilities are located within the three districts the study is being conducted.
  - Baseline data collection was then conducted in nine health facilities in Makadara, Starehe, and Kasarani districts, covering three facilities in each of the districts. In each district, the teams interviewed at least one health facility in-charge, five service providers (nurses, clinical officers, and Community Health Extension Workers, or CHEWs), and four community health workers. They also held a focus group discussion with young mothers in the respective catchment areas to get their insights about PPH. Data entry of the baseline assessment is complete and a draft baseline report of the findings is available.
  - Baseline findings were disseminated to the Division of Reproductive Health, provincial team, City Hall representative, and the three focus districts representatives.
- **PPH intervention training:** For the training, eight key topics revolving around PPH-FP were covered: preconception care, nutrition, focused ANC, emergency preparedness, PPH, infection prevention, postnatal care and FP/PPFP. Orientation packages for service providers, community health workers, and young mothers were developed from the national guidelines for quality obstetrics and perinatal care. Nine on-site trainers representing the nine facilities in the study were identified and given a two-day update on PPH-FP to enable them to facilitate on-site training of service providers. Select service providers and CHEWs in turn were able to orient the community health workers. The community health workers under the supervision of the CHEWs subsequently facilitated the young mothers' sessions. On-site training on PPH-FP was conducted for 52 service providers, and 37 community health workers, representing the nine facilities, were oriented to PPH-FP.
- **Formation of young mothers clubs:** The community health workers were able to recruit young mothers to form a young mothers club in each of the respective nine health facilities to discuss various issues on PPH-FP. Nine young mothers clubs were formed, each having an average membership of 30 mothers. The club meetings are currently on-going and are conducted weekly in the respective health facilities.

PVO/NGO Support

In PY5, MCHIP's PVO/NGO Support Team focused on documenting and diffusing community health-related learning from CSHGP grantees; providing direct technical support to CSHGP grantees, including field-based assistance and strengthening core technical materials and guidelines; and providing extensive data-related support to the team conducting the external evaluation of the CSHGP.

Technical Support to CSHGP Grantees

MCHIP's technical support to implementation of CSHGP projects in PY5 focused largely on supporting the startup of new innovation projects that began in October 2012, and in providing targeted assistance to grantees in the innovation portfolio that required specialized support. In countries where there were strong technical and geographic synergies between CSHGP grantees and MCHIP country programs, south-to-south dialogue and technical support was further strengthened. Specifically:

- MCHIP worked closely with the CSHGP to design new strategic workplan guidance, as well as corresponding annual and final reporting guidelines for grantees, to reflect a streamlined CSHGP where detailed implementation plans and mid-term evaluation reports were determined to no longer be required. Significant effort and collaboration with the CSHGP Team was required to work with grantees to explain the shifts in expectations from DIPS to strategic workplans, which have different requirements and different timeframes for submission. An expert TAG convened to support development of the guide.
- An operations research workshop with 36 participants was organized and facilitated by MCHIP, strengthening grantees' skills in this area and providing a standard set of expectations for the level of rigor and reporting required from innovation grantees in their operations research designs (see Success Story for more information).
- Seven grantee strategic workplans and operation research concept papers were reviewed by MCHIP PVO/NGO backstops, each with significant input from MCHIP technical teams. Grantees worked with MCHIP to address review comments, which strengthened their projects.
- Nine projects were visited in Kenya, Burundi, Liberia, Honduras, and Benin to monitor progress and address implementation challenges. New grantees benefited from advice regarding the start-up of their operations research and meeting with stakeholders, including USAID Missions and more experienced grantees.
- Greater collaboration between CSHGP grantees and MCHIP country programs was fostered, as was evident in Liberia and Kenya. In Liberia, MCHIP and grantees consult regularly on integrating FP and immunization activities. MCHIP input strengthened a grantee's project design and another grantee's experience has informed national and MCHIP discussions on this topic. With MCHIP in Kenya and the Child Health Team in Washington, D.C., the PVO/NGO Support Team facilitated collaboration with an NGO to conduct operations research on CCM. Updates to technical reference materials and KPC survey modules began in PY5, with plans for comprehensive input from MCHIP

Photo credit: Florence Nyangara

Photo of a maternity waiting home at Africare's (CSHGP grantee) project site in Liberia.

Photo credit: Melanie Morrow

A child's length is measured during KPC survey supervisor training at World Relief's (a CSHGP grantee) project site in Rwanda.

technical teams, USAID technical experts, CORE Working Groups, and other key global experts. Input on many modules was received and clarified by the end of PY5; revisions are expected to be completed in PY6.

During Year 5, MCHIP worked extensively to update the following KPC survey modules: Maternal and Newborn Care (MNC); Malaria – stand-alone; Pregnancy Spacing and Family Planning; Immunization; Sick Child (Acute Respiratory Infection, Control of Diarrheal Disease, and Malaria); Breastfeeding and Infant and Young Child Feeding (IYFC); and Water and Sanitation (WASH). MCHIP undertook an extensive consultation process for indicator development with USAID technical teams, MCHIP technical teams, SNL, CORE Group, and FHI 360. Comparisons were made to indicators from DHS, Multiple Indicator Cluster Surveys (MICS), MDGs, LiST, and WHO to ensure compatibility. Indicator lists and definitions were agreed on for MNC, Malaria, Pregnancy Spacing and Family Planning, Immunization, and Sick Child. Consultations on Breastfeeding, IYCF and WASH indicators were initiated. MCHIP progressed with developing questionnaires, tab plans, and instructions, but will finish this work in Year 6.

Program Learning for CSHGP

Program Learning priorities in Year 5 included papers and presentations highlighting grantees' work and demonstrating the methodological rigor of the CSHGP. Specifically:

- *Community-based intervention packages facilitated by NGOs demonstrate plausible evidence for child mortality impact,* co-authored by MCHIP's Program Learning Advisor, members of the PVO/NGO Support Team, CORE's Executive Director, and the CSHGP Team Leader was published in *Health Policy and Planning*, clearly establishing the rigor and technical contributions of CSHGP's wide portfolio of grants in the published literature.
- MCHIP produced a series of three external reviews of the CSHGP Portfolio's contributions to MNC, operations research, and implementation and scale-up of iCCM. Findings from each of these reviews were presented by CSHGP staff at various venues.
- MCHIP supported three papers led by CSHGP grantee authors. The first was published in the inaugural issue of *Global Health Science and Practice* and focused on the nutritional outcomes affected by Food for the Hungry's Care Group project in Mozambique. The second focused on an enhanced district health information system that Medical Teams International strengthened in Liberia. The third, *The Neglected Value of Small Population Based Surveys: Comparison of Knowledge, Practice and Coverage (KPC) child health survey coverage and mortality modeling with estimates from the Rwanda Demographic and Health Survey,* based on a CSHGP Expanded Impact Project in Rwanda, was submitted to the *Bulletin of the World Health Organization* and was under review at the time of this Annual Report.
- MCHIP analyzed behavior change approaches and malaria interventions in a sample of the CSHGP portfolio of projects. This information was presented to an interagency malaria behavior change working group convened by PMI and to practitioners at the CORE Group meeting.
- Through cost-share from ICF, PVO/NGO Support Team analyzed associations between the frequency of support contacts and exclusive breastfeeding coverage in 30 CSHGP projects and presented the findings at the University of North Carolina's Breastfeeding and Feminism Symposium.
- The PVO/NGO Support Team organized an NGO poster session at the Global Newborn Meeting. Ten posters reviewed by MCHIP and presented by NGOs illustrate the breadth of contributions NGOs make to newborn health and survival at district and national levels through CSHGP support, including piloting new interventions like chlorhexidine at community level in Nepal and using mobile technology in Afghanistan.

MCHIP worked with grantees to facilitate the delivery of presentations highlighting results from the first group of operations research projects in the CSHGP at CORE Group's Spring Meeting. Specifically:

- World Vision/Afghanistan presented results from their project to answer the question: does the use of mobile health technology (mHealth) affect the use of maternal and newborn services; improve knowledge of danger signs in pregnancy, delivery, and in neonates; and in turn, prompt lifesaving actions in the community and improve maternal and newborn health outcomes?
- Helen Keller International's research examined whether a district-level integrated food security and nutrition program could improve nutritional status of pregnant and lactating women and children under two years old and be scaled-up to reduce overall malnutrition in Nepal.
- Catholic Relief Services investigated effective approaches to increase male involvement in household MNCH activities and promote gender equality in Nicaragua.

MCHIP also supported the development of a CSHGP communications strategy to organize inputs and communication products.

CORE GROUP (COMMUNITY HEALTH NETWORK)

Building on Year 3 and 4, the collaborative partnership between CORE Group and MCHIP focused on the integration of services, improved performance of community health workers, increased access and utilization of health services to communities, and increased equity for integrated MNCH programs throughout Year 5. CORE Group's *Community Health Network* further contributed to MCHIP's expanded technical priorities, program learning, and global leadership. The synergies between MCHIP, the CSHGP, and CORE Group optimized the reach and impact of key community-focused, lifesaving MNCH and nutrition interventions and approaches. During Year 5, CORE Group's key achievements included: convening the Fall Meeting 2012 and Spring Meeting 2013; elevating and increasing NGO engagement with the Global Newborn Action Plan and A Promise Renewed efforts, including a member newborn health survey and contributing to the MCHIP Global Newborn Health Conference; and completing the Mortality Assessment for Health Programs (MAP) System manual and the *Community-Based Tuberculosis Prevention and Care: Why and How to Get Involved* handbook.

Global Leadership

- CORE Group continued strategic collaboration with MCHIP technical priority areas through facilitating linkages between MCHIP, CORE Group, CSHGP, and the wider *Community Health Network* to increase coordination and scale-up of high-impact, community-focused interventions and approaches with a focus on MNCH and nutrition. Specific engagement is described in the technical sections.

Program Learning for CORE Group

- As the key program learning and diffusion platform, CORE Group continued to support critical functions for the ***Community Health Network***. CORE Group expanded its membership and overall partner engagement, which now includes 56 international NGO Member Organizations, 21 Associate Organizations, and 26 Individual Associates. JSI Research & Training Institute, Inc. and Global Alliance to Prevent Prematurity and Stillbirth (GAPPS) were among the new Associate Organizations in Year 5. CORE Group also supported the eight technical Working Groups, five Interest Groups and Practitioner Academy to collaborate on technical updates, resource development, diffusion, and cross-linking with MCHIP technical teams and priority areas. In addition to resource

dissemination and global advocacy linkages, CORE Group worked with MCHIP to feature key learning in its two annual meetings.

- CORE Group convened its **Fall Meeting** with the theme "Call to Action to End Preventable Child Deaths: The INGO Response" in Washington, D.C., October 11–12, 2012, and keynote speaker, Amie Batson, USAID Deputy Assistant Administrator, Bureau for Global Health. The meeting had 211 representatives from 86 organizations and 10 countries. MCHIP led a pre-meeting workshop on kangaroo mother care, participated in multiple sessions, and presented on CCM, local determinants of malnutrition, immunization, PPH and PE/E, and rapid catch indicators. The PMI Malaria Communities Program grantee event was also linked to and promoted throughout the CORE Group Fall Meeting. Presentations and the meeting report are available at: http://www.coregroup.org/resources/meetingreports/273-core-group-fall-meeting-2012.

- CORE Group convened its **Spring Meeting** with the theme, "Capacity Strengthening for Global Health: Partnerships, Accountability, Integration and Learning" in Baltimore, MD, April 22–26, 2013. The meeting drew 271 participants from 98 different organizations and nine countries outside of the United States (Cameroon, Canada, Ethiopia, Haiti, India, Indonesia, Ireland, Kenya, and Switzerland) that were deeply committed to furthering their understanding and ability to advance community health in more sustainable, systematic, and resilient ways. A key plenary featured a USAID panel that focused on A Promise Renewed, the Global Newborn Action Plan, the USAID Maternal Health Strategy, and the USG Children in Adversity Strategy. In collaboration, MCHIP's presence and contributions included an operations research pre-meeting workshop, and sessions on integration and M&E, interconception, and CSHGP operations research projects' highlights focused sessions. Presentations and the meeting report are available at: http://www.coregroup.org/meeting-reports-n/364-core-group-spring-meeting-2013.

- CORE Group supported **strategic communications** for targeted diffusion of MCHIP and CORE Group *Community Health Network* products, technical guidance, and program learning, including MCHIP publications, webinars, the Global Newborn Health Conference, and other key events. Helping to increase MCHIP's reach, the overall CORE Group diffusion and social media platform was greatly expanded with 42,850 unique website visitors; more than 1,200 Tweets; over 1,000 new Twitter followers, more than double last year's numbers; and nearly 300 new LinkedIn members for a total of 1,266. Leveraging CORE Group's platforms and mutual publications significantly increased NGO registration for the Global Newborn Health Conference and partner engagement in general. MCHIP and CORE Group co-hosted and co-promoted several events and webinars, which increased engagement and attendance by a wider range of partners.

- CORE Group also continued its overall strategic engagement with **CSHGP** and wider USG initiatives to increase program learning, linkages, and diffusion of lessons, and to facilitate *Community Health Network* and MCHIP synergies. Specifically, CORE Group leveraged its Fall Meeting to implement a mobilization strategy to increase NGO engagement and program learning around the USG Call to Action Roadmap. At the close of this year's Fall Meeting of the *Community Health Network*, Professor David Pelletier from Cornell University provided a meta-level view of what he had witnessed during *the course of the event*, describing it as part of a larger evolution within international development. Professor Pelletier described this as a new learning paradigm, and offered this vision: "Hopefully, this movement will go beyond monitoring and evaluation and an emphasis on evidence, to give attention to the broader set of factors that influence the decisions, policies, procedures, and practices of individuals, organizations and governments." He made several recommendations to USAID and to INGOs to support country-owned aspirations; build cross-sectoral partnerships and strategic capacity for implementation at-scale; strengthen local actors; emphasize a "how" learning agenda; and shape a global and national discourse.

The closing remarks by David Pelletier, were compiled and widely distributed: Call to Action to End Preventable Child Deaths: The INGO Response.

- Also at the Fall Meeting, a panel was formed to present the CSHGP Program Learning Reviews. USAID commissioned three reviews of the CSHGP portfolio to strengthen program-based learning systems. David Marsh reviewed the iCCM portfolio, Marge Koblinsky reviewed the MNH portfolio, and Jim Foreit reviewed the operations research projects. All concluded that while grant recipients provide a huge amount of information, information is not provided in a uniform way that would enable a synthesis of cross project learning. Recommendations were shared on how to make PVO documentation more useful to global program learning and David Pelletier summarized the discussions and the program learning theme. At the Spring Meeting a special operations research pre-meeting session was featured and facilitated by the CSHGP; the highlights from CSHGP FY12 final evaluations of operation research were presented in another session.

- Building on CSHGP and MCHIP synergies, with authors Christopher Purdy, William Weiss, and Henry Perry, CORE Group supported the completion and dissemination of "The Mortality Assessment for Health Programs (MAP) System: An NGO Field Manual for Registering Vital Events and Assessing Child Survival Outcomes Using the Care Group Model." This manual is a guide for NGOs carrying out child health programs to assess under-five mortality rates and evaluate programs using the Care Group Model. By following this manual's methodology to establish a Mortality Assessment for Health Programs (MAP) System, organizations can collect valid and precise information about vital events and detect statistically significant changes in under-five mortality rates over the life of a child health program. This manual is practical and feasible for assessing correlations between program activities and mortality trends in a variety of settings.

- CORE Group co-authored an article for a peer review publication that analyzed the program results of a set of CSHGP grantees: "Community-based intervention packages facilitated by NGOs demonstrate plausible evidence for child mortality impact," which appeared in *Health Policy and Planning*. CORE Group also served as a reviewer for an article published in the first edition of the *Global Health Science and Practice* journal.

- CORE Group contributed to the analysis of the community platforms in several of the FY13 CSHGP grantee strategic workplans. CORE Group also participated in a technical consultation on the CSHGP reporting process, assisted in the analysis of a survey on technical reference materials, contributed to the CSHGP communications strategy, provided input into the development of two articles on the CSHGP Expanded Impact project in Rwanda, participated on the University Research Co. (URC) Traction Project review of equity proposals, reviewed submissions for an American Public Health Association panel on social and behavior change, and provided input and support to the CSHGP Performance Evaluation Team.

- CORE Group participated on the advisory panel of a WHO TDR review of *Incentives and the Recruitment, Retention and Performance of Community Health Workers* led by Chris Colvin. CORE Group became a member of the Global Health Workforce Alliance Global Resource Group on Community Health Providers (Community Health Workers and other Frontline Health Workers) providing comments on the CHW Framework for Harmonization and Synergies and Monitoring and Accountability; and participates as an advisor for the 1 Million CHW Campaign led by Earth Institute. CORE Group authored a chapter on CHW relationships with the community, co-authored a chapter on CHW relationships with the health system, and reviewed remaining chapters in the CHW handbook entitled *Developing and Strengthening CHW Programs at Scale: A Handbook for Program Managers and Policy Makers*. A draft for peer review was circulated to USAID, URC, and global experts; a final

copy is expected to be completed in early FY14. The document will be presented at the CORE Group Fall Meeting 2013.

- For **TB**, as a continuation of earlier collaborative work, CORE Group and MCHIP published Community-Based Tuberculosis Prevention and Care: Why and How to Get Involved–An International Handbook for Nongovernmental Organizations and Civil Society Organizations." This document is designed to serve as a handbook, or primer, for NGOs and CSOs that are considering joining the fight against TB. It provides information on TB and how it is prevented, diagnosed, and treated; how TB programs work on the ground; how communities and CSOs can get involved; and special populations that need extra attention. Step-by-step guidance on getting started in addressing TB, pitfalls to avoid, and a list of useful resources are included and is available at: http://coregroup.org/storage/TB/Community-Based_TB_FINAL.pdf

EHEALTH

Mobile health (mHealth) has been identified as a tool that can aid in the in the delivery, monitoring, and evaluation of MNCH interventions, however, there is a lack of evidence surrounding which mHealth activities are the most programmatically effective and there is limited integration across projects. Towards that end, MCHIP seeks to establish global expertise in mHealth for MNCH by leveraging knowledge from existing mHealth activities within the MCHIP portfolio and expanding in new areas.

Major Accomplishments

- Important progress was made with eHealth and mHealth-related program support. MCHIP's Senior mHealth Advisor, hired in January 2013, began an evaluation of MCHIP's previous and ongoing work in mHealth. Part of these findings will be presented at the mHealth Summit in December of 2013. In addition, the Senior mHealth Advisor has convened a group of e/mHealth experts from across MCHIP's partners as well as from external groups, such as the mHealth Alliance, in order to better leverage MCHIP's e/mHealth expertise as well as to provide input to a strategic, prioritizing framework on the use of e/mHealth for addressing maternal, newborn, and child health.

- Additionally, a series of workshops to introduce technical teams to topics in e/mHealth, which began in PY5, will take place throughout PY6. Recordings of the classes will be made available to country staff and supplemental materials are available through MCHIP's intranet.

- CORE Group continued to support the mHealth Interest Group and the sharing of best practices and learning. CORE Group also contributed to the advancement and increased engagement of NGOs as a member of the Technical Advisory Group of the mPowering Frontline Health Workers GDA, and as a member of the United Nations Foundation (UNF) mHealth Steering Committee, and has initiated work on an mHealth guide for newborn programs.

Global Development Alliances

MCHIP provides support on two mHealth related public-private partnerships sponsored by USAID: the Mobile Alliance for Maternal Action (MAMA) and mPowering Frontline Health Workers (mPowering).

Under MCHIP, a Global Director and a Program Officer were hired and began work on the mPowering Frontline Health Workers initiative in August 2013. Two more employees, a Senior Country Advisor and Knowledge Management Officer, are expected to be hired in 2014

contingent upon funding. Six focus countries—India, Kenya, Nigeria, Mozambique, Tanzania, and Uganda—have been selected for in-depth work by mPowering Frontline Health Worker's initiative. In FY13, a content platform needs assessment was completed, and a content strategy was also completed in response to the findings of the needs assessment. A content survey of existing mobile-enabled and other MNCH resources was completed; an initial scoping visit to India was undertaken with the mHealth Alliance and Qualcomm (meetings took place with government officials, private sector, NGOs, and Mobile Network Operators); a series of meetings took place in New York with mPowering partners and others to further develop the mPowering strategy for India and Nigeria; a communications strategy was developed; and mPowering presented at several conferences, including the Tech Change online mHealth program. Significant outreach work was undertaken in August and September 2013 in New Delhi, New York, and London to engage with the mPowering partners and potential new partners and advisors, including DFID, UN Foundation, Accenture Development Partnerships, the Barr Foundation, the Cherie Blair Foundation, the BMJ, and others, as well as connecting with other mHealth/mobile initiatives to explore collaborative opportunities including with MAMA, mSTAR, One Million Community Health Workers campaign, BBC Media Action, Dimagi, Medic Mobile, and others.

- The mHealth Alliance serves as the secretariat for MAMA in partnership with USAID, Johnson & Johnson, the United Nations Foundation, and BabyCenter.
- MAMA has launched two country programs in Bangladesh and South Africa and is expected to launch a third program in India in late 2013. MAMA Bangladesh was launched in December 2012 and currently reaches over 210,000 subscribers. Results of a preliminary phone survey show that 63% of MAMA Bangladesh subscribers attended four ANC visits (national average 32%), 45% had a facility-based birth (national average 29%), and 83% exclusively breastfed for six months (national average 64%). MAMA provides two types of messages: (1) core and (2) topic-based. The core messages are arranged by "age and stage" in two sets. The pregnancy/baby messages cover weeks five to 42 of pregnancy, and the first year of the baby's life. The child messages cover ages one to three years. The messages are built around key health behaviors and interventions that, evidence shows, can improve health outcomes. These include antenatal care, nutrition, vaccination, oral rehydration, and use of insecticide-treated bed nets. The messages blend health with child development information, so mothers are motivated to get the right care at the right time for themselves and their children.
- MAMA has responded to requests for topic-based messages. MAMA now offers messages on PMTCT, infant feeding, and post-partum family planning. We also offer messages designed for other household decision-makers in communities where phone ownership is often shared. MAMA will continue to release new message sets in response to demand from implementing organizations around the world and the guidance of our Health Content Advisory Council. MAMA's adaptable messages are based on WHO and UNICEF guidelines and have been developed in close collaboration with a group of global health experts who make up MAMA's Health Content Advisory Council. MCHIP manages the grant to MAMA Bangladesh and collaborates with the MAMA global team to share information on project progress. MCHIP continues to provide subject matter expertise to MAMA's message development team, which finalizes the content, as needed.
- Since the launch of MAMA SA, over 20,000 unique users have interacted with MAMA's services, which translates into over 67,000 unique page views, hundreds of mobi-site comments, and more than 110,000 SMSs and 8,500 USSD messages being sent thus far. Most registered mobi-site users (73.01%) have already delivered and are looking for information to care for the baby, while the rest (26.99%) have yet to deliver. A large portion of SMS users (21.88%) opted to receive HIV-related messages; this is lower than the

national HIV rate, which currently stands at 29.5%. Focus groups and user testing have shown that users of the service have found MAMA SA valuable.

- In the last year MCHIP has provided monitoring and evaluation (M&E) support to MAMA Bangladesh and MAMA South Africa, and has helped the MAMA global team to hire and orientate a full-time M&E consultant. MCHIP will participate in a panel discussing MAMA's global M&E framework at the American Public Health Association annual meeting in November 2013.

Program Learning for mHealth

MCHIP's current mHealth activities have not been well documented to date in terms of building evidence for the use of mHealth in MNCH. In PY5, a strategy for retrospectively reviewing MCHIP's previous mHealth projects was developed. This ongoing study involved reviewing country workplans for key words that could identify mHealth related work, reviewing project status with country program officers, interviewing key project stakeholders, and on-site evaluations where it has been determined that compelling evidence for the use of mHealth may exist. An additional review of lessons learned from the CSHGP operations research projects that had mHealth as a primary intervention will also be completed in PY6. The results of the two reviews, combined with a Delphi study of key stakeholders in both mHealth and MNCH, will result in the development of a prioritizing framework on the use of mHealth for MNCH.

With the establishment of an mHealth role at MCHIP, we are now able to contribute to global efforts toward the use of mHealth in MNCH programming. In the last year, the Senior mHealth Advisor (SmHA) has contributed to the following initiatives: The International Telecommunications Union's UN Economic and Social Council partnership clinic on mobiles for midwives and subsequent white paper on the use of mHealth by skilled birth attendants and improvement of birth registries; she has provided technical assistance to two of the UN Commission on Life Saving Commodities Working Groups; and she will be presenting the findings of the CSHGP Operations Research study at this year's mHealth Summit.

MONITORING, EVALUATION, AND RESEARCH

As a global program, MCHIP has identified three major priorities related to monitoring, evaluation, and research, beyond reporting on program results: 1) contributing to the evidence base on high-impact MNCH interventions and generating PL; 2) developing M&E indicators, tools, and resources; and 3) strengthening health information systems.

As part of its global leadership role in monitoring, evaluation, and research, MCHIP works with others to identify gaps in the available resources for conducting MNCH monitoring, evaluation, and research such as standardized indicators, M&E guidance documents, data collection tools, and M&E training resources. In turn, MCHIP identifies opportunities to work with global partners, such as WHO, other USAID-implementing agencies, and developing country research institutions to contribute to the development of new measurement resources that can improve availability and quality of key indicators for programmatic decision-making.

Over the past year, MCHIP conducted targeted operations and implementation research studies and program evaluations that contribute to the evidence base regarding programmatically effective MNCH interventions, including how these interventions can best be delivered at scale and how they can best be monitored and evaluated. With the support of the Monitoring, Evaluation, and Research Team, MCHIP investigated research topics of global interest including: community KMC; quality of MNCH services; iCCM; scale-up of the HBB intervention; implementation processes and outcomes of MIP programs; and delivery of integrated MNCH/FP services. These topics reflect key global program learning themes identified by the PY3.

At the country level, MCHIP M&E systems help provide evidence that contributes to the program's global program learning agenda, guide program decision-making, and provide accountability to our donor and partners. These systems often rely heavily on existing health information systems, such as national HMIS, rather than introducing new parallel systems. MCHIP worked to strengthen elements of the national HMIS in countries working to improve the quality of MNCH care in facilities and/or communities and documented what has been done in a technical working paper.

Global Leadership

- Results of the Mozambique maternal and newborn indicator validation study manuscript were published in *PLOS Medicine* as part of a supplement, "Measuring Coverage in Maternal, Newborn and Child Health." MCHIP presented at the supplement launch in May at the National Press Club in Washington, D.C., and at the Women Deliver conference in Malaysia. MCHIP also presented select study findings at the MNH Measurement meeting that the program hosted in Arusha, Tanzania, in January 2013. Two new indicators are recommended for inclusion in large-scale, population-based surveys such as Multi Indicator Cluster Surveys and Demographic and Health Surveys: "newborn placed skin to skin (naked) on mother's chest" and "companion present during labor or birth."
- The day preceding the 2013 Global Maternal Health Conference, 25 technical experts and conference attendees met for an all-day satellite event entitled "Improving Measurement of Maternal and Newborn Health Service Coverage and Quality." Key recommendations emerged from the meeting and are summarized in the meeting report, which is posted on online at: http://www.mchip.net/node/1566. A follow-up meeting with a subset of participants on measurement of the quality of facility-based maternal and newborn care is planned.
- The new 2012 WHO PPH guidelines, *WHO Recommendations for the Prevention and Treatment of Postpartum Haemorrhage*, have endorsed routine measurement of the use of a uterotonic in the third stage of labor. The recommendation was influenced by the advocacy efforts of MCHIP and the small group led by WHO. MCHIP is developing additional recommendations on routine indicators for measuring the content/quality of maternal health service. The guidelines include the following recommendation: Monitoring the use of uterotonics after birth for the prevention of PPH is recommended as a process indicator for programmatic evaluation. (Weak recommendation, very-low-quality evidence.) Prophylactic Uterotonic Coverage Indicator: The suggested indicator is calculated as the number of women receiving prophylactic uterotonics during the third stage of labor divided by all women giving birth.

Health Management Information System Strengthening

- Improved quality of MNH care and improved use of data for decision making was documented at four hospitals in Kenya participating in a pilot MNH monitoring activity in in Eastern Province. Over the past year, the pilot was also expanded to include ANC, including PMTCT. The data use logbook was revised and a set of M&E standards for Standards-Based Management and Recognition (SBM-R®) was developed and health facility staff were oriented to the documents. The MCHIP and MOH team continued to conduct M&E and clinical supportive supervision and collect service statistics for the four sites. Qualitative data collection is under way and a final report will be available in PY6. The pilot is intended to demonstrate how routine service data can be used for quality improvement and identify additional data elements that may be useful to incorporate into the national HMIS.

- Phase one of an MNH/MIP HMIS situation analysis was completed and a summary report on the ANC and MIP components of the analysis, which presented comparative information for six countries, was shared with PMI. Overall, MCHIP conducted a desk review of the MNH-related data elements captured in national HMIS in 13 countries. The six PMI focus countries selected for the review, in consultation with PMI colleagues, include: Kenya, Malawi, Mozambique, Mali, Tanzania, and Uganda. The seven additional countries include: Ethiopia, Nepal, Rwanda, Bangladesh, India (Jharkhand), Nigeria, and Liberia. The desk review consisted of a systematic review of ANC client cards, maternity charts, ANC and labor and delivery registers, and monthly facility reports to determine whether a list of priority ANC/MIP/MNH data elements were being collected and reported up through the system. In addition, to better understand issues surrounding MIP-related data quality and use, in two PMI focus countries (Kenya and Uganda), key informant interviews were conducted with stakeholders at multiple level of the health system, including National Malaria Control Program personnel at the national level, MOH reproductive and MCH staff at the national level, NGO staff, district and regional MOH staff, and health facility staff. An enhanced desk review in PMI focus countries also included review of additional documents such as national policy documents, M&E plans, and grey literature on MIP. Country reports and recommendations for Kenya and Mozambique were submitted to PMI for review. Preliminary results were presented at the newborn indicator working group meeting led by Save the Children in July and at the meeting hosted by MCHIP in July on national uterotonic coverage estimation. Consultancies were planned to conduct key information interviews in Tanzania, Mali, and Malawi to be completed by December 2013.
- A technical paper summarizing MCHIP's work in multiple countries to strengthen MNCH elements of national HMIS was developed and shared with USAID and others for review. The paper is intended to present results and lessons learned from these efforts and inform others who are working to improve national HMIS.

M&E Tools and Guidance

- The facilitator and learner manuals of the Clinical Observer Learning Resource Package were completed and accompanying videos of flawed and gold standard performances of MNCH skills were developed. The four videos developed include the gold standard and flawed videos using standardized checklists (ANC/PMTC visit, counseling for cervical cancer prevention, managing 2nd stage and 3rd stage of labor and newborn resuscitation. The first draft of the Clinical Observer Learning Resource Package materials were field-tested in Tanzania and then reviewed again by a group of clinical and M&E experts and revisions incorporated into the final manuals. The ANC/ PMTCT visit video has been completed and captures the WHO revised guidelines (previous video was Option A with new video being Option B). A comprehensive dissemination plan for the materials has been developed and will be implemented once the video is complete. The package is intended to be used by government agencies and organizations that are conducting observational assessments of client provider interactions during ANC, labor and delivery, postnatal, and reproductive health visits to train the data collectors. The package provides a systematic training approach and supporting tools and videos to help ensure observational data are highly reliable and valid.
- Adaptation of paper-based interactive PE/E modules for an Android phone application was initiated. A prototype application has been created and is functional on Android phones and tablets. With technical inputs from our MNH staff, we are revising the application to make small corrections, ensure readability on mobile phones, and ensure technical accuracy. The final application should be ready by the end of November. An accompanying dissemination document has been developed. The application will be available to be freely downloadable by anyone and can be used by a supervisor during routine visits to the health facility to assess a decision-making scenario for PE/E-related events that may not occur frequently.

- An article outline was developed and data analyses conducted for the QoC survey overview article, with assistance from the Johns Hopkins Bloomberg School of Public Health biostatistics office. The article will be submitted to the new open access global health *Lancet* journal. A writing workshop to develop an overview article and PE/E article was conducted in June with field-based study team members attending Jhpiego's country directors meeting. A first draft of the PE/E article was developed and will be submitted to *PLOS ONE*.
- MCHIP contributed to efforts of multiple M&E working groups to improve MNCH measurement:
  - Provided input into the agenda for USAID's Cooperating Agency M&E working group and organized and presented at a session on measuring integrated programs.
  - Participated in the December 2012 and July 2013 Newborn Indicators TWG. Provided input to the Newborn Indicators TWG terms of reference and measurement section of Every Newborn Action Plan and presented preliminary findings from the HMIS situation analysis findings relevant to newborns.
  - Participated in the Child Health Epidemiology Reference Group meeting in New York City in October 2012 and provided feedback on *PLOS ONE* supplement articles.
  - Supported Saving Newborn Lives (SNL) colleagues in the Newborn Indicators TWG to develop a panel presentation on M&E of newborn care that was given at the MCHIP Global Newborn Meeting in Johannesburg in April. Presentations on the M&E panel were made by professionals from Bangladesh, Uganda, Peru, and Washington, D.C. MCHIP facilitated the panel and also co-organized an M&E skills building session.
  - Participated in the Community of Practice on Scale-Up, co-facilitated by the E2A Project and IBP. This group is working on a literature review of scale-up and discussing how to monitor and evaluate the scale-up process.
  - Participated in and contributed to numerous working groups and online forums including M&E MIYCN-FP M&E Working group, the online forum on M&E of PPFP Integration on Postpartum Systematic Screening, and online "RHINO Forum on Innovative Applications of Mobile Technologies with Routine Health Information Systems."
  - Participated in the M&E subgroup of the MIYCN-FP integration working group. Revitalized the M&E sub-group in the past quarter and updated the conceptual framework and indicators, which MCHIP drafted in April 2012 based on the Cochrane review of MIYCN-FP integration.
  - Participated in the Respectful Maternity Care (RMC) TWG that is led by MCHIP with participation of groups outside of MCHIP. As a result CSHGP grantees have included a set of RMC indicators in baseline surveys and indicators are being included in the revised MNC module of the KPC survey.

Program Learning for Monitoring and Evaluation

1. **Can health extension workers in Ethiopia provide community KMC, essential newborn care and resuscitation with quality? (Data source: in-country partners; MCHIP theme: Quality, community)**

   The baseline survey report for the Ethiopia community KMC feasibility study was finalized and disseminated in-country and provided new information on the type and coverage of services provided by health extension workers in the community. A journal article on newborn care practices from the baseline survey was drafted and submitted to *Tropical Medicine & International Health*. The team is currently responding to comments from the

journal and publication is expected in the next few months. A Lot Quality Assurance Sampling—to determine the strength and reach of intervention implementation—was conducted and led to a delay in the timing of the endline survey due to relatively low coverage of the community KMC intervention. The endline survey is now planned for December 2013. A midline qualitative assessment was conducted and the report completed and circulated to stakeholders for review. Findings were used to inform implementation of the program intervention.

- **Are MCHIP program interventions reaching the disadvantaged populations intended? What resources and tools can be used to measure health equity? (Data source: desk review (project and/or country documents) analysis of project data; MCHIP theme: Equity)**

  This activity was postponed until Year 6.

- **What are best practices for including equity in project designs and what are the results of these pro-equity strategies? (Data Source: Desk review; MCHIP theme: Equity)**

  - A socio-economic profile analysis for ChildFund International's CSHGP project in Honduras was completed and showed that clients served by the community health centers run by community health volunteers succeeded in reaching populations in the lower wealth quintiles: 40% in the lowest; 35% in the second; 19 in the third; 5% in the fourth; and 0% in the highest quintile.

  - Gender questions based on joint decision-making indicators collected in the MCHIP Egypt household survey and based on RMC indicators—developed from work by MCHIP, Jhpiego, the RMC working group, and USAID's maternal health team—have been added to the CSHGP KPC survey modules. For example: Percentage of mothers of children 0-59 months with fever in the two weeks preceding the survey who made the decision to seek treatment jointly with their partner; % of mothers of children ages 0-23 months with support person or birth companion during labor and delivery. Finalizing the modules will continue in PY6.

  - The Egypt baseline survey collected socio-demographic data and the Egypt country team documented its approach to health equity improvement through qualitative assessments of how Community Development Associations determine vulnerable families; and developing a plan for how Community Development Associations target activities toward vulnerable families. A preliminary brief description was written of how Community Development Associations define disadvantaged families, what additional attention was paid to these families, and how the families were monitored, which is feeding into MCHIP's program learning around health equity approaches.

  - The health equity guidance and checklist were presented at the LAC newborn technical meeting in El Salvador in June 2013. Examples of CSHGP projects involving equity were presented. The LAC Newborn TWG made the decision to look closely at country-level information and work through the framework in order to make specific decisions about actions to take that move beyond just talking about reducing health equity. This program will be followed up in YR6, although funding is quite limited for LAC.

2. **Are improvements in compliance with clinical performance standards associated with improvements in use of evidence-based practices and health outcomes? (Data source: Analysis of project data; MCHIP theme: Quality)**

   A draft of a technical paper summarizing MCHIP's experience applying SBM-R in multiple country programs was developed that includes: strength of implementation; results in terms of performance scores; and service delivery outputs and outcomes. A total of nine country programs shared data on SBM-R score improvements and corresponding service delivery

data on improvements in service delivery outputs and outcomes. The paper will be finalized in PY6 and a manuscript will be prepared.

3. **As it scaled up, what results did the Malawi/HBB program achieve in terms of health system performance, provider competence, quality of care, and newborn health outcomes? (Data source: Qualitative data collection, quantitative data collection; MCHIP themes: Scale, quality)**

   A summary report of Round 1 findings from the national HBB performance evaluation in Malawi, being led by MCHIP through the Institute for International Programs, was prepared and circulated among partners. The report is currently being finalized based on feedback from USAID. The second round of data collection was completed at the end of September and data cleaning and analysis are currently under way.

STRATEGIC COMMUNICATIONS

During the reporting period, MCHIP leveraged a wide variety of communications platforms within the global health community to communicate the work of the program to multiple audiences at the global, national, and local levels. The project has fully *harnessed a multitude of communications tools* to promote, capture, and share the knowledge, resources, lessons learned, and impact of USAID's flagship program, utilizing technologies such as the MCHIP website and blog, partner websites, a monthly electronic newsletter, 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 develop strategic promotional campaigns. MCHIP communications also continued to join global advocacy efforts and actively participated in UN General Assembly Week activities and regularly held working groups for Every Women, Every Child and A Promise Renewed.

The MCHIP communications team *hosted or supported 36 events/conferences* on a variety of MNCH-related topics, including strategic knowledge-sharing activities such as the Kangaroo Mother Care country experiences event/webinar, the Malaria Communities Program event on Strengthening National Malaria Control Efforts through Community-Based Strategies, and an advocacy event on Capitol Hill marking the progress of the Child Survival Call to Action. The communications team, over the course of several months in advance of the Global Newborn Conference, led a group of more than 30 communications representatives from USAID, Save the Children, UNICEF, BMGF, WHO, United Nations Foundation, and Voice of America to leverage and harness the various partners' networks to widely create and disseminate conference messages, solicit media interest, and promote online engagement. MCHIP also participated in conferences such the CORE Group Fall and Spring Meetings, Women Deliver, International AIDS Conference, the mHealth Summit, International Congress of Nutrition, the U.S. Global Leadership Coalition Conference, the Second Global Symposium on Health Systems Research, and made 13 presentations at the Global Maternal Health Conference. A complete list of events organized by MCHIP can be found in Annex F of this report.

The team *contributed to the production of 73 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 in reach and influence, with 4.6 million impressions* from Twitter and Facebook during this reporting period (an aggregate of the number of people reached by each tweet, post, retweet, etc.). In addition, MCHIP experts were published externally in local newspapers, popular global health blogs, such as the Gates Foundation's Impatient Optimists, and in numerous esteemed public health journals.

Special Events/Conferences

The MCHIP communications team executed/assisted with 36 events in the reporting period. These events were organized to strategically disseminate and promote MCHIP technical expertise, innovations, and general MNCH knowledge at the global and country levels. Communications activities surrounding the events included promotion, logistics, collateral, strategic dissemination of materials and resources, and other support as required.

The MCHIP India team served as the Secretariat for India's Child Survival and Development Summit in Mahabalipuram, India. The event, hosted by the Indian Government, USAID, and UNICEF, served as an excellent example of a regional exchange of information and support among a variety of participants including Ministers, private sector leaders, and representatives from academia and funding agencies. In his welcome message, India's Minister for Health and Family Welfare expressed gratitude to MCHIP for its role in making this summit a success. Following India's example, MCHIP country teams have supported a number of the country-led Child Survival Call to Action events in PY5.

In April, MCHIP let the first Global Newborn Health Conference in Johannesburg, South Africa. Four hundred and fifty participants from more than 50 countries gathered for a thought-provoking, four-day meeting focused on the three main causes of newborn death. The conference was widely praised and was covered in both international and local media outlets. Communications and advocacy efforts dedicated to the conference were extensive; MCHIP led a group of 30 communications professionals from WHO, UNICEF, Save the Children, USAID, BMGF, United Nations Foundation, and Voice of America to leverage various partner networks for advocacy, media, and social media efforts. Following the success of the Asia Regional Meeting in Dhaka in 2012, the Newborn Conference was live webcast, allowing for 17,000 additional views and remote participation from around the world.

Prior to the conference, the MCHIP Nutrition Team hosted a one-day preconference nutrition symposium with SPRING and the Micronutrient Initiative. A number of other targeted meetings were hosted in conjunction with the Global Newborn Conference, including a consultation on the Global Newborn Action Plan. In June, the MCHIP LAC Team hosted a similar meeting focused on the primary causes of newborn health, focused on the LAC region. The conference was held in San Salvador, El Salvador.

Following the one-year anniversary of the Child Survival Call to Action, MCHIP joined with PATH and other partners to host an educational advocacy event for Congress on Capitol Hill. The event was hosted in the Rayburn Office Building, and gave participants the opportunity to get a better understanding of MNCH efforts by exploring innovations and viewing photos of beneficiaries. Speakers included Congresswoman Lois Capps, USAID Assistant Administrator Ariel Pablos-Mendez, MCHIP Kenya Country Director Isaac Malonza, Lynn Stratford from U.S. Fund for UNICEF, and Rachel Wilson, Senior Director of Public Policy from PATH.

Many of the other events from PY5 are highlighted in greater detail in their respective technical sections, and a list of events is provided in Annex F.

Web Site/Social Media

- During this reporting period, there were 79,906 visits to the site by 52,995 unique visitors. The online Resources section and interactive world map continue to be the pages most visited. Communications continues to post new content to the website multiple times a week, amounting to 236 new pieces since October 2012: 79 articles, 74 blogs, 36 event announcements, 33 "in the news" pieces, nine multimedia posts, and five news releases. In addition, more than 88 resources were uploaded during this reporting period. Topics included: World Breastfeeding Week; Women Deliver's Winning Video; four-part series on

World Malaria Day; Global Action Plan for Pneumonia and Diarrhea; CHWs in Kenya creating an AIDS-free generation; examining care and feeding in Egypt; the MenAfriVac campaign in Senegal; promoting handwashing for newborn survival with Unilever in Indonesia; co-authoring articles on community-based programs for PPH prevention at home birth and magnesium sulfate as drug of choice for PE/E; saving mothers' lives with calcium in Nepal; CHX as critical in the battle to reduce newborn mortality; India's Child Survival Call to Action; improving maternal health with the Africa Champions Program; Bangladesh as the first MAMA country to take mobile health messaging service national; MCHIP and the LAC Neonatal Alliance promoting priority newborn health interventions; and the zinc policy change in Kenya expanding access and paving the way for improved child health.

- During this reporting period, MCHIP Communications updated all technical intervention areas, the sortable interventions for all 50 countries in MCHIP's interactive world map, and added eight new country-landing pages and related country indicator profiles.
- MCHIP used the homepage banner to highlight and celebrate 19 global health themes and events to include: World Contraception Day; World Breastfeeding Week; Child Survival Event; Cervical Health Awareness month; International Women's Day; the Global Newborn Health Conference expert blogger series; International Day of the Midwife; World TB Day; International Prenatal Infection Month; World AIDS Day; and an MCHIP holiday/New Year's slideshow. Four additional International Health Themes were acknowledged in the site's content and/or through social media: World Pneumonia Day; Premature Babies Month; International Condom Day; and World Water Day.
- The "MCHIP Update" electronic e-newsletter continues to go out monthly to a mailing list of nearly 4,000 subscribers. Each newsletter features: a Letter from the Director, Blog Spotlight, Program Highlight, Global Leadership & Learning, and Key Resources. In this reporting period, the newsletter has generated a higher than average "click through" rate—peaking at 28% (compared to a 10% average, according to Internet research).
- MCHIP continued to post regularly to Facebook (321 posts). Facebook has increased to 1,527 fans, up from 825 at the end of PY4. On average, each of the Facebook posts reached 422 people. Over the entire reporting period, MCHIP's Facebook left an impression of 360,000 (total number of times any Facebook user could have seen any MCHIP content). The most reached cities include Bangkok, Thailand, Washington, D.C., and Nairobi, Kenya. MCHIP also continued to post regularly to Twitter feed (806 tweets), with 3,924 followers on Twitter, 2,500 more followers since the end of PY4. Posts consisted of links to content on www.mchip.net, stories from the field, infographics, as well as interesting news and research on MNCH and global health issues. To increase in-house social media capacity, MCHIP hosted a learning workshop for Twitter, geared to support MCHIP experts as they engage in online conversations about their expertise wherever they are around the world. MCHIP has also co-hosted or participated in a number of Twitter discussions ("tweet chats") including one for World Contraception Day and an ask the expert discussion on Maternal Health Commodities during the week of the United Nations General Assembly.

Media Placements

MCHIP work was highlighted externally on websites, blogs, and news outlets many times during this reporting period.

- Program work was shared among the partners of the consortium and featured in a variety of outlets, including the USAID Impact blog; Healthy Newborn Network website and e-newsletter; JSI website and newsletter; Maternal Health Task Force website; The Dose (in both hard and e-copies of GAVI's quarterly newsletter); WHO, UNICEF, CORE Group, and Misoprostol Gateway listservs; World Pneumonia Day website; USAID's *Global Health: Science and Practice* journal e-news; Clearinghouse on Male Circumcision for HIV

Prevention newsletter; *The Guardian* online; Gates "Optimist Blog;" K4Health website; Jhpiego website and Facebook page; Southern African HIV Clinicians Society HIV "Nursing Matters" Magazine; WASH website; International Confederation of Midwives website; Huffington Post; BMJ Group Blogs; and the Global Post website. 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. The scope of these communications clearly demonstrates that there are multiple audiences in the global health community and beyond who are interested in MCHIP's work, impact, and technical expertise.

- MCHIP promoted published research findings by technical teams published in the following: *International Journal of Gynecology and Obstetrics,* journal *Médecine et Santé Tropicales, Pregnancy and Childbirth, Midwifery, Journal of Health Communication, Journal of Infectious Diseases, BMC Pregnancy and Childbirth, Global Health: Science and Practice, The Journal of Urology, International Health, Health Policy and Planning, Vaccine, The American Journal of Tropical Medicine and Hygiene,* and *PLOS ONE Supplement*. A full listing of all published work during PY5 can be found in Annex F.
- MCHIP received both international and in-country positive media coverage, including reporting in *The Guardian*, Zimbabwe's *Manica Post*, *ATN Bangla News*, *The Independent*, Bangladesh's bdnews24.com, "After Thoughts" talk show, Voice of America, SABC, Forbes Africa, All Africa, and others.

Program Learning

In Year 5, MCHIP brought on Jim Ricca as the Program Learning (PL) Advisor. He led the MCHIP team through a process to finalize the project's strategy for Program Learning. The strategy defines the scope of PL, which is closely related to the concept of Implementation Science (that is, answering real world concern about the how and why of increasing coverage and quality of key interventions). The strategy centered on the five themes identified in Year 3 (scale-up, quality improvement, community activities, service integration, and equity). After a series of meetings between each MCHIP technical team and its USAID counterparts to finalize the Year 5 PL questions, each of the technical teams' PL questions were systematized, including specifying the justification, audiences, products, and dissemination plans. A similar process was done with the 11 countries with the bulk of the field-funded PL questions. This process was then also applied prospectively for the planning of Year 6 PL activities. Table 3 shows the distribution of Years 5 and 6 PL questions. Over 80% of core-funded and 70% of field-funded question touched on at least one of the five main MCHIP learning themes (note that a PL question can touch on more than one theme, so numbers do not add to 100% in the table).

Table 3. Distribution of Program Learning questions in Years 5 and 6

LEARNING THEME	FIELD – 11 FOCUS COUNTRIES (77 QUESTIONS)	CORE (76 QUESTIONS)
Scale-Up	**8%**	**29%**
Quality Improvement	**27%**	**29%**
Community Activities	**22%**	**21%**
Integration of Services	**9%**	**17%**
Equity	**3%**	**9%**
mHealth	4%	5%
Measurement	0%	9%
Training	10%	5%
Other	29%	17%

The core-funded questions are shown in Annex B, which also gives an update on progress for each of the PL questions. MCHIP leadership now monitors progress on PL during regularly scheduled meetings with teams and countries. There are also coordination meetings that include representatives for PL, M&E, Communications, and Knowledge Management functions. Through a series of meetings with the Agreement Officer's Representative (AOR) team, MCHIP has finalized the overall PL strategy and the plans for the summative analyses of the MCHIP portfolio by the cross-cutting themes that will occur in Year 6. These constitute the priority focuses for PL and will bring together the prioritized individual PL questions being asked under each of these topics. The first three (scale-up, quality, and community) will be the most emphasized.

Table 4. Program Learning themes, questions, and activities

LEARNING THEME	PL SYNTHESIS QUESTION THAT BRINGS TOGETHER INDIVIDUAL PRIORITIZED PL QUESTIONS	KEY MCHIP ACTIVITIES, WHOSE PL QUESTIONS AND EXPERIENCES WILL BE SUMMARIZED IN THE BRIEF
Scale-Up	What are the achievements, barriers/facilitators and best practices for attaining sustainable impact at scale for high-impact MNCH interventions?	▪ Use of uterotonic in the third stage ▪ HBB ▪ iCCM ▪ PPIUCD ▪ MIP ▪ NUVI
Quality Improvement	What are the achievements and best practices in measuring and improving quality of service provision of MNCH services?	▪ SBM-R linkages to health outcomes ▪ QoC studies in 7 African countries ▪ RAPID for immunization in India ▪ PBI for quality improvement ▪ Respectful Maternity care (i.e., client-defined quality) ▪ Scalable PVO approaches: Community Scorecards, etc.
Community Activities	What progress has been achieved and what barriers remain to scaling up key community-based approaches: 1. For service delivery? 2. For community support (mobilization)?	▪ Misoprostol for PPH prevention ▪ Home visits for PNC ▪ cKMC ▪ iCCM ▪ Selected MIP experiences ▪ Tailoring immunization services to community needs ▪ CBD of FP ▪ BCC activities for child nutrition and maternal anemia prevention ▪ Scalable PVO/NGO approaches (breastfeeding promotion, integrated approaches/community platforms (e.g., Care Groups))
Integration of Services	What are appropriate and feasible models for service integration that achieve higher utilization while maintaining quality?	▪ FP integration with IYCN, Immunization, MNH
Equity	What are best practices for measuring and improving equity (i.e., narrowing the gap in services for disadvantaged group(s) without losing gains in the advantaged group)?	▪ MCHIP Equity Toolkit for measurement

Challenges and Opportunities

CHALLENGES

- Platforms similar to the successful regional LAC alliance for newborn health do not yet exist in Africa. MCHIP has worked in close collaboration with different regional partners (e.g., RCHQC and ECSA-HC); however, the dynamism in LAC has not yet been replicated within these regional structures. MCHIP will continue to engage with regional partners in the hopes of identifying those that are well-positioned to stimulate and support meaningful technical discussion.

- Delays in the release of WHO recommendations on PNC home visits and infection/sepsis management have delayed the finalization and release of related MCHIP documents and resources. At the global level in Year 6, MCHIP plans to support dissemination of WHO's simplified antibiotic regimen recommendations, in concert with the release of the aforementioned newborn infection management guide. MCHIP also anticipates linking its Year 6 PNC home visit publication to the PY4 WHO PNC home visits meeting findings and possibly to the recently updated WHO PNC standards/guidelines, assuming the latter are publicly released by Q2 of Year 6.

- The scope and timeline of the CSHGP evaluation activity delayed MCHIP's completion of other workplan activities, due to both the time spent directly on evaluation-related work (data analysis, documentation, and participation in meetings and interviews) and delays in activities requiring coordination with USAID. USAID staff were flexible and responsive to requests, shifting resources and economizing as needed to ensure completion of high-quality deliverables. MCHIP staff and budget were also flexible in accommodating additional activities in the workplan throughout the year.

- Initial start-up of the HTC study assessing partner notification has had significant delays due to issues identifying a country that has the capacity, relevant program, and Mission support to undertake the study. Tanzania has now been identified and plans are under way to hire a local principal investigator who will lead the study.

- Reduced funding in LAC has challenged MCHIP's ability to support scale-up of proven interventions. In Nicaragua, MCHIP supported work leading to sustained reductions in episiotomies and maintenance of high rates of AMTSL, and has supported the development of a strategy to reduce cesarean births in the country. It has not been possible to further support this work as USAID activities in Nicaragua have been suspended Financial constraints also limit the ability to support the scale-up of KMC programming in the region. MCHIP will continue to advocate for inclusion of KMC work in country action plans, and continue to support the KMC network. HBB continues to be supported by a number of partners in the LAC region including the Church of Latter Day Saints Charities, PAHO, UNICEF, UNFPA and professional associations—there is a critical need to jointly monitor this work, strengthen coordination, and maximize the use of resources. There is a need to start measuring the impact of this strategy, as well as to take it to national scale-up. The Alliance has been advocating with governments for the uptake of HBB and will continue to support its implementation. Countries that were resistant to introduction are starting to request TA from MCHIP for HBB implementation (e.g., Paraguay, Guyana).

OPPORTUNITIES

- Two program learning activities—review of MIP country-level guidance and review of MIP monitoring at the country level—were well-timed with the October 2012 release of WHO's updated policy recommendation for IPTp-SP. Dissemination of recommendations from MCHIP's reviews will enhance WHO's efforts to quickly diffuse its latest guidance. Both reviews are an important opportunity to better understand and address key issues and bottlenecks affecting MIP programs.

- Building on Global and Regional Conferences: The Global Newborn Health Conference was followed by a one-day planning session in which multi-organization teams from MCHIP, SNL, USAID, BMGF, and UNICEF countries began discussions of national strategies for scale-up of priority newborn health interventions. These discussions continued and, in many cases, connected newborn health programming with resources and political commitment associated with the UN SG's global Every Woman/Every Child strategy, the "Promise Renewed" Call to Action to eliminate preventable child deaths, and the UN Commission on Life-Saving Commodities. The conference and the work planning meeting have led to specific actions at the country level. The MNH measurement meeting that MCHIP hosted in advance of the Global Maternal Health Conference in Arusha was-well received and led to specific plans by MCHIP to hold a follow-up meeting on measuring quality of MNH care at the facility level.

- When the coup in Mali resulted in restrictions in working with the government and the public sector, MCHIP reoriented its strategic approach and found new and creative ways to achieve program objectives. These strategies included engaging civil society organizations, particularly the National Federation of Community Health Centers (FENASCOM), on policy-related issues; working with professional associations to expand implementation to secondary health centers not included in the formal government system; and reinvigorating and enhancing partnerships and coalitions (such as the partners group supporting the Essential Community Health Package). As the coup restrictions were lifted in September 2013, MCHIP will collaborate closely with USAID and other partners, including UNICEF and FENASCOM, to identify the best strategies to work in collaboration with the Government of Mali for the remainder of the program.

- Because of the renewed interest in immunization in this Decade of Vaccines, MCHIP's deep and broad expertise and experience is in high demand and is able to influence the funding decisions of partners and the agenda of the many new entrants into the immunization arena. Also, as there are very few technical assistance groups that work in routine immunization, MCHIP has been actively disseminating learning through several channels including the peer-reviewed literature. MCHIP is in an excellent position to publicize and advance its approaches in routine immunization, including in the areas of engaging communities, reducing the equity gap by reaching the hard to reach, improving service quality, and scaling up use of services.

Annex A: Year 5 Financial Summary

At the end of Program Year 5 (September 2013), MCHIP has received core and field obligations totaling $298M. This represents 47% of the MCHIP award ceiling of $638M and is graphically represented in the chart below (Table 2).

Including the Associate Awards (AA), MCHIP has received $569M in obligations, or 89% of the overall award ceiling.

During the RFA (Request for Application) stage, USAID had anticipated that approximately 90% of the original award ceiling amount of $600M would ultimately come from field funds. Given that the AA represents field funding, MCHIP has received 87% of its overall obligations for field activities. This ratio is expected to increase as additional PY6 funding becomes available, reflecting USAID's vision.

Table 2. MCHIP Program Years 1 through 5: Total core and field funding

Core PYs 1 through 5	Program Year 1	Program Year 2	Program Year 3	Program Year 4	Program Year 5	Total
Obligations	$5.52	$23.61	$11.00	$26.61	$6.93	$73.67
Expenses	$3.14	$15.10	$16.31	$13.36	$16.02	$63.94
Pipeline *	$2.37	$8.51	($5.31)	$13.25	($9.09)	$9.74
Field PYs 1 through 5	**Program Year 1**	**Program Year 2**	**Program Year 3**	**Program Year 4**	**Program Year 5**	**Total**
Obligations	$4.70	$28.34	$48.55	$90.70	$52.50	$224.79
Expenses	$0.75	$16.32	$37.16	$56.52	$61.57	$172.32
Pipeline *	$3.95	$12.02	$11.39	$34.18	($9.07)	$52.47
TOTAL ALL FUNDING SOURCES	**Program Year 1**	**Program Year 2**	**Program Year 3**	**Program Year 4**	**Program Year 5**	**TOTAL**
Obligations	$10.22	$51.96	$59.55	$117.31	$59.43	$298.46
Expenses	$3.89	$31.42	$53.47	$69.88	$77.59	$236.26
Pipeline *	$6.33	$20.54	$6.08	$47.43	($18.17)	$62.21

** Note: (Negative) balances represent expenses > obligations in the defined 12-month fiscal year from October 1 through September 30. Expenses do not exceed obligations over the life of the award, however.*

Annex B: Program Learning Questions

LEAD TEAM	COLLAB GROUP	PL QUESTION	REASON FOR QUESTION	CATEGORY	LOCATION	DATA SOURCES	AUDIENCE	DISSEMINATION	CROSS-CUTTING TOPIC	NOTES
Child Health	Malaria	What key barriers and catalysts do countries need to consider when selecting, adapting and institutionalizing CCM indicators? How can MCHIP support institutionalization of CCM program monitoring through a country's national Health Management Information System (NHMIS)?	The Global CCM Task-Force developed a set of indicators to better track progress at global level and to harmonize program monitoring at country level. Documenting and sharing how these indicators are introduced and integrated into country programs would inform future development of M&E systems for CCM at country level.	Project-Based Learning/Case Study	Guinea Kenya Mali GLOBAL CCM Task Force	Desk review (project and/or country documents) qualitative data collection	GLOBAL Other donors/tech agencies In-country partners	conference presentation policy brief	Scale Integration Community	Y5 UPDATE: The CCM Benchmark Indicator Guide is complete and will be disseminated through a formal launch at the iCCM Evidence Review Symposium in January 2014.
Child Health	None	What Performance Improvement approaches for child health services can be adapted to build a linked community- and facility-based PI system and how can these approaches be integrated with an existing systems?	There has not been as much programmatic experience in Child Health with SBM-R for Performance Improvement as there has been in MNH. The feasibility and effectiveness of using SBM-R for Child Health needs to be explored.	Implementation/ Process documentation	Guinea Zimbabwe Mozambique	desk review (project and/or country documents) analysis of project data	Other donors/ tech agencies GLOBAL in-country partners	conference presentation policy brief	Quality Community	Y5 UPDATE: In-country adaptation of SBMR for child health is ongoing in Guinea and Zimbabwe. Lessons learned from these experiences are being documented. A desk review of performance improvement approaches in child health was completed. These activities will continue into PY6.
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?	Little is known at global level about how closely training and supervision tools used in countries adhere to the most recent WHO guidance in malaria diagnosis and treatment. The findings are expected to help countries to more rapidly scale-up (1) universal diagnostic testing, (2) correct treatment for positive test and (3) referral and management of severe malaria.	Formative/Descriptive Study	Angola Benin D.R. Congo Ethiopia Ghana Guinea Kenya Liberia Madagascar Malawi Mali Mozambique Nigeria Rwanda Senegal Tanzania Uganda Zimbabwe Zambia	desk review (project and/or country documents)	USAID GLOBAL in-country partners	policy brief	Other	Y5 UPDATE: This study was finalized and disseminated to country-based PMI staff. It should be published in a peer-reviewed journal in PY6.

LEAD TEAM	COLLAB GROUP	PL QUESTION	REASON FOR QUESTION	CATEGORY	LOCATION	DATA SOURCES	AUDIENCE	DISSEMINATION	CROSS-CUTTING TOPIC	NOTES
Child Health	None	What are factors that lead to high or low ORS coverage? What solutions have helped overcome identified obstacles?	Use of ORS solution could save millions of lives. However most low and middle-income countries have not achieved more than 30% coverage. Further understanding of factors related to supply, demand, and policy that influence ORS coverage would help provide evidence for better design of future programs.	Project-Based Learning/Case Study	Liberia Malawi Mali Senegal Zambia	qualitative data collection	GLOBAL in-country partners Other donors/tech agencies	peer-reviewed publication	Scale	Y5 UPDATE: This study is complete and the final report will be disseminated to USAID in November 2013.
Child Health	None	What are the important issues for introduction and expansion of iCCM?	Important lessons and promising practices were documented in mature programs in the DRC, Senegal and Malawi. The process can be adapted to the contextual needs of other countries while they introduce or expand CCM programs.	Project-Based Learning/Case Study	D.R. Congo Malawi Senegal	analysis of project data desk review (project and/or country documents)	GLOBAL in-country partners Other donors/tech agencies	conference presentation policy brief	Community Scale	Y5 UPDATE: The CCM Synthesis Report has been finalized and will be disseminated at the iCCM Evidence Review Symposium in January 2014.
Child Health	Malaria	What lessons can we learn about collaboration from the functioning of the CCM Task Force to inform future efforts in adopting and scaling up a new health strategy?	MCHIP is playing the role of CCM Task Force Secretariat. Documenting roles and responsibilities and evaluating the added value of this function would help the Task Force members better define future directions for the group.	Project-Based Learning/Case Study	CCM Task Force	qualitative data collection	USAID	policy brief	Scale Community	Y5 UPDATE: This study was completed and the report finalized. Findings were disseminated with the CCM Task Force Steering Committee, who are still discussing how the findings will impact the Task Force structure and purpose moving forward.

LEAD TEAM	COLLAB GROUP	PL QUESTION	REASON FOR QUESTION	CATEGORY	LOCATION	DATA SOURCES	AUDIENCE	DISSEMINATION	CROSS-CUTTING TOPIC	NOTES
Cross-Cutting		How can we achieve supervision outcomes with non-traditional supervision methods?	Qualitative Assessment of Approaches to Improving Health Worker Performance: Policymakers and managers need a range of options to consider for improving health worker performance and ensuring the delivery of quality care to the community. USAID's MCHIP program is therefore supporting an activity that examines alternative mechanisms in two countries (Indonesia and Tanzania). We focus particular attention on the combination of demand- and supply-side mechanisms to support, motivate, and hold health workers accountable. The assessment is exploring: 1. If and how these accountability mechanisms work, 2. Strengths and weaknesses of approaches, and 3) Sustainability of approaches.	Project-Based Learning/Case Study	Indonesia Tanzania	analysis of project data qualitative data collection	GLOBAL		Quality	PY5 Update: A literature review was conducted and fieldwork in the first country was conducted in May-June 2013, for the first intervention to be assessed in that country (SBM-R in Indonesia). Next steps are to analyze the data, and plan fieldwork for the second intervention to be assessed in Indonesia, and for the second country (Tanzania).

LEAD TEAM	COLLAB GROUP	PL QUESTION	REASON FOR QUESTION	CATEGORY	LOCATION	DATA SOURCES	AUDIENCE	DISSEMINATION	CROSS-CUTTING TOPIC	NOTES
Cross-Cutting		Is SBM-R sustainable?	Institutionalizing and Sustaining Quality Improvement Programs: The case of SBMR in Malawi and Bolivia: In many low- and middle-income countries, efforts to institutionalize and sustain health care quality improvement interventions continue to fall short of expectations. This qualitative case study examines lessons from two quality improvement programs to show how such programs can be designed and implemented in such a way as to increase the odds of institutionalization and sustainability. Using examples from Malawi and Bolivia of the scale up of a health service quality improvement approach called Standards-based Management and Recognition (SBM-R), we show how ownership, integration, resources, and incentives are critical to address throughout the design and implementation process, and provide examples of how to address them in order to help policy makers and program implementers plan for institutionalization and sustainability from the very beginning.	Project-Based Learning/Case Study	Malawi Bolivia	analysis of project data	USAID GLOBAL MCHIP Other donors/tech agencies in-country partners	peer-reviewed publication	Quality	PY5 Update: The Malawi case study and report are complete; the Bolivia case study data collection has been completed and the report is currently being drafted.

LEAD TEAM	COLLAB GROUP	PL QUESTION	REASON FOR QUESTION	CATEGORY	LOCATION	DATA SOURCES	AUDIENCE	DISSEMINATION	CROSS-CUTTING TOPIC	NOTES
Cross-Cutting		What is the impact of financial incentives on maternal health?	Systematic literature review of the impact of financial incentives on maternal health (part of USAID evidence review summit). Using the findings, MCHIP will contribute to a *PLOS Medicine* supplement on financial incentives and maternal health. We drafted two articles in the series: one reviewing the evidence of the impact of incentives to healthcare providers; and the summary article, which synthesizes the evidence from reviews of all incentive types.	Systematic Review	GLOBAL	review published lit review unpublished lit		peer-reviewed publication	Other	Q3: Currently, following a review from the PLOS editors, all the articles in the series are being reviewed by authors, and will be resubmitted towards the end of July or early August. Q4: The articles will now be published in Journal of Population, Health and Nutrition at the end of 2013 or early 2014.
Cross-Cutting		What are the strengths and weaknesses of P4P in Tanzania?	Tanzania P4P assessment: This assessment, carried out in April 2013 by representatives from the Tanzanian government, USAID, DANIDA and the World Bank, was designed to review strengths and weaknesses of P4P in Tanzania to date, to suggest options for national design and scale up, and to suggest structures to administer the national program. The assessment team reviewed documents on national and international experiences, developed structured interview instruments, and conducted field visits to interview health workers, local and regional administrators, community members, and representatives of potential support organizations.	Formative/Descriptive Study	Tanzania	desk review (project and/or country documents) qualitative data collection	in-country partners Other donors/tech agencies USAID		Other	PY5 Update: The assessment was conducted in April 2013 by MCHIP and partners. The assessment report is currently in draft and being reviewed by stakeholders.

LEAD TEAM	COLLAB GROUP	PL QUESTION	REASON FOR QUESTION	CATEGORY	LOCATION	DATA SOURCES	AUDIENCE	DISSEMINATION	CROSS-CUTTING TOPIC	NOTES
Cross-Cutting		What is a menu of quality MNCH indicators that can be incentivized, measured and verified without introducing perverse incentives?	3. Incentivizing Quality of Care in MNCH – Developing a Menu of Indicators: Most performance-based incentive (PBI) programs reward increases in the quantity of health services, but there is growing interest in rewarding improvements in quality as well. But program designers and policymakers have thus far lacked comprehensive guidance on the best quality indicators to reward. MCHIP is therefore creating a menu of suitable ("incentivizable") quality indicators for each of the key MNCH areas. Among the questions this menu will discuss: 1. What are the best quality indicators? 2. Which of these indicators can be measured, and how? 3. Which indicators can be verified, and how? 4. Will rewarding these indicators introduce perverse incentives?			desk review (project and/or country documents)	USAID MCHIP GLOBAL	non-peer publication	Quality	PY5 Update: A matrix of indicators has been developed, in coordination with most of the leads for the different health areas at MCHIP, although some meetings have yet to take place. A honed group of QoC indicators, which could be incentivized in PBI programs, will be shared with the PBI Community of Practice, and their feedback will be sought. We will facilitate discussions with the COP about which indicators would work best in PBI – i.e., can be routinely verified and paid on without negative unintended consequences. Launch of these discussions on the COP's online Google group will begin immediately.
Family Planning	Bangladesh/ JHU HFS Study	Beyond successful integration of FP with existing community MNH activities in the postpartum period, what are the infant health outcomes attributable to healthy pregnancy spacing?	To generate new knowledge in FP's impact on infant health outcomes	Operations Research/Special Study	Bangladesh	qualitative data collection quantitative data collection field assessment analysis of project monitoring data analysis of project data	in-country partners (MOH, professional societies) Other donors/tech agencies MCHIP	MCHIP website peer-reviewed publication conference presentation policy brief	Other Community Integration	Q4 UPDATE: All data collection has been completed. A national dissemination meeting was held in Dhaka in September 2013. A number of manuscripts (15) are being prepared. Three have been submitted for publication, and one thus far has been published in Global Health: Science and Practice 2013 (Volume 1, Number 2).

LEAD TEAM	COLLAB GROUP	PL QUESTION	REASON FOR QUESTION	CATEGORY	LOCATION	DATA SOURCES	AUDIENCE	DISSEMINATION	CROSS-CUTTING TOPIC	NOTES
Family Planning	India	Does use of the Postpartum Systematic Screening (PPSS) tool increase utilization of FP, immunization, postnatal care and other relevant services in facility and outreach settings?	There is global interest in effective models for integration of FP services with MNCH services.	Operations Research/Special Study	India Mozambique Nigeria	qualitative data collection analysis of HMIS/country data quantitative data collection	Other donors/ tech agencies MCHIP in-country partners	conference presentation peer-reviewed publication	Integration	Q4 UPDATE: The India PPSS has been completed and preliminary data analysis suggest that the screening tool did result in increased acceptance of FP among women with a child less than one year old. The preliminary results also show that the uptake of immunization services was not adversely affected by introducing the tool during the VHNDs that were a part of this study. A draft manuscript has been prepared. The Mozambique study is underway and data collection has begun in three study sites.
Family Planning	Nutrition	What are the key program elements in MIYCN/FP integration and how does it affect FP use among postpartum women?	There is global interest in models of integrating FP with MNCH services.	Operations Research/Special Study	Kenya	qualitative data collection quantitative data collection	Other donors/ tech agencies MCHIP in-country partners	conference presentation policy brief	Integration Community	Q4 UPDATE: Data from the last supportive supervision visit revealed gaps about return to fertility, LAM criteria, and cues to transition—among community health workers. As a result, an all-site orientation was held in June 2013 to review this content further with them and to ensure that they felt confident counseling on these topics. A final assessment will be conducted in early 2014 (as part of a larger integration country case study), and meetings will be held with key stakeholders to review findings and discuss potential for expanding the approach.
Family Planning	Immunization	Does integration of FP messages with Immunization increase utilization of both services and what are the key programming elements?	There is global interest in FP integration with other MNCH services.	Project-Based Learning/Case Study	Liberia	quantitative data collection qualitative data collection analysis of HMIS/country data field assessment	in-country partners MCHIP Other donors/ tech agencies	conference presentation non-peer publication peer-reviewed publication	Integration	Q4 UPDATE: The Endline Assessment Report has been finalized and is on MCHIP website. A national stakeholders meeting was held to share lessons learned. A Program Managers Guide has been drafted. A consultant has been hired to draft a manuscript
Family Planning	Multiple	What are the lessons learned for revitalization and scale-up of PPFP/PPIUCD?	To document lessons learned, both programmatic and technical knowledge for future programming considerations in PPFP/PPIUCD	Formative/Descriptive Study	GLOBAL Guinea India Kenya Rwanda	analysis of project data analysis of project monitoring data	in-country partners MCHIP Other donors/ tech agencies	MCHIP website conference presentation peer-reviewed publication policy brief non-peer publication	Scale Integration	Q4 UPDATE: Two version of a technical brief have been produced (an 8-page and a 4-page version). A regional PPIUCD meeting was held in Lusaka, Zambia in April 2013 and another planned for Burkina Faso in February 2014. A manuscript of data from 6 countries has been drafted for IJGO.

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Family Planning	Mali	Are lower-level providers such as matrons competent in implant provision, according to recognized international and national standards of service provision?	There is interest in task shifting to increase the reach of services, but this raises concerns about the quality of service provision.	Project-Based Learning/Case Study	Mali Nigeria	analysis of project monitoring data qualitative data collection	in-country partners Other donors/ tech agencies	policy brief conference presentation non-peer publication	Quality	Q4 UPDATE: IRB was obtained, implementation completed and documentation in process in Mali. Nigeria is pending IRB approval.
Family Planning	Multiple	What are the essential components for successful MNCH/FP integration?	Given the global interest in integrating FP services, there is a desire to establish a framework for successful MNCH/FP integration.	Project-Based Learning/Case Study	GLOBAL	field assessment analysis of project data	Other donors/ tech agencies in-country partners USAID GLOBAL	conference presentation peer-reviewed publication	Integration	Q4 UPDATE: A concept note has been reviewed by USAID. Research plan and tools are currently being developed for IRB. Plan is to conduct a paired country case study in Kenya (Embu, Bondo) and India (Jharkhand, Bihar).
Family Planning	Futures	What would be the fertility, and maternal and child mortality impacts of scaling up postpartum FP coverage (LiST analysis)?	To establish a model to calculate PPFP impact using LiST	Project-Based Learning/Case Study	37 country analysis	desk review (project and/or country documents) analysis of HMIS/country data	GLOBAL in-country partners Other donors/ tech agencies USAID	MCHIP website conference presentation non-peer publication peer-reviewed publication		Q4 UPDATE: Analysis complete. Writing up results. Will be presented at ICFP2013 in November 2013. Manuscript has been drafted.
Family Planning	Guinea	What are the barriers and facilitating factors for integrating long-acting and permanent methods in both post-partum and post-abortion FP services in Guinea?	There is global interest in integration of FP with other MNCH services.	Project-Based Learning/Case Study	Guinea	analysis of project monitoring data field assessment qualitative data collection	GLOBAL in-country partners Other donors/ tech agencies USAID	conference presentation peer-reviewed publication non-peer publication	Integration	Q3 UPDATE: USAID has approved. IRB protocol is near final.
Family Planning	Jhpiego-GLO	What are best practices for incorporating Social and Behavioral Change Communication (SBCC) messages in PPFP programs?	To consolidate experience in SBCC through multiple country programs and develop learning resource package	Implementation/ Process documentation	37 country analysis		GLOBAL in-country partners Other donors/ tech agencies USAID	non-peer publication	Other	Q4 UPDATE: Updated message guide has been drafted and is currently under review. E-learning SBCC course is currently under development.

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HIV	None	Is partner notification with linked HIV testing and counseling (HTC) for newly identified HIV positive individuals an effective method of identifying cases of HIV or high risk negative persons for further prevention interventions? Study is taking place in Zimbabwe	It is not clear what the role of stand-alone VCT is now that PITC has become the norm, not only in Zimbabwe, but many other countries.	Operations Research/Special Study	Zimbabwe	desk review (project and/or country documents) field assessment	USAID in-country partners	policy brief	Other	The qualitative data interviews are complete, transcribed and translated and an initial report has been drafted. The quantitative data has been compiled and the initial analysis has been completed.
HIV		1. Determine the safety and efficacy of the PrePex™ device. 2. Evaluate the ability to task shift using the PrePex™ device. 3. Determine the acceptability of the device among providers, clients and community.	The use of devices for MC may help VMMC programs scale up. This study will inform many factors that can be applied to informed scale up of VMMC using devices	Operations Research/ Special Study	Lesotho Tanzania				Integration	The two principal investigators visited both Lesotho and Tanzania in August 2013. The Lesotho research protocol has been developed and submitted to the appropriate institutional review boards. The Tanzania research protocol is currently being finalized.

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HIV	SYMMACS, HPI, R2P	VMMC Supplement	MCHIP has been working with partners Systematic Monitoring of the Male Circumcision Scale-up (SYMMACS), the Health Policy Initiative (HPI), and Research to Prevention (R2P) to coordinate a VMMC supplement with the anticipation of publication in a prestigious peer-reviewed journal in Quarter 4. The supplement's papers cover a wide variety of topics from efficiency of service delivery and VMMC quality assurance to VMMC provider burnout. All the papers highlight important findings that can be used to improve existing implementation and operational practices of current VMMC programs. MCHIP staff are primary authors on two of the 12 papers and are supporting USAID in the coordination and management of the supplement.	Project-Based Learning/Case Study	Africa: South			peer-reviewed publication	Quality	A total of 13 articles have been submitted to PLOS. All have been reviewed by PLOS and are appropriate for publication. Four of the articles have been formally accepted, while the other nine have been peer reviewed and are in various stages of resubmission. Individual manuscript and a global dissemination plan have been developed to aid in the dissemination of the various manuscripts.
Immunization	None	What are the operational aspects to introduce a new vaccine into a national immunization program in Africa?	The timely preparation of introducing a new vaccine receives little focus, in comparison to the actual launch of the vaccine. This monograph will follow the layout of the NUVI scale-up map, providing a step-by-step guidance to introducing a new vaccine, using MCHIP country examples to provide context.	Implementation/ Process documentation	Kenya Malawi Rwanda Senegal Tanzania Zimbabwe D.R. Congo Uganda	desk review (project and/or country documents)	in-country partners (MOH, professional societies) Other donors/ tech agencies CORE Group USAID GLOBAL	MCHIP website non-peer publication peer-reviewed publication conference presentation	Scale	Y5 UPDATE: Document has been drafted and is undergoing revision and review. Based on the monograph, a journal article will be prepared for publication and submitted to Global Health Science and Practice.

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Immunization	None	How can newborn tracking be used to reduce the number of children who are unreached with vaccination?	As immunization coverage rises, the need for reaching all children becomes more important, as does the issue of closing the equity gap. In several countries, MCHIP's immunization team has worked on innovative ways to identify and reach newborns.	Implementation/ Process documentation	MCHIP India Timor-Leste Zimbabwe	desk review (project and/or country documents) analysis of project data	Other donors/ tech agencies in-country partners (MOH, professional societies) CORE Group GLOBAL CSHGP USAID MCHIP	MCHIP website peer-reviewed publication non-peer publication	Equity Scale Community	Y5 UPDATE: MCHIP collaborated with WHO to analyze 126 documents from global grey literature to understand and identify reasons for why eligible children had incomplete or no vaccinations. Findings from this analysis identified the main reasons for under-vaccination most commonly related to immunization services and parental knowledge and attitudes. Frequently cited factors included: access to services, health staff attitudes and practices, reliability of services, false contraindications, parents' practical knowledge of vaccination, fear of side effects, conflicting priorities and parental beliefs. A manuscript was published in the journal of International Health during this reporting period. As follow-on to this collaboration, WHO coordinated the "UnVacc" initiative to develop procedures and tools for district or sub-district health staff to use and analyze underlying causes of children remaining unvaccinated. MCHIP has been a member of the UnVacc working group since October 2012 and is responsible for drafting the procedures and tools to enable local health staff to investigate health workers' practices and how they impact on vaccination coverage. MCHIP was invited to present at the WHO/Geneva Unvacc Initiative Workshop on "Tools to identify root causes of children remaining unvaccinated: health worker factors." MCHIP will continue its engagement as the tool is developed.

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Immunization	WHO, CDC	What is the impact of the introduction of new vaccines on developing country immunization programs and health systems?	To understand how the introduction of new vaccines impacts national immunization programs and broader health systems through 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.	Systematic Review	GLOBAL	review published lit desk review (project and/or country documents)	Other donors/ tech agencies in-country partners (MOH, professional societies) CORE Group GLOBAL MCHIP USAID CSHGP	peer-reviewed publication	Quality Scale	Y5 UPDATE: A WHO ad hoc working group, composed of global immunization partners (including MCHIP), was tasked to examine the positive or negative impact of new vaccine introductions on immunization and health systems in countries through a review of both published and grey literature. Strengths of NVI identified included: reduction of disease burden, improved surveillance, training, cold chain and logistics; however, opportunities for broader health system strengthening were found to fall short. Weaknesses identified included: need for improved human resource and financial planning. It appeared that when technical assistance or tools were available, there was a positive outcome in planning and implementation. MCHIP's contributions to this work resulted in a manuscript published in the journal Vaccine and also contributed to updated WHO guidance for countries on NVI.

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Malaria	None	What are countries including in MIP training curricula for both in-service training and pre-service education, and is it consistent with WHO guidance?	WHO issued an updated policy recommendation in October 2012 on IPTp-SP dosing and timing for MIP. Recognizing that many countries may not have harmonized policies based on WHO policies, MCHIP is conducting a systematic review of national level materials in 5 countries to understand what is included in guidance to health workers and to make recommendations to countries for correcting any inconsistencies in guidance and adopting the WHO updated policy recommendation.	Formative/Descriptive Study	Kenya Mali Mozambique Tanzania Uganda	desk review (project and/or country documents)	Other donors/ tech agencies PMI in-country partners	conference presentation	Training Quality Scale	Q4 UPDATE: MCHIP reviewed MIP guidance in policies, guidelines, in-service training materials, supervision materials and pre-service curricula across malaria and reproductive health programs in Kenya, Mali, Mozambique, Tanzania and Uganda. The review found that WHO guidance on MIP is incorporated in country-level documents to varying degrees of consistency and guidance tends to be discordant among each country's documents. A report on findings and specific recommendations for countries to align their documents with WHO guidance has been developed. MCHIP is collaborating with PMI and the Roll Back Malaria Malaria in Pregnancy Working Group to disseminate specific findings and recommendations to countries for aligning their documents with current WHO guidance, clearly and consistently across country-level documents. This activity is particularly timely and beneficial for countries as they consider actions for revising their guidance in light of WHO's recent updated policy recommendation on IPTp. MCHIP has shared the document with MCHIP colleagues in each country encouraging its use as an advocacy tool to promote discussion and action to update country-level documents. In Tanzania, the findings and recommendations have been informed the process of revising the countries' malaria case management guidelines, including MIP, and in-service training and pre-service materials.

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Malaria	Maternal Health	What data are countries currently collecting and reviewing routinely at health facilities for MIP outcome coverage?	It is important for MIP programs, at the national and facility levels, to have access to program performance data and to use the data to build stronger programs with improved results - pregnant women using malaria prevention and case management products and services. Obtaining reliable, valid and timely MIP data is challenging. The purpose of this activity is to better understand in select PMI countries how Ministries of Health are monitoring and reporting on their MIP-related program results, how the data is being used and to provide specific recommendations for improving data collection, monitoring and use.	Formative/Descriptive Study	Kenya Mali Mozambique Tanzania Uganda Malawi	desk review (project and/or country documents) qualitative data collection	in-country partners Other donors/ tech agencies PMI	conference presentation	Measurement Quality	Q4 UPDATE: MCHIP collected and reviewed HMIS data formats and guidance from Kenya, Mali, Malawi, Mozambique, Tanzania and Uganda to understand how information is captured and reported specific to provision of IPTp, ITNs, folic acid and iron supplementation, and testing for and treatment of malaria in pregnancy. MCHIP conducted interviews with stakeholders in Kenya, Mozambique and Uganda to gain further insight into how information is collected, managed and used. A summary report was submitted to PMI on the information collected to-date. MCHIP will conduct interviews with the final two-countries in Q1 of PY6 and develop a final report in Q3 on all findings, recommendations on priority MIP indicators that should be collected, and an ideal system for collection. The report will be disseminated to countries to inform updating HMIS and shared with WHO to advocate for revised MIP indicators.
Malaria	None	What are success factors for community-based strategies that MCP grantees have used to increase ANC attendance and IPTp uptake?	Highlighting innovative and successful strategies to increase ANC attendance and IPT uptake can inform new program and country strategies to address stagnating progress in MIP	Project-Based Learning/Case Study	MCP Portfolio	desk review (project and/or country documents) analysis of project data qualitative data collection	USAID CORE Group PMI MCHIP Other donors/ tech agencies GLOBAL in-country partners CSHGP	MCHIP website non-peer publication	Community	Q4 UPDATE: Final document disseminated 11/7 to PMI, CSHGP and MCHIP
Malaria	None	What are characteristics of successful models of community outreach and engagement used by MCP grantees to increase community capacity to sustain malaria control activities?	Highlights the importance of community engagement in successful and sustainable malaria control, with the intention of informing larger program and country strategies	Project-Based Learning/Case Study	MCP Portfolio	desk review (project and/or country documents) qualitative data collection analysis of project data	USAID CORE Group CSHGP GLOBAL in-country partners MCHIP Other donors/ tech agencies PMI	MCHIP website non-peer publication	Community	Q4 UPDATE: Final document disseminated to PMI, CSHGP and MCHIP 11/7

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Maternal Health	None	Did regional technical meetings in Addis Ababa and Dhaka serve as catalysts for change, i.e., development of tools, improvement in programming and/or national policy?	Globally, it is not clear what the best mechanisms are for encouraging uptake of learning. This question is to help gather evidence about that.	Operations Research/Special Study	Africa Central/North/ East Africa: South Africa: West Asia	qualitative data collection	USAID	policy brief	Other	Information gathering is ongoing. MCHIP has followed up with the country teams from Pakistan and India to receive updates on country programs. Highlights include: ▪ Pakistan: Developed the Lahore Declaration on May 30, 2012 to affirm the commitment to 12 action points on prevention and treatment of postpartum hemorrhage (PPH), pre-eclampsia/eclampsia and essential newborn care (including resuscitation and kangaroo mother care). As part of the action points, a PPH Prevention Strategy Meeting was conducted in November 2012. ▪ India: Multiple maternal health advocacy efforts have been undertaken with all concerned in the Ministry of Health and Family Welfare. The Additional Secretary/Mission Director has committed to pursuing community-based distribution of misoprostol and calcium supplementation for inclusion in government policies.
Maternal Health	None	Are approaches to improve quality of care with SBM-R associated with improvements in implementation of evidence-based MNH practices and improvement in maternal and newborn health outcomes (reduction of maternal and newborn mortality)?	It is not currently known whether quality improvement methods (specifically SBMR) result in measureable improvements in use of interventions or improvement in health status.	Project-Based Learning/Case Study	Bangladesh Ethiopia Indonesia Mozambique Pakistan Zimbabwe	Analysis of project data	USAID Other donors/ tech agencies	policy brief peer-reviewed publication	Quality	Q2 UPDATE (See also M&E PL Question on SBM-R): Analysis of country case studies ongoing. Working with technical writer. Expect to have manuscript in Q4. Q4 UPDATE: Manuscript is in draft form pending finalization of case studies. Anticipated completion planned in Q1 of Y6.

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Maternal Health	LAC Region	What interventions can lead to increased uptake of practices to prevent PPH, focusing on AMTSL and uterotonic use?	This question will add to the current global knowledge base about which strategies (tailored to country and regional contexts) can most effectively lead to uptake and scale up of AMTSL and Uterotonic Use.	Project-Based Learning/Case Study	Guatemala Honduras Nicaragua	qualitative data collection	USAID Other donors/ tech agencies in-country partners (MOH, professional societies)	conference presentation peer-reviewed publication	Other	Q4 UPDATE: A) MCHIP disseminated results at a regional obstetrics/gynecology conference in Mexico and work is ongoing with PAHO to include OiU on the Strategic Fund Products List. MCHIP has contracted with IECS in Argentina to perform an economic evaluation that compares the cost-effectiveness of two different delivery systems for oxytocin, ampoules and in the Uniject™ injection system (OiU), for prevention and initial management of postpartum hemorrhage (PPH) in Latin America. IECS will compare the costs of incorporating OiU into health systems with the costs of the current practice of administering oxytocin in ampoules in disposable syringes with needles. B) A multi-faceted intervention to increase use of AMTSL and reduce unnecessary episiotomies, both interventions to prevent PPH, was implemented and evaluated in selected facilities in Nicaragua. MCHIP has focused on dissemination of results of the successful multi-faceted intervention that led to sustained reductions in episiotomies and maintenance of high rates of AMTSL. MCHIP presented the results at a national conference in Nicaragua, and submitted an article on the multi-faceted intervention to the International Journal of Obstetrics and Gynecology.
Maternal Health	LAC Region	What are providers' perceptions of the reasons for high cesarean birth rates and possible interventions to reduce the rate of cesarean births?	It is currently unknown why the rates of cesarean births are higher than expected in Nicaragua. This learning question will help inform targeted interventions which aim to bring the cesarean rate into WHO recommended range.	Operations Research/Special Study	Nicaragua	Quantitative data collection	in-country partners (MOH, professional societies) USAID Other donors/ tech agencies	conference presentation peer-reviewed publication	Other	Q4 UPDATE: Formative research was conducted in Nicaragua to contribute to answering this question. During Y5, MCHIP focused on dissemination of results of the formative research on cesarean births in Nicaragua. MCHIP presented the results at a national conference in Nicaragua. In addition, they submitted an article to the Maternal and Child Health Journal.

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Maternal Health	LAC Region	What are the lessons learned from the South-to-South learning process between Paraguay and Peru for strengthening midwifery education?	This question will add to the local and global knowledge base by documenting and analyzing strategies for south-to-south learning. Documented successes and strategies can be employed by other programs within Paraguay, Peru, and other countries.	Project-Based Learning/Case Study	Paraguay Peru	Analysis of project data	USAID in-country partners (MOH, professional societies)	peer-reviewed publication	Training	Q4 UPDATE: By the end of Q4, 40 faculty from 6 Midwifery schools (20 from IAB and 20 for private universities) are finishing the basic CBC with the Peru team and MCHIP support. It is necessary to update the faculty on MNH evidence based knowledge as well as standardize and reinforce their clinical skills, in order to model and teach them how to use the CBC. Also, to support the MOH and Midwifery Assoc, the 6 midwifery schools faculties will also need to be trained on the implementation of the CBC, in order to guide and support the scale-up of the process to adapt and implement the basic CBC nationwide. Lessons learned continue to include: ▪ need to closely monitor and follow-up with regular TA, at least over the first 2 or 3 years of CBC implementation ▪ need to identify and work closely with key stakeholders from the beginning.
Maternal Health	Africa	Through the MNH Champions Program, can champions strengthen their own abilities and develop regional partnerships by the use of e-learning and web based communication on best practices?	This question will document the use of e-learning and web based communications by the Africa Champions, and will inform future learning strategies and mechanisms for the Africa Champions.	Project-Based Learning/Case Study	Benin Guinea Kenya Liberia Madagascar Mali Senegal South Sudan Uganda Zambia	Analysis of project data	in-country partners (MOH, professional societies) GLOBAL	conference presentation peer-reviewed publication	Scale mHealth	Q3 UPDATE: Follow-up of Champions has taken place via email to obtain the final versions of action plans from all 10 countries, as well as activity logs so that their work as Champions can be documented. Action plan progress will continue to be assessed via email communication as well as during TA trips to Champions' countries by MCHIP staff for other purposes. Work continues on the data analysis related to use of Qstream and COP sites. The West African Health Organization (WAHO) supported follow-up visits to Champion teams in Benin and Liberia, and provided funds to the MOH in both countries for BEmONC trainings to be coordinated by the Champions. Q4 UPDATE: Follow-up of Champion activities continued through updates submitted in their activity logs. Francophone teams have led trainings in BEmONC, PMTCT; long-acting FP methods (Jadelle and IUD); participated in evaluations of PAC programs and

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										integration of FP and cervical cancer screening services; organized community-level health fairs on FMG, early marriage and PMTCT. Achievements for the Anglophone group include acceptance of abstracts for presentations at the June 2014 International Confederation of Midwives Triennial Congress. All of the 5 Anglophone countries will be represented. Representative events from submitted activity logs include ▪ Supervising trainings for health professionals on BEmONC skills, Kangaroo Mother Care (KMC) ▪ Mentorship of MNH providers using the Helping Mothers Survive platform ▪ Team leader for policy (now finalized) on chlorhexidine for newborn cord care ▪ Development and validation of MNH job aids in coordination with MOH and multiple donors ▪ National and international presentations (Women Deliver in Malaysia, Newborn Health in Johannesburg) ▪ National level advocacy for maternal health programs ▪ Monitoring of hospital quality improvement efforts
Maternal Health	LAC Region	Is distance learning a sustainable model for continuing professional development in small countries and for regions with little infrastructure for professional learning? Can it be utilized to influence programming or national policy?	This question will add to the global knowledge base by documenting and analyzing strategies for continuing professional development in low resource settings.	Implementation/Process documentation	Caribbean	Analysis of project data	in-country partners (MOH, professional societies) USAID	conference presentation	MHealth Training	Q4 UPDATE: Continuing work with CRMA involved planning a Competency Based Education Workshop for October 2013. This workshop requires all participants to complete 2 eLearning modules in preparation for the workshop. By end of Q4, 15 of 21 participants had completed the courses with the rest anticipated to be finished by October 15. This workshop builds on the prior two CRMA events.

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Maternal Health	None	In misoprostol programs for PPH prevention with distribution though ANC/community for self-administration, can quality be maintained in realistic programmatic settings likely to be encountered during scale up?	This question will provide additional data to understand which modes of distribution are most effective for increasing coverage of misoprostol for prevention of PPH (community distribution versus ANC visits).	Project-Based Learning/Case Study	Guinea Liberia Madagascar Mozambique Rwanda South Sudan	Analysis of project data	in-country partners (MOH, professional societies) USAID Other donors/tech agencies	conference presentation non-peer publication peer-reviewed publication	Scale Quality Community	Q2 UPDATE: Rwanda and South Sudan finished data collection and results were presented in-country; Liberia and Madagascar implementation is occurring now. Guinea to start in Q3 2013. Q3 UPDATE: Study implementation continued in Rwanda, Madagascar, and Liberia. The S. Sudan dissemination meeting was held in country. Initial JHU IRB approval was received for the Guinea protocol pending local approval. Q4 UPDATE: Data analysis was completed in Liberia and findings were presented in a local dissemination event. The manuscript for South Sudan study was finalized during Q4. The study protocol in Guinea was finalized and submitted for local IRB approval. Madagascar data analysis completed and the briefer on study findings is under development.

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Maternal Health	None	Are all the necessary components in place and are countries successfully scaling up best practices in prevention and management of PPH?	To determine which factors, if any, need to be addressed to facilitate successful scale up of best practices for prevention and management of PPH.	Operations Research/Special Study	37 country analysis	desk review (project and/or country documents) qualitative data collection	in-country partners (MOH, professional societies)	conference presentation policy brief	Scale	Q2 UPDATE: Data collection is ongoing: ▪ MCA ' light' versions were prepared and shared with 15 countries – these summarize identified gaps and recommendations for each country and can help focus efforts as well as need for targeted TA ▪ To date we have received 5/15 completed MCA light forms. For example, progress is highlighted in S Sudan on AMTSL: ISDP has incorporated AMSTL in the training on normal delivery and management of PPH for the two states. An AMSTL checklist is available. AMSTL is now part of the basic Midwifery training at the midwifery schools for all levels of midwifery training (Enrolled and Diploma levels). Q4 UPDATE: Work continues to analyze responses to the 2nd round of data collection for the MCA survey. Program learning will be captured in a manuscript on the surveys; manuscript is under development.
Maternal Health	None	Are all the necessary components in place and are countries successfully scaling up best practices in prevention and management of PE/E?	To determine which factors, if any, need to be addressed to facilitate successful scale up of best practices for prevention and management of PE/E.	Operations Research/Special Study	37 country analysis	desk review (project and/or country documents) qualitative data collection	in-country partners (MOH, professional societies)	conference presentation policy brief	Scale	Q2 UPDATE: Data collection is ongoing: MCA ' light' versions were prepared and shared with 15 countries – these summarize identified gaps and recommendations for each country and can help focus efforts as well as need for targeted TA Q3 UPDATE: 13 of the 15 countries responded to the MCA light analysis, and 11 of these 13 countries identified actionable gaps in PE/E. All 11 countries outlined how they were taking steps to focus efforts and targeted TA to address these gaps. Q4 UPDATE: Work continues to analyze responses to the 2nd round of data collection for the MCA survey. Program learning will be captured in a manuscript on the surveys; manuscript is under development.

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Maternal Health	Monitoring & Evaluation	Which indicators best measure quality of maternal and newborn (MNH) care?	Identification of a small and feasibly collected set of valid indicators is an ongoing challenge in MNH interventions. This question will provide knowledge to assist the global MNH community to measure the degree to which interventions result in improved quality of care and track them, helping to facilitate quality improvement at scale.	Operations Research/Special Study	Ethiopia Kenya Madagascar Mozambique Rwanda Tanzania Zimbabwe	desk review (project and/or country documents) qualitative data collection	GLOBAL in-country partners Other donors/tech agencies	conference presentation peer-reviewed publication	Quality Measurement	Q2 UPDATE: The sensitive indicators subset conceptual framework, development process, and preliminary results were presented at the Global Maternal Health Conference in Arusha, Tanzania in Q2 (Jan 2013). The pilot research plan was developed and circulated for initial review and being expanded for submission to the Johns Hopkins IRB in Q3 with pilot data collection to follow in TZ. Q4 UPDATE: The pilot research plan and data collection instruments were submitted to and approved by Tanzania and Johns Hopkins School of Public Health IRBs. Further validation analysis was conducted for the 9 potential revised informative indicator subsets generated following expanded expert surveys, including evaluating performance in the 2012 Tanzania QoC survey dataset, available in August 2013. Results of the expanded experts surveys and validation of the 9 potential indicator subsets were presented to USAID representatives on September 19, 2013. Draft outlines were developed for 3 manuscripts related to the indicator subset development tasks – a literature review on QoC measurement, an article on the development of the indicator subset, and an article on the indicator subset pilot. Planning is underway for the Tanzania pilot in Q1 of Y6.
Maternal Health	Monitoring and Evaluation	Can Maternal Newborn Quality of Care study results be used to improve antenatal care and delivery services?	Measurement of quality happens frequently. Getting this data to be used for improvement has been difficult.	Operations Research/Special Study	Ethiopia Kenya Madagascar Mozambique Rwanda Tanzania	qualitative data collection	USAID in-country partners	policy brief non-peer publication MCHIP website	Quality	Q2 UPDATE: Information gathering is ongoing through MCHIP offices in countries where QoC assessments were done. Q4 UPDATE: The MCHIP team has furthered thinking on how to foster quality improvements using QoC data. A program report on findings from the QoC experience and program learning from the QoC experience is under development.

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Monitoring & Evaluation	Newborn Health	Can Health Extension Workers in Ethiopia provide community KMC and essential newborn care with quality and high coverage?	This question will help determine if task shifting to HEWs in Ethiopia is an effective model given policy and other factors. Learning from this question can be applied at the national level in Ethiopia to inform the scope of work and responsibilities of HEW in Ethiopia.	Project-Based Learning/Case Study	Ethiopia		in-country partners	conference presentation/ non-peer publication peer-reviewed publication	Quality Community	Y5 UPDATE: The baseline survey report for the Ethiopia community KMC feasibility study was finalized and disseminated in- country and provided new information on the type and coverage of services provided by health extension workers in the community. A journal article on newborn care practices from the baseline survey was drafted and submitted to Tropical Medicine & and International Health. The team is currently responding to comments from the journal and publication is expected in the next few months. A Lot Quality Assurance Sampling (LQAS) survey to determine the strength and reach of intervention implementation— was conducted and led to a delay in the timing of the endline survey due to relatively low coverage of the community CKMC intervention. The endline survey is now planned for December 2013. A midline qualitative assessment was conducted and the report completed and circulated to stakeholders for review. Findings were used to inform implementation of the program intervention.
Monitoring & Evaluation	Maternal and Newborn	Are we measuring the right things to monitor and evaluate the quality of antenatal care and labor and delivery care services?	There are few routine or household survey indicators that measure the content and quality of maternal and newborn care services and no global consensus on what should be recommended to countries or included in the DHS/MICS.	Operations Research/Special Study	GLOBAL Ethiopia Kenya Mali Mozambique Nepal Tanzania Uganda	quantitative data collection	Other donors/ tech agencies	conference presentation non-peer publication peer-reviewed publication	Quality Measurement	Y5 UPDATE: The Mozambique maternal and newborn indicator validation study results were published in the *PLOS Medicine* supplement on MNCH coverage measurement. The new WHO PPH guidelines recommend tracking use of a uterotonic immediately after birth routinely.

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Monitoring & Evaluation	Maternal Health	Are improvements in compliance with clinical performance standards associated with improvements in use of evidence based practices and health outcomes?	There is a need to demonstrate the linkages between improved performance standard scores and health service statistic outputs and outcomes. The audience for this technical paper is the same group targeted by "Finding Common Ground"— those involved in implementing quality improvement initiatives.	Project-Based Learning/Case Study	Bolivia Malawi	analysis of project data	USAID Other donors/ tech agencies	MCHIP website policy brief non-peer publication	Quality	Y5 UPDATE: A draft of a technical paper summarizing MCHIP's experience applying SBM-R in multiple country programs was developed that includes: strength of implementation; results in terms of performance scores; and service delivery outputs and outcomes. A total of nine country programs shared data on SBM-R standards score improvements and corresponding service delivery data on improvements in service delivery outputs and outcomes. The paper will be finalized in PY6 and a manuscript will be prepared
Monitoring & Evaluation	Newborn Health	As it scaled up, what results did the Malawi/HBB program achieve in terms of health system performance, provider competence, quality of care, and newborn health outcomes?	HBB is a global initiative and is being implemented now in many countries. Small scale impact evaluations have been conducted but no large scale performance evaluations to understand how the intervention works when scaled up as part of the routine health system.	Operations Research/Special Study	Malawi	qualitative data collection quantitative data collection		conference presentation peer-reviewed publication	Scale Quality	Y5 UPDATE: A summary report of Round 1 findings from the national HBB performance evaluation in Malawi, being led by MCHIP through IIP, was prepared and circulated among partners. The report is currently being finalized based on feedback from USAID. The second round of data collection was completed at the end of September and data cleaning and analysis are currently under way.
Monitoring & Evaluation	PVO/NGO Support	What are best practices for including equity in project designs and what are the results of these pro-equity strategies?	There is little evidence on the best practices for pro-equity programming.	Project-Based Learning/Case Study	Egypt Indonesia	desk review (project and/or country documents) qualitative data collection quantitative data collection	GLOBAL	peer-reviewed publication	Equity	Y5 UPDATE: ▪ A socio-economic profile analysis for ChildFund International's CSHGP project in Honduras was completed and showed that clients served by the community health centers run by community health volunteers succeeded in reaching populations in the lower wealth quintiles: 40% in the lowest; 35% in the second 2nd; 19 in the third 3rd; 5% in the fourth 4th; and 0% in the highest quintile. ▪ Gender questions based on joint decision- making indicators collected in the MCHIP Egypt household survey and based on respectful maternity care (RMC) indicators— developed from work by MCHIP, Jhpiego, the RMC working group, and USAID's maternal health team— have been added to

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										the CSHGP Knowledge, Practice and Coverage KPC survey modules. For example: Percentage of mothers of children 0-59 months with fever in the two weeks preceding the survey who made the decision to seek treatment jointly with their partner; % of mothers of children ages 0-23 months with support person or birth companion during labor and delivery. Finalizing the modules will continue in PY6 . ▪ The Egypt baseline survey collected socio-demographic data and the Egypt country team documented its approach to health equity improvement through qualitative assessments of how Community Development Associations (CDAs) determine vulnerable families; and developing a plan for how Community Development Associations CDAs target activities toward vulnerable families. A preliminary brief description was written of how Community Development Associations CDAs define disadvantaged families, what additional attention was paid to these families, and how the families were monitored, which is feeding into MCHIP's program learning around health equity approaches. ▪ The health equity guidance and checklist were presented at the LAC newborn technical meeting in El Salvador in (June 2013). Examples of CSHGP projects involving with equity were presented. The LAC Newborn technical working group TWG made the decision to look closely at country- level information and work through the framework in order to make specific decisions about actions to take that move beyond just talking about reducing health

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										equity. This program will be We will followed up with this in MCHIP YR6, although funding is quite limited for LAC.
Newborn Health	Africa	What is necessary to ensure that new midwifery graduates have the appropriate ENC/HBB skills to provide care for newborns?	As HBB is scaled up in many countries, pre-service education is a crucial health system element that needs to be in place for countries to sustain gains.	Project-Based Learning/Case Study	Ghana Malawi	Analysis of project data	USAID in-country partners	non-peer publication MCHIP website	Training	Q4 UPDATE: Draft report completed. Will be revised and finalized in Q1/PY6. Q2 UPDATE: review of MCHIP Core's support to pre-service strengthening in Malawi and Ghana conducted by external consultant. Report to be completed in Q4.
Newborn Health	None	How can PNC home visits be introduced and scaled up? What conditions are necessary to achieve high coverage and quality at scale?	PNC visits are now policy in many countries but have not yet achieved high coverage in many. Further investigation is needed to determine best practice for scale up.	Project-Based Learning/Case Study	Bangladesh Malawi Nepal Nigeria Rwanda	Analysis of project data	Other donors/tech agencies in-country partners USAID	conference presentation peer-reviewed publication MCHIP website	Scale Community	Q4 UPDATE: consultant hired, manuscript to be drafted and submitted in Q1/PY6 (target: Bulletin of the WHO). Q2 UPDATE: Technical brief (based on PY4 review report) developed by MCHIP and SNL; plan to adapt into a journal article by Q4.
Newborn Health	None	What is required to introduce and sustainably scale up KMC services?	KMC has not been scaled up very few places. Investigation is needed to determine best practice for achieving scale.	Project-Based Learning/Case Study	Malawi Mali Rwanda Uganda	Analysis of project data	Other donors/ tech agencies USAID in-country partners	conference presentation peer-reviewed publication	Scale	Q2 UPDATE: Findings presented at Intl KMC Conference in November 2012 (& GNHC in Johannesburg April 2013). Journal article drafted and will be submitted to *Acta Pediatrica* in Q3.
Newborn Health	Africa	What are the necessary programming elements to improve newborn infection management at the peripheral health facility level?	Infection management protocols need to be simplified and sufficient support given to make infection management sustainable and scalable in peripheral facilities where newborns many are seen.	Project-Based Learning/Case Study	Nigeria	Analysis of project data	Other donors/ tech agencies USAID in-country partners	non-peer publication MCHIP website	Quality	Q2 UPDATE: due to continued insecurity in Nigeria, MCHIP has been unable to complete final data collection. This PL question may need to be dropped; final decision will be made in Q3.

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Newborn Health	LAC Region	What elements of a regional platform are critical to support advocacy and uptake of evidence-based interventions (KMC) at the regional and national levels?	This is to analyze the utility of using a regional mechanism like the LAC Regional Neonatal Alliance as a catalyst for implementation and scale-up of priority newborn programs	Implementation/ Process documentation	LAC	Analysis of project data	Other donors/ tech agencies in-country partners	conference presentation non-peer publication	Scale	Q4 UPDATE: A toolkit for strengthening/initiating national alliances in English and Spanish has been almost completed. The concept was presented in the Alliance regional meeting in El Salvador in June 2013 and will be branded, formatted, and uploaded to K4H and other relevant websites. New or renewed national neonatal alliances will use the toolkit to coordinate their initiation efforts (i.e. Paraguay and the DR). The team is considering a peer-reviewed publication based on the experience of the development of the Alliance and of the kit. Data from the regional LAC KMC network was presented during the global newborn meeting in South Africa, which led to an invitation for an experts consultation on KMC organized by the BMGF and SNL in Turkey in October 2013. An electronic automated data collection tool for KMC programs was developed by MCHIP and it is being shared regionally (later on globally as well). MCHIP organized and led the 2nd regional meeting of the LAC KMC networking El Salvador in June 2013 where new developments at country level were shared. Feedback has also been received on HBB programs in Peru and the DR. MCHIP is working on a scale-up brief that includes the dissemination of HBB in LAC as a success story.
Newborn Health	LAC Region	How can a regional platform be leveraged to improve the quality of management of newborn sepsis with limited funds?	Searching for innovative ways in which newborn health priorities introduced at small scale can be expanded by leveraging partnerships	Implementation/Process documentation	LAC	qualitative data collection	in-country partners Other donors/tech agencies	conference presentation non-peer publication	Quality	Q4 UPDATE: Work on neonatal sepsis is a priority for the LAC neonatal Alliance for PY6. Survey questions were formulated for participants at the MCHIP regional technical meeting to get feedback from countries on possible regional sepsis initiatives. A working group has been formed under the LAC neonatal alliance to further support this work. The DR will be used as a model to take to scale.

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Newborn Health	LAC Region	What is the role of professional associations in the scale-up and planning for sustainability of ENC/HBB in LAC?	This will illustrate how regional trainings during professional associations events catalyzed interest for TA from MCHIP for the implementation of HBB in various countries in LAC	Project-Based Learning/Case Study	LAC	Analysis of project data	Other donors/tech agencies in-country partners	conference presentation non-peer publication	Scale	Q4 UPDATE: Professional associations and other Alliance members continue to be instrumental for scaling up HBB in LAC. During PY5 there were TOTs in Paraguay, Colombia, and Peru in coordination with the Pediatrics, Neonatology and Midwifery associations. This will be documented in a scale-up success story already in draft.
Newborn Health	Africa	How can community-based newborn infection management be introduced at the country level?	Sepsis is one of the three leading causes of NB deaths worldwide. Scaled effective community interventions have not happened although there are promising smaller scale examples like Bangladesh and India. In order to achieve the greatest impact at scale, community approaches need to be explored that can be scaled.	Project-Based Learning/Case Study	Liberia	Analysis of project data	in-country partners USAID Other donors/ tech agencies	MCHIP website non-peer publication	Community	Q2 UPDATE: Core-funded implementation began during this reporting period, including stakeholders' meeting that resulted in MoHSW adoption of CHX for umbilical cord care into national policy. Core-funded TA and implementation support to continue in Q3, documentation in Q4.
Newborn Health	Africa	What is necessary to ensure that new midwifery graduates have the appropriate ENC/HBB skills to provide care for newborns?	As HBB is scaled up in many countries, pre-service education is a crucial health system element that needs to be in place for countries to sustain gains.	Project-Based Learning/Case Study	Ghana Malawi	Analysis of project data	USAID in-country partners	non-peer publication MCHIP website	Training	Q4 UPDATE: Draft report completed. Will be revised and finalized in Q1/PY6. Q2 UPDATE: review of MCHIP Core's support to pre-service strengthening in Malawi and Ghana conducted by external consultant. Report to be completed in Q4.
Newborn Health	None	How can PNC home visits be introduced and scaled up? What conditions are necessary to achieve high coverage and quality at scale?	PNC visits are now policy in many countries but have not yet achieved high coverage in many. Further investigation is needed to determine best practice for scale up.	Project-Based Learning/Case Study	Bangladesh Malawi Nepal Nigeria Rwanda	Analysis of project data	Other donors/ tech agencies in-country partners USAID	conference presentation peer-reviewed publication MCHIP website	Scale Community	Q4 UPDATE: consultant hired, manuscript to be drafted and submitted in Q1/PY6 (target: Bulletin of the WHO). Q2 UPDATE: Technical brief (based on PY4 review report) developed by MCHIP and SNL; plan to adapt into a journal article by Q4.
Nutrition	None	Does M-technology improve compliance with iron-folic acid supplementation?	Information supporting M-technology improving compliance with iron-folic acid supplementation will enhance our global efforts to improve programming in maternal anemia.	Project-Based Learning/Case Study	Kenya		in-country partners (MOH, professional societies) GLOBAL	non-peer publication	mHealth	Q2 UPDATE: Activity is under discussion and design with the Kenya team. Q4 UPDATE: Design and planning efforts continue for this program learning question. Concretized plans for implementation to be confirmed in Q1 of Y6.

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Nutrition	None	What are countries' successes and challenges in anemia prevention and control programs in Africa and Asia?	Understanding country experiences in anemia prevention and control, gathered and discussed at MCHIP Nutrition Symposiums in Asia and Africa, helps to identify gaps/barriers to improve maternal anemia programs.	Implementation/Process documentation	GLOBAL HIDN Priority	desk review (project and/or country documents)	in-country partners (MOH, professional societies)	MCHIP website non-peer publication	Other	Q4 UPDATE: Survey Monkey was sent out to participants from both Johannesburg and Dhaka meetings to gain perspectives on country activities, lessons learned from meetings, and what information is needed by countries, for feedback by mid-September 2013. The team will be collating these responses and analyzing the results. At MCHIP urging, Kenya was chosen by the ATF Secretariat as a country where the ATF might work to encourage the uptake of activities to improve anemia control. MCHIP will lead this activity for Kenya and discussions about the activity were held with the MCHIP Kenya Nutrition and Malaria teams, Division of Nutrition in the MOPHS and other partners (including two of the APHIA+ programs).
Nutrition	None	Are National Consultations on anemia prevention and control effective tools to increase funding and improve interventions on maternal anemia prevention and control?	Knowing the effectiveness of National Consultations on anemia prevention and control will support our global effort to improve programming in maternal anemia.	Implementation/Process documentation	Kenya Rwanda		in-country partners (MOH, professional societies) GLOBAL	non-peer publication peer-reviewed publication	Other	Q4 UPDATE: Kenya held a national stakeholders' meeting that resulted in an anemia control workplan and budget in Q2. While follow-up will be required, this was a first step to improve attention to the problem of anemia. Rwanda had a similar consultation in September. In the case of Rwanda, stakeholders from various health disciplines/ sectors, including maternal and child health, nutrition, malaria, agriculture, education, and the private food industry, were represented. The meeting resulted in consensus that an operational plan, should be developed to serve as a road map to accelerate the reduction of anemia in the next 3-5 years.
Nutrition		Are tailored messages on infant and young child feeding delivered at the household level a feasible strategy to improve infant and young child feeding practices and related behaviors?	To gain an understanding whether delivery of messages at the household level, possibly through community workers, is an effective strategy to support efforts to prevent stunting and improve infant and young child feeding practices.	Operations Research/Special Study	MCHIP Kenya Egypt	qualitative data collection quantitative data collection analysis of project data	MCHIP USAID in-country partners GLOBAL	peer-reviewed publication	Community	Q4 Update: Three parts of a four part stunting study in Egypt are in analyses and write-up - these include dietary data, in-depth interviews and Trials for Improved Practices. The longitudinal part of the study tracking children's growth, which will also look at program exposure to messages, in relation to feeding and illness will be completed in June 2014 (data collection).

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PVO/NGO Support	Child Health	What are effective NGO experiences in implementation and scale up of iCCM programming?	There is a lack of knowledge globally about NGO experiences in implementation and scale up of iCCM programming.	Project-Based Learning/Case Study	Nicaragua		CORE Group MCHIP in-country partners (MOH, professional societies)	conference presentation policy brief	Scale Equity	Q4 UPDATE: Paper awaiting introduction from USAID; Katherine Farnsworth has the final version.
PVO/NGO Support	Monitoring Evaluation	What is the usefulness of the Program Planning, Design, Monitoring, and Evaluation Tools: Annotated Guide to Incorporating Health Equity for incorporating health equity considerations into project designs and monitoring and evaluation?		Project-Based Learning/Case Study	CSHGP		USAID MCHIP	MCHIP website	Quality	Q2 UPDATE: Final draft submitted to USAID. Further action on hold pending USAID activity clarification and identification of next steps. Q4 update: USAID changed SOW and activity has been reassigned to PY 6.
PVO/NGO Support	None	Can an enhanced district health information system evaluate local performance and serve as a national evaluation platform?	Currently, it is unclear whether an enhanced DHIS can evaluate local performance or serve as a national evaluation platform.	Project-Based Learning/Case Study	Liberia		GLOBAL	peer-reviewed publication	Measurement	Q2 UPDATE: Bill Weiss is currently working on writing the paper. Q4 update: paper was submitted to GHSP journal and was rejected.
PVO/NGO Support	None	What were the nutritional outcomes of the integrated child health interventions carried out through volunteer mothers' groups (i.e., Care Groups)?	There is a lack of evidence regarding the nutritional outcomes resulting from Care Groups or interventions with volunteer mother's groups.	Project-Based Learning/Case Study	Mozambique		GLOBAL	peer-reviewed publication	Integration Community	Q2 UPDATE: Paper published in inaugural issue of the Journal of Science and Practice!
PVO/NGO Support	None	Can the results of small sample community based surveys (i.e., KPC surveys) be validated by comparison with concurrent DHS results?	It is currently unknown whether small sample community based surveys can be validated through comparison of national results.	Project-Based Learning/Case Study	Rwanda		GLOBAL	peer-reviewed publication	Measurement	Q2 UPDATE: Paper submitted to Journal of Health Policy and Planning Q4 update: paper rejected. Authors are identifying another journal for submission.
PVO/NGO Support	Malaria	What behavior change strategies enhance malaria control and prevention?	There is a lack of information about the effectiveness of different behavior change strategies in improving malaria control.	Project-Based Learning/Case Study			PMI in-country partners	conference presentation policy brief peer-reviewed publication	Other	Q2 UPDATE: Scheduled presentation at CORE Spring Meeting in Q3. Q4 update: presentation given at CORE meeting. Part II (expanded version) of this activity canceled by PMI/CSHGP.

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PVO/NGO Support	Nutrition	Can a district-level integrated food security and nutrition program improve nutritional status of pregnant and lactating women and children under 2 years old and scaled-up to reduce overall malnutrition in Nepal?	Currently, there is a lack of evidence supporting scale up of district level integrated food security and nutrition programming.	Project-Based Learning/Case Study	Nepal		CORE Group	conference presentation policy brief	Scale Integration	Q2 UPDATE: Scheduled presentation at CORE Spring Meeting Q4 update: presentation delivered at CORE Spring Meeting
PVO/NGO Support	None	What are effective approaches to increase male involvement in household MNCH activities and promote gender equality?	Currently, there is a lack of evidence supporting approaches to increase male involvement in Nicaragua.	Project-Based Learning/Case Study	Nicaragua		CORE Group CSHGP	policy brief conference presentation	Equity	Q2 UPDATE: Scheduled presentation at CORE Spring Meeting Q4 update: presentation delivered at CORE meeting.
PVO/NGO Support		Did the CSHGP Expanded Impact project in Rwanda (led by Concern Worldwide) contribute to reductions in morbidity and mortality? What else have we learned from this project?	EI project is larger than usual investment by CSHGP–need to understand what it achieved	peer-reviewed publications	CSHGP Rwanda	desk review (project and/or country documents) field assessment analysis of project monitoring data analysis of project data analysis of HMIS/country data qualitative data collection quantitative data collection review published lit	GLOBAL	peer-reviewed publication	Community Integration Measurement Quality Scale	Q4 update: A series of five papers–the first was funded by CSHGP and is listed separately. The others examine: Sustainability (Sarriot); Impact (Langston); Lessons Learned from iCCM Scale-up (Weiss); and Community health peer support groups (Landegger).
PVO/NGO Support		Does the use of mobile health technology (mHealth) affect the use of maternal and newborn (MN) services, improve knowledge of danger signs in pregnancy, delivery and on neonates, and in turn prompt life-saving actions in community and improve health MN outcomes	There is limited evidence on how mobile technology is implemented to reach people in remote areas who need health and other services quickly and effectively to save lives	Operations Research/Special Study	Afghanistan	desk review (project and/or country documents) analysis of project data	GLOBAL in-country partners	policy brief MCHIP website	mHealth	

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PVO/NGO Support		What delivery modes and contact frequency provide effective support for exclusive breastfeeding?	While it is clear that mothers need support to optimally breastfeed, the most effective delivery mode and frequency of support remains questionable in different contexts. Various community-based strategies have been developed and evaluated over time, yielding mixed evidence. The analysis of associations between the type and frequency of facility- and community-based interpersonal contacts related to breastfeeding promotion and support and EBF coverage in project areas presented in this paper contributes to the mixed evidence published to date.	Operations Research/Special Study	GLOBAL	desk review (project and/or country documents) analysis of project data analysis of multicounty data (e.g., DHS, etc.) review published lit review unpublished lit	GLOBAL	conference presentation non-peer publication	Community	This paper was presented at UNC's Breastfeeding and Feminism Symposium in March. The paper was submitted to the conference organizers for publication. NOTE: this study was funded by ICF and uses CSHGP project data

Annex C: Africa S/D Results

MATERNAL HEALTH

- The third meetings of the Africa MNH Champions from 10 countries took place in Conakry, Guinea, (for Francophones) and Lilongwe, Malawi, (for Anglophones), focusing on acquiring skills in advocacy to garner country-level commitments to attaining MDGs 4 and 5. Champions also attended technical updates on PMTCT and MIP. In Year 5, champions have led trainings in BEmONC, PMTCT, and LARC and participated in evaluations of PAC programs and integration of FP and cervical cancer screenings in their respective countries. Representatives of five of the 10 champion teams submitted and received acceptance of abstracts for presentations at the June 2014 International Confederation of Midwives Triennial Congress. Please see additional highlights below.

COUNTRY	KEY ACCOMPLISHMENTS
Benin	Initiation of project to encourage presence of companions at labor/birth; training of providers in conducting maternal death audits; training of private midwives in use of vacuum extractor for delivery; coordinated conference for adolescent sexual and reproductive health; EmONC training facilitator for World Bank-funded activity; supportive supervision of providers trained in partograph and infection prevention.
Guinea	Trained Comprehensive EmONC providers in MCHIP-supported program; advocacy for and training of providers on HIV counseling and testing for women in labor; with MCHIP, evaluated use of partograph and PAC.
Kenya	Abstract for ICM accepted.
Liberia	Abstract for ICM accepted; panelist at midwifery symposium at Women Deliver 2013 conference; part of team developing and finalizing policy for cord care (chlorhexidine) and for KMC guidelines; trainer for Collaborative Improvement Workshop for Rebuilding Basic Health Services; conducted SBA trainings on Bleeding after Birth; consulting on MNH and RH for Ministry of Health.
Madagascar	Facilitators for various EmONC and PPIUD trainings; facilitator for pre-service education workshop on formation of skills labs; facilitators in ob/gyn and pediatric association updates.
Mali	Expert participant in launching of Red Cross work to improve MNH in Mali; trainer in several trainings on normal and sick newborn care, EmONC, and PPIUD; support for PPIUD course for providers; facilitator for course for midwives on IUD and implants; facilitator for workshops on consequences of female circumcision and HIV counseling and testing; orientation of providers to woman-friendly care during labor.
Senegal	Comprehensive EmONC facilitators for district-level providers funded by UNICEF; advocacy for KMC unit and newborn care; participated in national workshop for ISSU (Urban Reproductive Health Initiative) program work planning (funded by BMGF); trainer for safe motherhood in ISSU workshops; radio and TV programs to educate the public on FP/safe motherhood issues; provider training in long-acting FP methods funded by UNFPA; participant in national workshop to finalize evidence-based safe motherhood training of trainers curricula; pre-service faculty for obstetrics/gynecology using updated evidence-based information; HBB facilitator in WHO-sponsored trainings in Nouakchott.
South Sudan	Abstract for ICM accepted.
Uganda	Abstract for ICM accepted; mentorship on Bleeding after Birth for district health department; supervisor for infection prevention training at district level.
Zambia	Abstract for ICM accepted; PMTCT and BEmONC trainings conducted; mentoring and supervision visits for midwives and nurses in remote areas; one champion working with the First Lady of Zambia (an ob/gyn) on workshops to provide skills updates to providers working in remote/hard-to-reach areas.

All 10 country teams (3 members per team) have been involved in the MNH Champions initiative since its inception in 2011.

NEWBORN HEALTH

Global Newborn Health Conference

- The Global Newborn Health Conference brought together more than 450 researchers, health officials, policymakers, health experts, and advocates from over 50 countries to review progress made to reduce newborn deaths and what can be done to address this challenge in countries where the needs are greatest.
- The participants, including 70 officials representing health ministries from around the world, agreed to support the development of a new global action plan aimed at reducing the annual global death toll of nearly 3 million babies during the first month of life.
- The conference leveraged technology to reach a much larger audience than the 450 individuals in attendance. It was live cast over the Internet, drawing a large international audience with more than 16,000 views of the webcast in 90 countries. In addition, satellite viewing parties were held in countries such as Bangladesh, India, Nepal, and Madagascar and there were 28,000 contributors on Twitter, reaching 48 million people worldwide.
- This exchange of information and experiences was followed by a one-day planning session during which multi-organization teams from MCHIP, SNL, USAID, BMGF, and UNICEF countries began discussions of national strategies for scale-up of priority newborn health interventions. These discussions continued and, in many cases, connected newborn health programming with resources and political commitment associated with the UN SG's global Every Woman/Every Child strategy, the "Promise Renewed" Call to Action to eliminate preventable child deaths, and the UN Commission on Life-Saving Commodities.
- Specific country commitments and follow-on actions resulting from the GNHC included: **India** announced significant policy changes related to scaling up the use of several key interventions including the use of antibiotics to treat infections, antenatal corticosteroids for preterm labor, and Kangaroo Mother Care for low birth weight and premature babies. Health ministry representatives from **Liberia, Mozambique, Sierra Leone, Yemen, and Zambia** indicated their intention to expand use of one or more proven interventions.

Newborn Resuscitation

- MCHIP partnered with Save the Children, UNICEF, the WHO/Regional Office for Africa and Laerdal Global Health to organize a **Training of Trainers (TOT) workshop on ENC/resuscitation (Helping Babies Breathe [HBB]) in Senegal** in Q1 of Year 5. The goal of the workshop was to improve newborn survival in Francophone West Africa by improving provider capacity in ENC, including neonatal resuscitation. Using a combination of WHO's ENC course and the HBB teaching approach and training materials, the partnership conducted a five-day training for 26 participants from five Francophone countries (Benin, Guinea, Guinea-Bissau, Senegal, and Togo). Country teams were composed of MOH officials, implementing partners, pediatricians or neonatologists affiliated with a teaching institution and available to support training activities back in their own country, and country and regional WHO and UNICEF representatives. The training helped to catalyze action in Senegal where, with UNICEF's support, elements of the HBB approach have been integrated into the national technical training service manual on newborn care. As of late September 2013, UNICEF had purchased 250 NeoNatalie newborn simulators and plans were under way for a national TOT). Cascade training and distribution of equipment to select districts was slated to begin immediately following the TOT.

Newborn Infection Prevention and Management

- In Year 5, MCHIP continued to participate in a multi-agency technical working group on newborn sepsis management. MCHIP and partners expected to finalize and disseminate an implementation guide on newborn infection management. This plan, however, was tabled to

await—and align guidance with—WHO's updated recommendations resulting from their multi-country study of simplified antibiotic regimens. As of the end of Year 5, WHO had not yet released its recommendations and, as such, the implementation guide remains in draft form. MCHIP expects the guide to be revisited and revised in Year 6, following the release of WHO's recommendations.

- MCHIP has also made a catalytic Core investment in the introduction of CHX for umbilical cord care in Liberia, where MCHIP's Year 4 Core-funded newborn situation analysis recommended, among other actions, that the MoHFW "adapt the use of chlorhexidine [CHX] 4% application to the umbilical stump to replace the current practice of alcohol application or leaving the cord clean and dry." Less than a year later, through a national stakeholder process supported by MCHIP, the Liberia MoHFW did indeed endorse CHX for cord care, stating "chlorhexidine will be applied to the tip of the cord, the stump and around the base of the stump cord of all babies delivered in Liberia immediately after cutting the cord and with repeat application once daily until the cord separates." Liberia's National Essential Medicines List (EML) previously listed chlorhexidine digluconate in different concentrations as general antiseptic; the MoHFW's endorsement of CHX for umbilical cord care should help expedite the inclusion of 7.1% chlorhexidine digluconate onto the EML. Given that local production is not feasible in the near future, MCHIP helped secure funds through Save the Children from the UNCoLSC's CHX working group budget to purchase an initial order of CHX product from a manufacturer in Nepal.

CHILD HEALTH

MCHIP continues to support scaling up key child health interventions that can help to end preventable child deaths, such as integrated community case management (iCCM) and revitalized low osmolarity oral rehydration salts (ORS) combined with zinc for diarrheal disease. Year 5 has continued to see expanding momentum for child health; MCHIP has been contributing to and harnessing the energy of "A Promise Renewed" (APR), the CCM Task Force, and the Diarrhea and Pneumonia Working Group. These forums have been effective mechanisms to disseminate key MCHIP learning on iCCM, care-seeking behaviors, and more. As the CCM Task Force Secretariat, MCHIP ensured that consolidated iCCM implementation tools, such as the CCM Indicators Book and revised supply chain management resource guides were available to country implementers through the CCM TF website, CCMCentral.com. MCHIP also supported a Child Health and Nutrition Research Initiative (CHNRI) process on iCCM, which provided a revised iCCM research agenda, both as identified by global researchers, but more importantly by iCCM program managers and academics at the country level.

- In addition to providing technical assistance and participation in country and regional APR launches, MCHIP is supporting the APR effort by working with Ministries of Health and their implementing partners to develop integrated scorecards that can be used to track progress against key MNCH indicators.

- MCHIP acted as the Secretariat for the India Child Survival and Development Summit, held in February 2013. The Summit was a national follow-up to the 2012 Global Child Survival Call to Action and brought together a wide array of key stakeholders. MCHIP facilitated all of the technical committees supporting the Summit and completed a series of related LiST analyses. *Note: this was funded by both Core and field funding.*

- MCHIP Child Health and Immunization Teams provided technical input into the Integrated Global Action Plan for the Prevention and Control of Pneumonia and Diarrhea (GAPPD), which was launched in April in Geneva, London, and Washington D.C., along with a related *Lancet* series on childhood diarrhea and pneumonia. The launch of this global plan is a reflection of the joint advocacy and coordination efforts between key child health agencies, of which MCHIP has been an active player.

- As the Secretariat of the CCM Task Force (TF), MCHIP has contributed to stronger iCCM programs that are using state-of-the-art iCCM tools (e.g., supply chain management, M&E, operations research, and most recently costing and financing). During the past year, MCHIP organized one Steering Committee teleconference and five TF teleconferences. Included in Secretariat tasks was the (re)vitalization of four subgroups:
  - **Operations Research Subgroup:** MCHIP supported monthly teleconferences to bring together leaders in CCM to prepare joint panels on iCCM at various academic and programmatic conferences, as well as an ongoing CHNRI process to establish an updated prioritized research agenda for iCCM. MCHIP is supporting this CHNRI process and is especially proud to have encouraged that the process include a focus on in-country iCCM experts, which has led to key findings highlighting differences between the research priorities of global experts as opposed to in-country experts. Findings will be shared with donors and members of the iCCM Task Force, and will also be presented at the iCCM Evidence Review Symposium in Year 6, which will be attended by between 30–35 country delegations.
  - **Monitoring and Evaluation Subgroup:** MCHIP assisted in finalizing the Benchmark Indicator book, which will assist countries in identifying and adapting appropriate indicators to measure their CCM efforts. The Indicator Book will be available on CCMCentral.com, but more importantly will be disseminated in a special launching session at the iCCM Evidence Review Symposium.
  - **Supply Chain Management (SCM) Subgroup:** MCHIP supported the subgroup in starting an inventory of available SCM tools for iCCM and in developing a SCM Tips resource tool to provide guidance to individuals, organizations, and communities as they begin to plan iCCM programs. MCHIP also supported the subgroup in organizing a webinar series highlighting SCM issues in the context of CCM; two webinars were conducted this year on an "Introduction to Supply Chain for CCM Program Managers" and "mHealth tools for iCCM." There has been great participation in these webinars (over 60 participants each, with multiple in-country representatives as well). As such, the webinar series will continue into Year 6 and will focus on topics identified by participants of previous webinars.
  - **iCCM Costing and Financing Subgroup:** MCHIP worked with several different TF members working on costing to establish a subgroup that will review the various iCCM costing tools and develop an accompanying training package on how partners should use these tools with Ministries of Health to plan funding. The subgroup has plans to contribute to increasing the number of experts who can do costing of iCCM plans.
- MCHIP continued to refine the CCMCentral.com website as a global resource for iCCM, hosting current global events, tools, documents, meeting reports, etc. Google Analytics indicated a *total of 5,488 visitors* during the reporting cycle with *3,125 unique* visitors. CCMCentral.com is increasing the visibility of iCCM and continues to facilitate the sharing of standardized resources and the latest information on iCCM to a wide community of more than 100 members.
- In Year 5, MCHIP engaged external consultants to conduct a review of the accomplishments of the CCM Task Force and of the role of the TF Secretariat (held by MCHIP). The review included in-depth interviews, an online questionnaire, and a key document review, as well as a cost analysis of the Secretariat function. The review gathered *perceptions* of efficacy and value of both the overall CCM Task Force and the Secretariat role in particular. Overall, the positive contributions to date of the Task Force and the Secretariat role were clear; however, how the TF engages at a country level was found as an issue requiring further strategic discussion. Results of the study will be discussed by the CCM Task Force Steering Committee in Year 6 Quarter 1 to make strategic decisions about how the TF and Secretariat role could be changed.

IMMUNIZATION

- **Expanded Program on Immunization (EPI) Managers Meetings**: WHO hosts annual sub-regional meetings for Central, West, and East and Southern Africa to evaluate the current state of the EPI, share cross-cutting lessons learned among countries, and discuss major themes such as New and Underutilized Vaccine Introduction (NUVI), polio, and accelerated disease control. MCHIP headquarters and field staff participated in each of the three sub-regional meetings, providing technical input on routine immunization and on strengthening and operationalizing new vaccine introduction at country level. At the EPI Managers Meeting for East and Southern Africa, MCHIP participated in sessions that examined the innovative strategies being executed to combat poliovirus and measles transmission. MCHIP presented during one of the plenary sessions on findings from the Gates-funded African Routine Immunization System Essentials (ARISE) project, describing drivers of improved and sustained high-immunization coverage.
- **Mid-level Manager (MLM) Communication Training Module**: At the request of WHO/AFRO, MCHIP provided extensive revisions to the WHO/AFRO MLM Communication Module, to be published as part of an updated series of immunization MLM modules for use in all countries in Africa. MCHIP staff had previously assisted in co-drafting and reviewing various modules.
- **Vaccine Logistics meeting**: MCHIP participated in the first-ever vaccine logistics meeting in the West African region. MCHIP provided technical contributions that were incorporated into a final report with recommendations, including:
  - Definitions, country-level issues, expected skills, and incentives to motivate country health logisticians
  - Actions necessary to scale up training and rational use of health logisticians at all levels of health systems in the Africa region
  - Strategies for advocacy with governments and institutions to take into account resource requirements of logistics of health programs in human resource development
  - A mechanism for information exchange at regional and country levels on the development of professional logisticians.
- **Semi-Annual Eastern and Southern Africa GAVI sub-regional working group meeting**: MCHIP participated in the GAVI sub-regional working group that is held semi-annually to update countries on progress and challenges in new vaccine introduction. The meeting objective was to review the status of different GAVI support mechanisms provided to eastern and southern African countries and discuss coordinated technical support. MCHIP provided a progress update on countries where MCHIP has a presence in the region.
- **cMYP Regional Meeting**: MCHIP representatives from Kenya and Malawi participated in the regional Comprehensive Multi-Year Plan (cMYP) meeting where they updated their country cMYPs for applications submitted to GAVI for measles 2nd dose and human papillomavirus vaccine (HPV) introduction.
- **AFRO Mid-Level Managers (MLM) Training**: At the request of WHO/AFRO, MCHIP co-facilitated an MLM course for East and Southern African countries in Zimbabwe, facilitating sessions, reviewing modules, and providing guidance and feedback on the MLM course for finalization of the MLM module series (which MCHIP has assisted in revising).
- **Africa Regional Conference on Immunization (ARCI)**
  - The annual African Regional Conference on Immunization is attended by country representatives, UN agencies and other partners in immunization, including MCHIP HQ and country staff. MCHIP provided technical guidance on strengthening routine

immunization systems and innovations in the field. MCHIP also participated in sessions that examined the innovative strategies being executed to combat poliovirus transmission, in addition to discussing the critical role that new technologies can play in reaching the hard-to-reach populations toward accelerating the control of vaccine preventable diseases. MCHIP staff chaired one of the parallel sessions on *Immunization Systems Support* and another MCHIP staff shared MCHIP's commitment to supporting AFRO and African countries in strengthening their immunization efforts.

- **GAVI Annual Reports Peer Review Meeting:** MCHIP participated in the GAVI Annual Reports Peer Review Meeting in Benin in April 2013. Participants provided input on how the technical quality of annual evaluation documents and coherence of data provided in them can be improved. MCHIP provided technical guidance on planning a new road map to enable countries to receive GAVI funds more easily.
- **EPI Curriculum Review Meeting:** Several MCHIP staff participated in the Regional Workshop to revise EPI curriculum for nursing and medical schools, hosted by WHO in May 2013. MCHIP worked with other partners to gain consensus on the content of the EPI prototype curricula, which each country will adapt to their country context and educational system. MCHIP/Kenya participants also presented on the revision of EPI curriculum experience in Kenya, titled "Revision of Nursing and Medical Manuals in Kenya." Upon returning to their countries, each of the MCHIP-supported participants prepared a plan for including immunization topics into pre-service curricula.
- **WHO/AFRO External Evaluation:** MCHIP served on a multi-agency evaluation panel to review WHO/AFRO's Regional Immunization and Vaccine Division (IVD) strategic plan in June 2013. MCHIP co-wrote the section on Communications as well as provided input into the sub-section on integration. The final evaluation was shared with WHO/AFRO IVD and will be widely disseminated within WHO/AFRO.

PROGRAM LEARNING FOR AFRICA S/D

MCHIP continues to promote learning and provide state-of-the-art tools for the implementation of child health programs, notably iCCM and revitalization of use of ORS and introduction of zinc in the management of diarrheal disease.

In Year 5, MCHIP contributed to the evidence base in child health helping to inform child health programming, focusing primarily on iCCM. At the global level, MCHIP has brought iCCM learning together on factors influencing scaling up iCCM in three countries and also on how countries have adapted global iCCM training and supervision guidelines in six countries. Although many countries have made significant progress in increasing diarrheal disease treatment, many countries are still lagging behind. To help inform how future programming can better support countries with low utilization of ORS to expand their treatment patterns, MCHIP has analyzed key factors impacting uptake of ORS.

MCHIP provided support to the Operations Research subgroup of the CCM Task Force to write, edit, and finalize articles addressing various elements of iCCM implementation. These were developed for the Special Supplement to the *Journal of American Tropical Medicine and Hygiene* on Integrated Community Case Management (MCHIP Theme: Quality, Community). MCHIP also provided funding to make this journal accessible free to readers online.

In Year 4, MCHIP completed the "documentation of iCCM implementation in DRC and Senegal while the USAID Mission in Malawi supported a similar exercise in Malawi. To make the findings across the three programs more accessible, MCHIP created a CCM Synthesis Report of Facilitating and Constraining Factors in Scaling Up iCCM in DRC, Senegal, and Malawi (MCHIP

Theme: Community, Scale-Up). This report seeks to increase the number of people reading about the findings, thereby facilitating adoption of promising practices from these programs.

The CCM Task Force was formalized in 2010. To understand how members perceive the TF and how well the MCHIP Secretariat role is contributing to fulfilling the mandates of the TF, MCHIP conducted a Review of the CCM Task Force and MCHIP's Role as the Secretariat of the CCM TF (MCHIP Theme: Quality).

ORS was introduced as a low-cost treatment for life-threatening dehydration in acute diarrheal disease in the 1980s. Countries have varied in the speed at which they have increased and sustained the use of ORS in the management of acute diarrheal disease. To continue advocacy for ORS use, MCHIP reviewed ORS usage in five countries (three high/sustained and two, low/declining) to understand "Factors influencing High and Low ORS Utilization" (MCHIP Theme: Scale-Up).

ICCM is often introduced by an NGO in a limited setting and expanded over time. As the program grows, there is often a process of harmonization of materials and tools. WHO/UNICEF have provided standard training guidelines for iCCM. To understand how countries are adapting these global guidelines and maintaining quality of training and supervision of CHWs providing iCCM, MCHIP commissioned a review: CCM Training and Supervision Review (MCHIP Theme: Quality, Community).

1. How have Bangladesh and ***Malawi*** introduced and scaled up HBB? What conditions have—or have not—helped to achieve high coverage and quality at scale? *Process documentation of HBB in Bangladesh and Malawi; Themes addressed: scale up*

   In Year 5, MCHIP undertook an in-depth review of the experiences of Bangladesh and Malawi in introducing and scaling up HBB, with Africa Bureau funds supporting the Malawi portion of the documentation. This exercise identified elements of the interventions that did and did not work, recorded lessons learned and drafted recommendations to inform other countries' efforts to introduce or expand HBB. Findings and recommendations will be written up in Q1/PY6 and a manuscript drafted for journal submission (target: *Global Health Science and Practice).*

2. What is necessary to ensure that new midwifery graduates have the appropriate ENC/HBB skills to provide care for newborns? *Analysis/case study of MCHIP experiences in* ***Ghana and Malawi****; Themes addressed: training*

   In Year 4, with Africa Bureau funding, MCHIP collaborated with the Regional Center for Quality of Health Care (**RCQHC) and ECSA-HC/ECSA-CON** to assess and strengthen the ENC/resuscitation elements of pre-service midwifery curricula, with focused support and assistance to Malawi. At the same time, MCHIP undertook similar activities through the MCHIP Ghana Team using core funds. In Year 5, MCHIP assessed both efforts; the resulting country case studies will be finalized in Q1 of PY6 and disseminated in each country as well as to global audiences through HBB GDA members and via the HNN and MCHIP websites.

3. How can community-based newborn infection management be introduced at the country level? *Country case study; Themes addressed: community*

   Following the Year 4 Africa Bureau/MCH Core-funded situation analysis of newborn health in ***Liberia***, in Year 5, MCHIP used AFR/MCH funds to support introduction of several interventions and approaches, including community-based management of newborn infection and use of CHX for cord care. MCHIP and Save the Children Liberia are looking to identify additional funding that can support onward implementation while MCHIP uses Core funds in Year 6 to document and disseminate program learning.

Annex D: LAC Bureau Results

In MCHIP Year 5, LAC continued efforts to reduce maternal and newborn morbidity and mortality by implementing priority technical interventions, spearheading midwifery education and exchanges, and providing technical leadership through its participation advisory groups for HBB and KMC implementation, the Global Newborn Action Plan, the Promise Renewed, as well as in the LAC Regional Maternal Mortality Reduction Task Force, the LAC Neonatal Alliance, and the Regional Caribbean Midwives Association, all regional platforms through which MCHIP has successfully promoted information sharing and scale-up of evidence-based practices.

By targeting the primary causes of mortality through its technical focus on ENC, HBB, KMC, and infection prevention and management, MCHIP has achieved notable successes in the area of newborn health, including advocacy and progress toward increased uptake of priority interventions at the national and regional level in LAC. Taking contextual realities into account—namely funding limitations—LAC has worked with partners to develop regional strategies by coordinating and levering common efforts, and developing networks (communities of practice) for interventions such as for KMC. MCHIP has also succeeded in scaling up interventions at the country level, such as HBB (in the Dominican Republic and Colombia), and at the regional level through its active participation and leadership in regional forums for information sharing and trainings.

Notable accomplishments for the year in the area of maternal health include the wide dissemination of results of successful interventions and formative research through presentations and articles submitted to peer-reviewed journals. Progress has also been made toward the development and adoption of a competency-based curriculum by midwifery schools in Paraguay and through South-to-South exchanges between midwifery leaders in Paraguay and Peru. Through this exchange, six midwifery schools in Paraguay have committed to implementing the competency-based curriculum during the 2014 academic year. In addition, building on Year 4 activities, MCHIP provided technical assistance for the development of initial management and program structures for the Caribbean Regional Midwifery Association (CRMA), which now has a constitution that is being reviewed by the Caribbean legal system. In coordination with CRMA, ICM, and UNFPA, MCHIP also developed and conducted an eLearning workshop at the ICM Regional Congress. Finally, MCHIP has provided technical assistance to the Regional Maternal Mortality Reduction Task Force to monitor its annual workplan and help revise the Interagency Strategic Consensus for Latin America and the Caribbean Document.

MCHIP's achievements in LAC clearly demonstrate the value added of its integrated approach, in evidence through its influential role in numerous regional forums, including its role in the Regional Maternal Mortality Reduction Task Force and as Chair of the LAC Neonatal Alliance, which includes maternal as well as newborn health experts who define regional policy and action. MCHIP coordinated and provided financial support, along with its partners, for the back-to-back annual meeting and the technical updates event of the LAC Neonatal Alliance and the KMC network reunion, and for the LAC Regional Meeting held at the Women Deliver Conference in Malaysia. In PY6, MCHIP will further apply this integrated approach by working with the Regional Maternal Mortality Reduction Task Force and the Neonatal Alliance to identify and implement integrated activities. As many of USAID's MCH programs in the region are closing, it has become very important to maximize efforts under a regional scope to continue to support activities in these countries.

MATERNAL HEALTH

- MCHIP disseminated results of the oxytocin in Uniject™ (OiU) feasibility study at a regional obstetrics/gynecology conference in Mexico, and work is ongoing with PAHO to include **OiU on the Strategic Fund Products List**.
- MCHIP focused on dissemination of results of the successful **multi-faceted intervention that led to sustained reductions in episiotomies and maintenance of high rates of AMTSL**, as well as results of the **formative research on cesarean births** in Nicaragua. MCHIP presented the results at a national conference in Nicaragua. In addition, MCHIP submitted an article on the multi-faceted intervention to the *International Journal of Obstetrics and Gynecology*, and an article on cesarean births to the *Maternal and Child Health Journal*.
- MCHIP also guided and supported the **linkages among Paraguay Midwifery Schools Association, the National Midwives Association, and the MOH Midwifery Director**. The Midwives Association has proposed a new law, under review in Congress, for midwifery regulation in Paraguay. One component of this law is related to pre-service training, mandating at least four years of competency-based training.
- As a direct outcome of MCHIP's support for **South-to-South learning involving Peruvian midwifery mentorship of Paraguayan midwife faculty**, the deans of all six midwifery schools confirmed their commitment to approve and implement the competency-based curriculum in their respective institutions during the 2014 academic year. In addition, the five private midwifery schools signed a memorandum of understanding with the Universidad San Martin de Porres for the provision of further technical assistance, as needed.
- With MCHIP's support, the **CRMA now has a constitution** that is being reviewed by the Caribbean Community and is expected to be legalized by the end of the year. CRMA is housed in Trinidad and has its own logo and registered address.
- MCHIP created **linkages between the CRMA and other regional groups** such as the Caribbean Nurses Association for strategic input and regional development, to facilitate leadership development, and to promote resource support of the CRMA at national levels.
- In coordination with the CRMA, ICM, and UNFPA, MCHIP developed and conducted an **eLearning workshop** at the ICM Regional Congress in Quito, Ecuador, in April 2013. With the goal of developing capacity for distance learning, 31 participants were assisted in downloading eLearning modules. Participants registered for online courses (Qstream and ModCAL). Post meeting support was provided by technical staff from MCHIP and Jhpiego.
- As part of **CRMA capacity development**, MCHIP technical staff worked with five CRMA members to draft abstracts for submission to the ICM triennial meeting in Prague, Czech Republic. Four abstracts were selected.
- As a member of the LAC **Regional Maternal Mortality Reduction Task Force**, MCHIP participated in several task force meetings during the year, in person and virtually, to discuss and monitor the implementation of the 2013 workplan, and to develop the 2014 workplan. MCHIP also provided technical assistance to help update and revise the Interagency Strategic Consensus for Latin America and the Caribbean, which serves as the guiding framework for the prevention of maternal mortality and morbidity in the region, as followed by Task Force agencies including PAHO, UNFPA, UNICEF, FCI, Pop Council, IDB, World Bank, and USAID. The review was led by a sub-committee of UNFPA, PAHO and MCHIP, supported by FCI as the Regional Maternal Mortality Reduction Task Force Secretariat. During the past year, Task Force members agreed on the approach for the revision of this document, including what needs to be updated and new topics that need to

be incorporated. A Task Force meeting will be held in November 2013 to review and discuss the preliminary draft of the Interagency Strategic Consensus for Latin America and the Caribbean.

- MCHIP provided support to the RTF for the organization of the LAC Regional Meeting held at the May 2013 Women Deliver conference in Malaysia. The objective of this meeting was to promote a guided discussion on the strategic priorities for improving maternal health and rights and reducing maternal mortality in LAC and strategies for advocating for these regional priorities at the global level. MCHIP shared materials and delivered a presentation entitled "**Promoting Respectful Maternity Car**e: The LAC Country Experiences."

NEWBORN HEALTH

- As **Chair of the LAC Neonatal Alliance** since 2011—elected unanimously for the third year in a row—MCHIP has provided technical leadership during a dynamic growth period. The LAC Neonatal Alliance expanded membership with the addition of regional professional associations (pediatric, obstetrics and gynecology, ICM, and nursing) and other new members, including the Colombian MOH, World Vision, the Mesoamerica Health Initiative 2015, 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 PY5, MCHIP co-organized and co-funded the annual LAC Neonatal Alliance workplan meeting with the participation of representatives of the professional associations and other partners from the region in El Salvador, in June of 2013. Also, with TA and support from the LAC Neonatal Alliance, new national neonatal alliances are being formed in Haiti and Paraguay, and efforts have been carried out to revitalize the Dominican alliance. As a result of its high visibility, the LAC Neonatal Alliance was invited to participate in efforts such as the Promise Renewed, the UN Commission on Life Saving Commodities for Women and Children for Newborn Commodities, the Every Newborn Action Plan, and others.

- MCHIP has helped to spearhead the development of a KMC regional network with its own virtual community of practice (developed and managed by URC's ASSIST) 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 regional KMC network. The second meeting of this network was organized and funded MCHIP and other LAC Neonatal Alliance partners were countries discussed their progress. MCHIP shared the electronic data collection tool that is being already adapted and used by the KMC program in Nicaragua. In PY5, the MCHIP Newborn Team presented a panel on experiences implementing KMC in Africa and LAC at the International KMC Conference in India in November of 2012 and in the Global Newborn Conference in South Africa in 2013, which led to the inclusion of the LAC KMC experiences in the experts consultation to be carried out in Turkey in October 2013 by the Bill & Melinda Gates Foundation and SNL

- 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 ASSIST project, PAHO, the professional associations (mainly pediatric, ICM, and neonatology), implementing the curriculum in the Dominican Republic, and carrying out regional and national trainings for various cadres of professionals. MCHIP disseminated HBB trainings to initiate or strengthen implementation at the regional and/or country level as follows : 1) Colombia—regional TOT in the ALAPE meeting in October of 2012, national

training of providers of vulnerable areas in the Regional Neonatology Association meeting in November of 2013; (2) Paraguay—training of providers in September 2013; (3) Postponed two back-to-back TOTs in Guyana (in collaboration with the MOH, ICM and PAHO) for Quarter 1 of PY6 due to delays in procurement of equipment by PAHO. 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 will continue throughout the region with support from the LAC Neonatal Alliance and other partners. MCHIP is part of the implementation advisory group of the HBB GDA and continues to provide inputs related to the LAC experience.

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 for South-to-South learning, midwifery exchanges, and continuing professional development (CPD) using distance learning through the regional platform of the Caribbean Regional Midwives Association (CRMA). In PY6, MCHIP will look at how the process of competency-based learning can be systematized to guide future replication in other countries, as well as to evaluate the sustainability and appropriateness of distance learning for CPD and regional leadership development. MCHIP has also focused program learning activities on disseminating results and lessons learned from pilot initiatives to promote the uptake of interventions to prevent PPH, reduce the number of episiotomies, and reduce the rates of cesarean operations.

For newborn health, the LAC Neonatal Alliance has provided MCHIP with a regional platform to advance priority newborn health interventions, skills, and knowledge as evidenced by active participation at various high profile meetings, conferences, trainings, and input into the development of various products, such as the tool kit to strengthen national alliances. In PY5, MCHIP pinpointed elements of this regional approach to enable us to effectively scale-up, so that other countries can more easily benefit from lessons already learned.

- **Pilot projects in Nicaragua and Honduras using the oxytocin Uniject™ injection system to promote the administration of oxytocin as part of AMTSL (MCHIP theme: Quality).**

  MCHIP is working with PAHO to advocate for the inclusion of OiU to the PAHO Strategic Fund Products List. During PY5, MCHIP disseminated results at a regional obstetrics/gynecology conference in Mexico and work is ongoing with PAHO to include OiU on the Strategic Fund Products List. MCHIP has contracted with Institute for Clinical Effectiveness and Health Policy in Argentina to perform an economic evaluation that compares the cost-effectiveness of two different delivery systems for oxytocin—ampoules and the Uniject™ injection system (OiU)—for prevention and initial management of in Latin America. The institute will compare the costs of incorporating OiU into health systems with the costs of the current practice of administering oxytocin in ampoules in disposable syringes with needles. Throughout the entire project the Institute's research team is interacting regularly with PAHO and the PATH TAG to coordinate the review.

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

  During PY5, MCHIP focused on dissemination of results of the successful multi-faceted intervention that led to sustained reductions in episiotomies and maintenance of high rates of AMTSL. MCHIP presented the results at a national conference in Nicaragua. In addition, they submitted an article on the multifaceted intervention to the *International Journal of Obstetrics and Gynecology*. Although MCHIP recommended scaling up use of the intervention to other facilities in Nicaragua and possibly using the intervention for other

maternal health interventions, they have not been able to pursue this as USAID activities in Nicaragua have been suspended.

- 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).

  During Y5, MCHIP focused on dissemination of results of the formative research on cesarean births in Nicaragua. MCHIP presented the results at a national conference in Nicaragua. In addition, they submitted an article to the *Maternal and Child Health Journal*. Although MCHIP recommended using the results to develop a strategy to reduce cesarean births, they have not been able to pursue this as USAID activities in Nicaragua have been suspended.

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

  During PY5, MCHIP and the Peruvian faculty of Universidad San Martin de Porres continued building the capacity of the Paraguayan faculty of the National Midwifery School of Institute Andres Barbero of Universidad Nacional de Asuncion via online coaching, feedback, conference calls, and through three workshops in Asunción. The goal was to support and monitor the changes that had been incorporated into the midwifery curriculum in order to include ICM competencies and competency-based methodology. The five private midwifery schools that joined the process in PY4 started to develop a competency-based curriculum along with the Institute. Memorandums of understanding between the Universidad San Martin de Porres in Lima and the midwifery schools were signed for further TA. The Paraguay Midwifery Schools Association, created in 2012 by the Institute Andres Barbero and the five private midwifery schools, agreed to adopt a basic unified competency-based curriculum for midwifery teaching to be implemented in their respective schools. Linkages between the association, the Midwives Association, and MOH Midwifery Directorate were created to facilitate the adoption of the unified competency-based curriculum nationwide. In PY6, MCHIP will continue to document this South-to-South learning process between Peru and Paraguay for strengthening midwifery education and to share lessons learned that can help guide future replication in other LAC countries.

- **CRMA use of distance learning for CPD (MCHIP theme: Other).**

  Recognizing the need for additional development of midwifery educators and preceptors, MCHIP developed a competency-based education workshop that was held in October 2013. This workshop requires all participants to complete two eLearning modules in preparation for the workshop. It will build on the prior two CRMA meetings (April 2012, April 2013) and will include direct development of teaching capacity and further support for use of blended learning. Follow-up will include supervisory visits by master trainers, thus completing the cycle started in April 2012 with the first meeting. In PY6, MCHIP will assess whether distance learning is a sustainable model for CPD in small countries with little infrastructure for professional learning. MCHIP will also look at whether distance learning is an acceptable model for regional leadership development, based on documentation of the process developed for use by the CRMA and how it was utilized to influence programming or national policy.

- **Contribute to activities of the LAC Neonatal Alliance (MCHIP theme: Integration)**

  MCHIP has contributed to the Neonatal Alliance activities by providing technical assistance and leadership as acting chair. In PY5, MCHIP looked at the impact of training on immediate care of the newborn—particularly with respect to provider practices at the time of birth 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. During PY5, the LAC

strategy and action plan for newborn health was positively evaluated by PAHO countries as a tool to address newborn mortality at the national levels. The results of the evaluation were disseminated in two meetings (one for Spanish speaking countries in Peru, and one for English speaking countries) in Barbados. A toolkit for strengthening/initiating national alliances in English and Spanish has been almost completed. The concept was presented at the alliance regional meeting in El Salvador in June 2013 and will be branded, formatted, and uploaded to K4H and other relevant websites. New or renewed national neonatal alliances will be able to use the toolkit to coordinate their initiation efforts (i.e., Paraguay and the Dominican Republic). The team is considering a peer-reviewed publication based on the experience of the development of the alliance and of the kit.

- **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. In PY6, MCHIP will seek to determine 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 HBB curriculum integrated into ENC under a regional approach (MCHIP theme: Scale-up)**

  MCHIP has successfully continued to use this regional platform to implement and scale up HBB in PY5. In PY6, MCHIP will seek to document key programming elements for ensuring a successful scale-up of improved newborn resuscitation skills at health facilities by developing success stories on scale-up. MCHIP will also develop and distribute an electronic, automated data collection tool for generating HBB indicators. MCHIP is working on a scale-up brief that includes the dissemination of HBB in LAC as a success story.

- **Technical support to in-country partners for implementation and scale-up of KMC under a regional approach (MCHIP theme: Scale-up)**

  MCHIP has successfully used this regional approach to scale up KMC throughout the life of the project. In PY6, 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. MCHIP will also contribute to the translation into English of the training website of the Colombian Kangaroo Foundation (which can be downloaded for free), and develop an electronic, automated KMC data collection tool that will be distributed in the region and available globally. Data from the regional LAC KMC network were presented during the global newborn meeting in South Africa, which led to an invitation for an experts' consultation on KMC organized by the Bill & Melinda Gates Foundation and SNL in Turkey in October 2013. MCHIP organized and led the second regional meeting of the LAC KMC network in El Salvador in June 2013 where new developments at country level were shared.

Annex E: MCHIP Success Stories

CORE-FUNDED

HIV

Webinars on VMMC

- The MCHIP-supported VMMC webinars have been very successful, with over 200 participants attending each of the three webinars to date. Feedback from the field indicates that the webinars are creating an interactive forum for VMMC implementers to receive technical updates and also provide an opportunity for the field to ask technical leaders specific questions on VMMC implementation. The webinar has been a successful platform to link research to practice; for instance, the device webinar brought new research on the current VMMC devices to the field staff. The webinars have the ability to allow all 14 countries to log-in at the same time, learn lessons from each other, and receive key technical updates and information without having to pull people from the field.
- The PEPFAR's *Best Practices for Site Operations: A service guide for site operations* is a significant contribution to the global arena in VMMC. The comprehensive document provides details on every aspect of VMMC implementation and has been widely distributed to all PEPFAR VMMC programs. This document is yet another MCHIP-supported document that showcases MCHIP's global involvement and knowledge on VMMC. Case studies highlighted throughout the document feature many of MCHIP's VMMC programs. In addition, the VMMC training video supported through MCHIP has also been widely distributed to provide a standardized tool to be used when training VMMC providers.

On World Pneumonia Day, MCHIP Celebrates Strides against Preventable Child Deaths

Pneumonia is the deadliest disease among children under the age of five, killing an estimated 1.4 million children annually. Today on World Pneumonia Day, we not only recognize the burden of this disease, but we at MCHIP also celebrate the fact that pneumonia is preventable, and that safe, effective, and affordable tools are helping to avert and treat the disease. The Pneumococcal Conjugate Vaccine (PCV) can protect susceptible children against severe forms of pneumococcal diseases—mainly pneumonia, meningitis, bacteremia, and sepsis—and MCHIP is assisting countries in introducing this lifesaving vaccine in high-mortality countries.

In Tanzania, pneumonia accounts for an estimated 18% of deaths in children under the age of five. In recognizing the gravity of this disease, the Government of the United Republic of Tanzania will introduce the PCV-13 form of this lifesaving vaccine nationwide in January 2013 (with an official launch planned for December 5, 2012). Tanzania will also introduce the rotavirus vaccine to help protect against another major killer of children—diarrhea.

This simultaneous introduction is a major undertaking for the Tanzanian Ministry of Health and its partners. However, given the high immunization coverage of other routine vaccines throughout Tanzania for the last several years (e.g., DTP3 coverage sustained over 85%), the integration of the PCV-13 and rotavirus vaccines into this system is likely to make a significant impact in the reduction of morbidity and mortality due to vaccine-preventable diseases in children under five.

MCHIP is part of a multi-partner collaboration—which includes the GAVI alliance, WHO, UNICEF, and other organizations—that is supporting the Government of Tanzania to plan, implement, and evaluate the introduction of these vaccines. To help countries prepare, MCHIP has been providing technical assistance with applications for these new vaccines, immunization program readiness, and capacity building for health professionals to the Expanded Program on Immunization/Ministries of Health in several countries. In Tanzania, MCHIP will also continue to provide support after the launch to help further strengthen the country's routine immunization program.

Globally, MCHIP has supported the introduction of PCV vaccines in the Democratic Republic of the Congo, Kenya, Malawi, Rwanda, and Zimbabwe, and will be assisting with PCV introduction in Senegal, Uganda, and Tajikistan in the coming years. This work is part of a larger MCHIP technical support effort to ensure that new vaccines will be incorporated into a routine immunization system that can provide safe, timely, and affordable protection against some of the major contributors to child death, such as pneumonia.

This World Pneumonia Day, MCHIP acknowledges those affected by this disease, striving toward the work ahead, and celebrating our successes in preventing this disease!

MCHIP Contributes in Effort to Tighten the "Meningitis Belt": Senegal MenAfriVac Campaign

Meningitis is a less popular topic on the global health scene, but for those living in the region spreading from Senegal to Ethiopia—dubbed the "meningitis belt"—it remains a major public health concern. Meningitis is an inflammation of the meninges, the lining that protects the precious brain and spinal cord, and without treatment can lead to death or result in serious, long-term consequences such as deafness, epilepsy, and mental retardation.

Meningitis occurs most commonly in young children under 5, those aged 17–25 (who often live in close quarters like dormitories and barracks), and people over age 55. People with compromised immune systems, such as people with HIV or AIDS, are also at increased risk. As dangerous as meningitis is, it is almost always caused by an infection, usually by bacteria or a virus, and among the five types of infection, four can be prevented by immunization (Serogroups A, B, C, and W135).

Initially, only the A/C vaccine was available and, unfortunately, was primarily used in campaigns that targeted areas where meningitis outbreaks were already occurring. These reactive campaigns were expensive and ineffective. Today, a highly immunogenic and safe new vaccine—the Men A conjugate vaccine (MenAfriVac)—is available.

In contrast with the previous licensed polysaccharide vaccine, the new conjugate vaccine induces a long-lasting superior immunity, results in herd immunity, and can protect children younger than two years old, providing protection for up to 10 years. The Meningitis Vaccine Project (MVP), a partnership between the World Health Organization (WHO) and PATH, has pre-tested this new vaccine in Burkina Faso, Mali, and Niger with compelling results.

Now, MCHIP will be collaborating with the MVP to implement a MenAfriVac campaign in Senegal, targeting all children and adults from 1–29 years old from 12–21 November. The Senegalese Ministry of Health, in collaboration with MCHIP, MVP, UNICEF, WHO, and other partners, will reach into the eight regions that have the highest risk of meningitis. About 3.9 million people have been targeted for the campaign, though the mobile populations and those aged 15–29 years have been notoriously hard to reach. Health facilities at fixed sites, outreach, and mobile strategies will be used to reach the target population, focusing on those most in need. In addition, specific messages and social mobilization will be reinforced around this campaign.

MCHIP has played an active role during the preparation for the MenAfriVac campaign, including providing technical support and guidance during the planning process at regional and district levels, developing an activity monitoring checklist, and finalizing the guidelines and management tools to be used during the campaign. MCHIP will also work with partners involved to supervise and provide guidance during the campaign, as well as monitoring and evaluation afterward to assess the quality of the campaign.

This campaign in Senegal, along with the others that have taken place in the "meningitis belt," has the potential to significantly reduce the number of meningitis cases and associated deaths in the region. After the campaign in November, this "meningitis belt" may lose a few notches.

MCHIP Supports Successful Mass Meningitis Vaccination Campaign in Senegal

In November 2012, Senegal became the ninth country in the "meningitis belt" (a band of 26 countries stretching from Senegal to Ethiopia) to introduce the effective, low-cost MenAfriVac™ vaccine through the Meningitis Vaccine Project (MVP), a partnership between the World Health Organization (WHO) and MCHIP partner PATH. In countries where the vaccine has been introduced, a profound impact has been seen on reported meningitis cases[14], with no cases reported among those who were vaccinated and with dramatically reduced bacterial carriage—even among those too old to have been vaccinated.

The Senegalese Ministry of Health launched a successful two-week MenAfriVac™ campaign in November[15] in one of the area's most severely affected by meningitis outbreaks, targeting a cohort of 3.9 million people between the ages of one and 29 years old. The launch and distribution of the vaccine were a success by many measurements due to the organization and management of the processes. All districts received the required supplies in a timely manner, with special attention given to resource mobilization for eight of the 14 regions that were targeted as having the greatest need. Senegal came up with resourceful vaccine mobilization solutions by using transport means such as automobiles, bikes, motorcycles, and even carts pulled by donkeys and horses.

With vaccination campaigns typically targeting infants under the age of one, reaching 15- to 29-year-olds proved a difficult feat, and finding these hard-to-reach individuals required a well thought out and creative strategy. Imagine a taxi stand with hundreds of commuters trying to find the correct vehicle and bargaining for the right price, while drivers yell for passengers, drop them at their destination, and squeeze their vehicles in and out of a congested area.

These are the kinds of environments that campaign volunteers had to venture into to reach 15- to 29-year-olds, who are more likely to be at work than home. Campaign volunteers also visited gathering places such as markets, colleges and universities, and military camps, and district teams went to prisons, taxi stands, labor workshops, and out to the fields. All of them went the extra mile to reach the targeted 3.9 million people.

MCHIP was a key technical partner in supporting this campaign during the preparatory and implementation phases, and will continue to collaborate with the Ministry of Health and partners to monitor and evaluate post-introduction activities to assess the coverage, quality, and impact of the campaign. (Coverage will be calculated after all data have been reported from the 35 districts in which the campaign was rolled out.)

This campaign, and the process leading up to it, required careful preparation, public information, meticulous organization, staff training, logistics, community partnerships, crowd control, surveillance, and active monitoring. And yet, after only 10 days, it is complete. MCHIP and partners can breathe a sigh of relief, but not for long.

Senegal now has a lot of work ahead as they prepare to introduce a new pneumococcal conjugate vaccine (PCV) in the coming months to protect against varieties of pneumonia due to *Streptococcus pneumoniae. Once new* vaccines are introduced, they quickly become old vaccines, dependent on the same vaccination system. As people working in the world of immunization know, the work to achieve and sustain improvements in routine immunization systems and raise coverage rates is a marathon requiring steady effort, and not a sprint to an imaginary finish line.

[14] http://www.afro.who.int/en/media-centre/pressreleases/item/5116-countries-commended-for-reaching-important-milestone-in-prevention-and-control-of-meningitis.html
[15] http://www.mchip.net/node/1361

Reaching Remote Populations: What Do MCHIP, the U.S. Marines, and Crocodiles Have in Common?

In Timor-Leste, MCHIP coordinated a recent visit by the 15th United States Marine Expeditionary Unit, which arrived in-country in October for various activities, including a joint training exercise with the Timor-Leste Defense Force. This operation, dubbed "Joint Exercise Crocodilo," focused not only on military-to-military training, but also on community relations events such as school sports tournaments, book donations to schools, engineering training, and medical and dental assistance to Timorese citizens.

But where does "Crocodilo" come from? The crocodile is part of the nation's creation myth, and the island on which this small country is situated is shaped like a crocodile. The crocodile is respected as the "friendly and wise" animal, so Joint Exercise Crocodilo was a natural name for an effort to encourage defense and humanitarian cooperation between the American and Timorese people.

Timor-Leste is a post-conflict, fragile state, and many of its health and development indicators—especially immunization coverage—are the poorest in the Asian region. Seventy percent of the population is rural, with most people living in small, scattered villages isolated by mountainous terrain and poor roads. Limited access to health facilities is one of the big challenges faced by the health system; average walking distance from household to nearest health facility is about 70 minutes, and during the wet season, even short distances become impassable. As a result, outreach activities are often postponed or never occur.

The Imunizasaun Proteje Labarik (IPL) project in Timor-Leste, funded by the Millennium Challenge Corporation (MCC) and managed by MCHIP in collaboration with USAID/Dili, assists the Ministry of Health to identify and plan outreach activities from community health centers to hard-to-reach communities. In spite of what is planned, however, many times these activities cannot be executed due to bad road conditions, heavy rain, and flooding, as well as shortages of staff and operational funds for transport and per diem.

Joint Exercise Crocodilo was planned to take advantage of the U.S. Marines' helicopters and skilled professionals, which enabled services to reach communities in very remote areas. The exercise carried out 10 integrated outreach activities in five focus districts—namely Ainaro, Baucau, Ermera, Manufahi, and Viqueque—from 10–15 October. MCHIP mobilized communities through church meetings and community radio spots, and with the help of community health volunteers and staff and local leaders, who informed people that the services were coming to their village.

The U.S. Marines and the Ministry of Health offered the following services: surgery referrals to local hospitals; dental care; optometry screenings; eyeglass prescriptions; and medications for minor illnesses or injuries. MCHIP also managed the human resources, including vaccinators and translators, as well as other necessary immunization equipment to make the exercise successful.

Mr. Thomas, a health staff member of Viquequevila CHC, said, " Since independence, this is the first time we have seen such activities in such remote areas where many patients received eyeglasses at no cost, and many children [were] vaccinated."

While this exercise was successful in immunizing more than 60 children, these same children require additional vaccinations, and many more children remain unvaccinated. The ongoing challenge to the Ministry of Health and MCHIP's Imunizasaun Proteje Labarik project is to establish ways to enhance the equity of health services by reaching these poor, isolated communities on a routine basis.

The project is highly valued by the Ministry and other stakeholders. "They demonstrated capability to handle and manage such a big event," said one Ministry of Health official at the closing ceremonies. U.S. Marine Dentist Shukor described his experience, saying, "The 15th US Marine Expeditionary Unit is very happy to provide medical and dental care among the people in very hard-to-reach communities that are indeed in need. I would like to thank IPL for organizing such event and supporting us."

Joint Exercise Crocodilo was called a success by the Ministry of Health, as it promoted equity and enhanced access to basic health and immunization service while strengthening the partnership between the American and Timorese people. MCHIP's Imunizasaun Proteje Labarik was honored to be included in this work and is committed to continuing these efforts at its best.

PVO/NGO

Building Capacity of Organizations: Operations Research Workshop Facilitates Relationships between NGOs and Research Partners

Since 2008, USAID has funded nongovernmental organizations (NGOs) through the Child Survival and Health Grants Programs (CSHGP) to conduct operations research (OR). The purpose of OR is to test innovative solutions to programming challenges in the scaling-up of sustainable reproductive, maternal, newborn, and child health (RMNCH) high-impact interventions in resource-poor settings.

To ensure quality, credibility, relevance, and usefulness of the research evidence, the NGOs have partnered with researchers and other key in-country stakeholders to design and conduct these OR studies. Previous experience has shown that the collaboration between NGOs and researchers is often challenging due to differences in work approach, use of technical terms, and outlook; this necessitates dialogue regarding research questions, study design and methods, and the use of results.

MCHIP's PVO/NGO Support Team, in collaboration with USAID/CSHGP, organized a regional workshop in Accra, Ghana, from 3–5 April 2013. The purpose of the workshop was to bring research partners and program staff together to share information, learn from each other, and develop a shared understanding of expectations and collaborative relationship to implement credible and high-quality OR studies.

The meeting was attended by 36 participants representing eight CSHGP projects that incorporate OR studies in their work in six countries: Benin, Ghana, Liberia, Kenya, India, and Pakistan. The participants included program staff (OR field coordinators, project manager, monitoring and evaluation staff, and/or project headquarter backstops), research partners/principal investigators (PIs), government representatives, and USAID/ Mission staff.

Participants, including program support and research partners, as well as USAID/CSHGP and MCHIP PVO/NGO support team staff at the Ghana Regional Operations Research workshop.

Participants were surveyed before the workshop to inform the objectives and the agenda, and to assess their understanding of the OR subject and their roles in its implementation. At the end of the workshop, another survey was conducted to find out if their needs and expectations were met. Findings show that, before the workshop, most PIs did not see a need to participate since they are research experts. However, by the end of the workshop, all participants reported finding the meeting invaluable, and said they will recommend this workshop to others.

An experienced PI said: "To be honest, I was skeptical and doubtful of learning anything from this workshop, but now I have learned a lot, especially from program staff, expectations of this grant, and the overall purpose of these studies. This information will help me in working with the NGO staff to design and implement a good study."

Specifically, participants found the meeting useful in terms of building relationships and getting focused technical support on research proposals. They also felt that they benefited from peer learning—regardless of the difference in projects—and the opportunity to exchange ideas with other implementers. Attendees appreciated the opportunity for program staff to meet with their research partners face-to-face and to work together on their OR protocols, which may never have happened without this workshop. Participants also learned how to position their OR studies to contribute to policy and other local decisions, and about the need for the OR protocol to be detailed in design and analysis plans.

An attendee said: "One of the best parts of the workshop was face-to-face communication between us (program staff) and our PIs, and it has really strengthened our relationship and set the stage for ongoing collaboration in our OR study."

Another participant commented: "Definitely—this workshop has improved the relationship and partnership between [the] NGO and the researcher."

The workshop helped participants to develop an understanding of the time it takes to achieve stakeholder engagement, which has long-term advantages for the uptake of the OR results. This realization encouraged the participants, who better understood that engaging stakeholders is not only possible, but desirable— no matter how laborious and painstaking the process may be.

Most encouraging, immediately after the workshop, some of this new knowledge—the intervention impact and conceptual framework models, analysis plans, and process documentation—were already being used.

MCHIP Technical Assistance Helps Grantee Integrate Services in Liberia

Liberia's maternal and child mortality rates are among the highest in the world—with an estimated 994 women dying per 100,000 live births, and 110 under-five deaths per 1,000 live births. Moreover, there is a clear link between high child mortality rates and high fertility rates. In resource-poor settings like Liberia, increased fertility rates are also associated with high maternal mortality rates.

The good news is that family planning (FP) can save the lives of women and children by delaying motherhood, spacing births, and avoiding unintended pregnancies and abortions.[16] In Liberia, contraceptive prevalence is extremely low, with only one in 10 women using a modern form of contraception, and the total fertility rate is 5.2.

The International Rescue Committee (IRC) is implementing the Better Futures, Better Lives (BFBL) project in Liberia to reduce maternal and child mortality. The project focuses on integration of:

- Injectable contraception into the service package of community health volunteers;
- FP services into school health programs; and
- FP services into routine health services, including EPI, antenatal care, labor and delivery, and postpartum care.

The project also trains clinical staff in the provision of postpartum insertion of intrauterine contraceptive devices.

MCHIP provides technical assistance in program design, monitoring, implementation, and evaluation to grantees in USAID's Child Survival and Health Grants Program (CSHGP) to ensure that recipients have the expertise needed to implement high-quality projects. And because the BFBL project involves comprehensive, high-impact, and integrated interventions with maternal and child health, FP, and immunization components, MCHIP's technical teams have collaborated to provide support to IRC/Liberia.

The MCHIP FP and immunization teams meet regularly to provide integrated feedback and guidance to IRC on a range of technical issues to ensure that they implement the strongest possible project. One of the key components of BFBL is supervision visits to health facilities to monitor the impact of FP interventions and integration with other services. During these visits, the project is strengthening immunization services and the antigen supply chain by monitoring stock-outs and measuring the number of children who receive DPT1 and DPT3 vaccinations. This illustrates why it is important for IRC/Liberia to receive integrated technical assistance from MCHIP staff.

According to the external baseline consultant: "The opportunity to use community health volunteers for FP is a very good grass roots strategy to increase coverage roughly—particularly for people they know and trust, which is different from the clinic staff they don't know or don't trust."

With this level of integrated support on FP, MNCH, and immunization from the MCHIP technical teams as well as the PVO/NGO Support Team, IRC has been able to successfully complete its strategic framework and baseline survey, including the appropriate indicators to measure for program outcomes in each technical area.

World Contraceptive Day at James Davies Junior Memorial Hospital. (Photo courtesy of IRC/Liberia).

[16] "Family Planning Saves Lives." Population Reference Bureau. 4th Edition, 2009.

Innovation Can Increase the Impact of Immunization Programs

Robert Steinglass, Guardian Professional, Monday 10 December 2012

A child receives a polio vaccine in Mumbai, India. Photograph: Divyakant Solanki/EPA

The ultimate goal of immunization programs is to reduce morbidity, mortality, and disability from preventable diseases, but the intermediate objective is to deliver effective, safe, timely, and affordable immunization services.

But what works? And under what conditions do innovations and good practices emerge, take root, and spread? What are the pre-conditions that we should cultivate to make innovations more likely?

I recently moderated a Gavi Partners' Forum[17] workshop on 'Innovative approaches to immunisation and health delivery', held in Tanzania. The workshop aimed at finding how different approaches work.

Dr. KO Antwi-Agyei from Ghana[18], which has one of the most successful immunization programs in Africa[19], shared his experiences through a presentation on 'Making reaching every district (RED) work: an experience from Ghana.' Country director of Maternal and Child Health Integrated Program for John Snow, Inc.[20], in India, Dr. Karan Singh Sagar, talked about "Performance improvement using supervision and monitoring: an experience from India." Both discussed the relevance of their innovative intervention and how it was designed, planned, implemented, adapted, and spread.

In the Volta Lake region of eastern Ghana, for example, the health authorities have devised strategies across districts to reach distant fishing communities residing around the lake. In some urban and adjoining areas in Kenya, health staff send SMS messages to remind mothers of immunisation appointments. In India, supervision is organized in periodic pulses at district-level with results instantly analyzed, discussed, and fed back to all staff. In Timor-Leste [East Timor] and some areas of India, health staff are experimenting with a combined monitoring and health education tool called "my village is my home," which tracks newborns through completion of their vaccinations and establishes a new social norm of shared responsibility between individual families and their community.

A recent Bill & Melinda Gates-funded study by Arise[21] found that well-performing districts in Ghana, Ethiopia, and Cameroon could be distinguished from stagnant districts by having linked peripheral health services with communities in a variety of creative ways. Efforts are under way in several countries to use mobile phone technology to track vaccine supply levels and adjust re-supply accordingly. Opportunities for districts and health facilities to learn from each other are needed to accelerate replication of good practices.

I believe the ultimate innovation could be to deliberately create a stimulating culture of learning that seeks to do this! Such a culture of learning is more likely to emerge when it is inclusive of multiple perspectives, diverse disciplines, and broad partnerships, and when staff have an opportunity to learn from peers working on the same problems.

Innovation can also be thought of as a process leading to better learning of what works and how it works in given contexts. While we should more generally identify promising and proven approaches appropriate for our unique contexts, these may or may not be novel or innovative. Investments in incremental improvement in activities, processes, and products operating at scale can also overcome programme stagnation, lead to significant performance improvement, and produce value over time.

[17] http://www.gavialliance.org/partnersforum2012/
[18] http://www.theguardian.com/world/ghana
[19] http://www.theguardian.com/world/africa
[20] http://www.jsi.com/JSIInternet/
[21] http://arise.jsi.com/technical-resources

Global Action Plan for Pneumonia and Diarrhea Urges Governments and Partners to Take Immediate Steps to Achieve Impact

MCHIP joins more than 100 nongovernmental organizations (NGOs) and civil society organizations (CSOs), along with national and global experts, to express their support for the World Health Organization (WHO) and UNICEF's first-ever global action plan to simultaneously tackle the two leading killers of children—pneumonia and diarrhea. This plan, linked with ownership by national governments and partners' involvement, will make the plan a reality.

The Global Action Plan for the Prevention and Control of Pneumonia and Diarrhoea (GAPPD) provides the strategies and evidence needed to significantly reduce childhood death and illness from pneumonia and diarrhea, which together account for nearly one-third of deaths worldwide in children under age five. The Global Action Plan calls on all parties to coordinate their approach to fighting these diseases, for which there are complementary interventions to provide protection, prevention, and treatment. Having collected and analyzed the most recent evidence on the impact of pneumonia and diarrhea interventions and country practices, The *Lancet* series,[22] also released today, provides additional scientific underpinning for the GAPPD.

Lora Shimp, MCHIP Senior Immunization Technical Officer, speaks to the importance of the GAPPD and partner involvement:

"With the Decade of Vaccine commitments and recent Calls to Action for child and neonatal health globally and in countries like the US, India, Liberia and elsewhere, this is an opportune time to use the GAPPD guidance to address some of the leading causes of morbidity and mortality in children and particularly in infants under 1 year. Through efficient use of pneumococcal (PCV), Haemophilus influenzae type b (HIB), and rotavirus vaccines, vitamin A, zinc, ORS, and other commodities, we can address MDG4. This requires commitment, support and focus on implementing the GAPPD and strengthening countries' routine health systems in partnership with communities."

The world's leading NGOs and CSOs have expressed their commitment[23] to working with countries and their partners to develop country-specific plans designed to achieve the greatest impact. MCHIP was actively involved in the development of the GAPPD. Experts from the Immunization and Child Health teams participated in the Regional Workshops on coordinated approaches to pneumonia and diarrhea prevention and control (co-organized with WHO and UNICEF in the Africa and SE Asia regions in 2011) and provided technical guidance and inputs into the GAPPD strategy and document. While the launch of this document is important to spread awareness of these causes of child mortality and suggestions on ways to address them, the road ahead is to adapt the GAPPD and put it into action in countries. The GAPPD lays out a detailed path of necessary action and coordination in order for the plan to move from a document to results in lower child mortality.

Next steps among key partners must include:

National governments:

- Prioritizing the fight against pneumonia and diarrhea;
- Determining what concrete next steps, investments, and partners are needed to achieve impact;
- Identifying where needs and opportunities exist for coordination across sectors, ministries, and partners;
- Establishing transparent governance and accountability structures;
- Focusing on and dedicating resources to reducing inequities; and
- Engaging affected communities and partners and supporting their efforts to implement national plans.

Private sector:

- Committing to producing quality, affordable treatments and vaccines in child-friendly formulations and presentations that are easy-to-administer and to improving distribution to ensure these products reach the most vulnerable children;
- Developing and delivering improved water treatment and sanitation products; and
- Conducting communications campaigns to reach families and health care providers about best practices.

Bilateral organizations and donors:

- Providing technical and financial support to countries adopting the GAPPD as part of their national child survival commitments.

[22] http://www.thelancet.com/series/childhood-pneumonia-and-diarrhoea
[23] http://www.defeatdd.org/take-action/global-action-plan/ngo-statement-support

WHO and UNICEF:

- Harnessing their regional and national program staff to work with member countries on effectively implementing the GAPPD.

The launch of the Global Action Plan comes at a critical time, as the global community strives to achieve the Millennium Development Goals (MDGs) by the 2015 deadline. While tremendous progress has been made and child deaths have plummeted in the last 20 years, too many children are still dying from pneumonia and diarrhea. Simultaneously tackling these two leading killers of children will have the single greatest impact on improving child survival. While stepping up efforts to meet MDG 4—a two-thirds reduction in child deaths—those working on the post-2015 development framework must continue to prioritize integrated approaches to improving child health, as outlined in the GAPPD, and set goals for expanding access to health care, safe water, and sanitation.

Collectively around the world, we owe it to our future generation to protect these most vulnerable children from diseases and illnesses that can be prevented and treated.

MCHIP Contributes to Decade of Vaccine Supplement in Journal *Vaccine*

To showcase recent developments and new directions in global immunization, the peer-reviewed medical journal has published a special supplement this month on the Decade of Vaccines (DoV)[24]. The vision for the DoV is a world in which all individuals and communities enjoy lives free from vaccine-preventable diseases. The "roadmap" for achieving this vision is captured in the Global Vaccine Action Plan.[25] As we move into the third year of the DoV, this new supplement to encourages the conversation around this major topic.

Five MCHIP staff members co-authored articles that contribute to this global discussion. Rebecca Fields (MCHIP Senior Technical Advisor), Manish Jain (MCHIP/India), and Karan Singh Sagar (MCHIP/India)—together with Alya Dabbagh (WHO)—authored the article "Moving Forward with Strengthening Routine Immunization Delivery as part of Measles and Rubella Elimination Activities."[26] While there have been debates for decades about whether mass vaccination campaigns (sometimes known as supplementary immunization activities or SIAs) have a positive or negative effect on routine immunization, this paper explores whether measles-rubella SIAs can be used to help address specific challenges to routine immunization. It emphasizes the need to take action before, during, and after the SIA to bring about lasting improvements for routine immunization and the need to assign clear responsibilities for work in this area.

Robert Steinglass, MCHIP Immunization Team Leader, co-authored the article "Applying an Equity Lens in the Decade of Vaccines"[27] with Lara Brearley (Save the Children), Rudi Eggers (WHO), and Jos Vandelaer (UNICEF). Emphasizing the importance of addressing the inequities in immunization, this article sets forth an agenda for closing the equity gap by using tools and approaches that are largely available now and increasing the political will needed to reach the unreached. Doing so will be critical to achieving the ambitious goals set out by the DoV.

As a member of a WHO ad hoc working group to the WHO Scientific Advisory Group of Experts examining the effect of new vaccine introductions (NVIs) on immunization and health systems, MCHIP Senior Immunization Technical Advisor Mike Favin co-authored the paper, "New vaccine introductions: Assessing the impact and the opportunities for immunization and health system strengthening."[28] The paper describes how there is no simple, unequivocal answer to the question of whether NVIs have a positive or negative effect on immunization and health systems; rather, their effect is a function of the existing health system context, the characteristics of the vaccine in question, and the preparations undertaken.

While these articles address specific topics, they share a common emphasis: the importance of the routine immunization system and the need for it to be sufficiently strong to achieve universal coverage with all vaccines for all people. These articles call for a perspective on immunization that extends beyond just vaccines or campaigns for certain diseases and rather calls attention to the importance of the health care system that delivers these vaccines. Therefore, the coming years are truly the "Decade of Vaccines."

[24] http://us4.campaign-archive1.com/?u=b8850f7ac388c1b2675eb77fd&id=b2da64cc93&e=8cf96df365
[25] http://www.dovcollaboration.org/action-plan/
[26] http://www.sciencedirect.com/science/article/pii/S0264410X12017458
[27] http://www.sciencedirect.com/science/article/pii/S0264410X12017392
[28] http://www.sciencedirect.com/science/article/pii/S0264410X12015927

In Timor-Leste, Drivers Become Valued, Contributing Members of Technical Teams

The scene: a crowd gathers in a remote mountain village, one that is often unreachable by motor vehicle, but which today is visited via helicopter by medical staff from a U.S. Marine Expeditionary Force, along with local health staff. The village—a community in Hauteo sub-district, Ainaro district—is located in one of the world's newest, smallest and most isolated countries: Timor-Leste (East Timor).

Among the crowd is a mother with two young children, one of whom is two years old but unable to walk because of a deformed leg. She has brought her children for medical consultations, but the local health workers say that neither child has received any vaccinations because the father refuses, having heard stories of children who became sick from them.

Two of the visitors go to talk with the children's father. One is burly and tanned, a large man by Timorese standards; the other is slim, of average height, with a sporty mustache. The two men do not have the manner of medical professionals and, in fact, are not—they are drivers for the foreign assistance project that works with the Ministry of Health to strengthen immunization services and coverage. The drivers, Antonio and Jose, finally convince the father to allow the children to be vaccinated, and the vaccinations are given.

This is not an unusual intervention by drivers from the Imunizasaun Proteje Labarik (Immunization Protects Children, or IPL) project. Over the project's two years of operation, all seven project drivers have received training and encouragement to develop their skills and to participate. In addition to their driving and vehicle maintenance responsibilities, they have become active, contributing members of the field-based technical teams.

An IPL driver works with an IPL technical officer and a local leader to update a monitoring tool. (Photo courtesy of JSI.)]

Particularly during integrated outreach and child health activities, the drivers mobilize people to bring their children, screen child health booklets to see which children have vaccinations due, help weigh children, and assist local health volunteers with such tasks as recording vital data. They also counsel individual mothers and fathers on such topics as vaccination, breastfeeding, nutrition, and handwashing, and—along with professional health workers and trained community volunteers—give health education talks and answer questions.

They support a project initiative in which local volunteers and leaders keep a list of all of the community's infants and their vaccination status, so that any child who falls behind will be noted and visited. Drivers participate in supportive supervision visits to community health centers, in particular, advising the local health staff about proper recording and reporting of vaccinations. Some drivers also serve as "masters of ceremony" for orientations that IPL provides for local leaders. They often take photos of program activities.

How were IPL's seven drivers transformed from their traditional roles—as drivers who dozed or chatted while the technical work was going on—to active members of the technical teams, whose contributions are highly praised and appreciated by both technical health staff and community members? The idea in Timor-Leste seems to have germinated in the head of the IPL project director, a Bangladeshi doctor who had worked for an NGO in Bangladesh that gave its drivers additional duties.

There was no grand plan in Timor. Although the drivers received formal training from the USAID Mission on taking photos and making videos, they picked up most of their new skills and abilities by observing in the field and learning from technical staff on the job. Over time, the drivers were given more responsibilities and grew more confident, while the technical staff became increasingly appreciative of their contributions.

Today, as the project is entering its final six months, the seven drivers have learned computer skills and are lobbying for English classes. They participate actively in IPL's monthly staff meetings, first contributing to the technical team's reports and later reporting on vehicle (traditional driver) issues. Some have begun submitting their expense forms via email. These drivers feel like respected members of the project team, and at home they report playing a much more active role in the care of their own children, and have become advocates for immunization among their neighbors and relatives.

It may be premature to say that providing opportunities for support staff such as drivers to enhance their capabilities and contributions should be done routinely in development projects, but it is fair to say that it should at least be considered. What can be said confidently about IPL's experience is that it has been a win-win-win situation. The drivers' expanded horizons have benefited the drivers themselves, their technical colleagues, and the project as a whole, as well as the communities and children where IPL works.

An IPL driver facilitates training on the community monitoring tool. (Photo courtesy of JSI.)

FIELD-FUNDED

Basic Emergency Obstetric and Newborn Care Training in Ghana Builds Confidence to Save Lives

27 June 2013

During an afternoon shift in the maternity ward where she works, Evelyn Bash-Amankwah, a midwife and preceptor from Mampong Municipal Hospital, was called upon to supply more gloves.

"When I reached the labor ward, I saw that a woman had just delivered but she was bleeding," Evelyn said. "I asked the midwife who had conducted the delivery about this and she explained that as soon as the placenta was delivered, she started bleeding."

Evelyn then asked to examine the placenta and found that there was a missing lobe and, therefore, a high probability that there were retained placental products. "I immediately remembered what I learned in my training and started acting to stop the bleeding," she said.

Evelyn is referring to the MCHIP trainings she received in Basic Emergency Obstetric and Newborn Care (BEmONC) and training skills. The Program is strengthening the skills and competencies of tutors and their students at 38 schools in Ghana. At these schools—for community and public health nurses, medical assistants, and midwives—current best practices are being taught regarding HIV/AIDS, tuberculosis, malaria, family planning, and newborn resuscitation. Providers are also learning to address stigma and discrimination in their work. In addition, MCHIP is working with targeted midwifery schools to equip their skills labs, and strengthen preceptors' clinical skills and teaching competencies.

During both of the trainings she attended, facilitators were impressed with Evelyn's enthusiasm for improving her skills. Shortly after, she received a follow-up visit from MCHIP Senior Technical Advisor Martha Appiagyei to provide supportive supervision and mentorship.

And on this day, Evelyn's new skills yielded lifesaving results: "This was a very encouraging experience for me and I know that without the training I received, I would not have been able to save this woman's life. I am proud of myself for managing this so confidently," she said.

Evelyn's story illustrates the importance of building confidence and clinical competence. Service providers need to put their knowledge into practice when it is needed most.

After successfully removing the retained placental products from the patient, she administered oxytocin through the drip and performed uterine massage. Nevertheless, the woman continued to bleed. "I then applied the clinical decision-making skills that I learned and decided to progress to performing internal bimanual compression," Evelyn said. "After 20 minutes of compressing the uterus, when I released the uterus gradually, I found that the woman was still bleeding, so I instructed an assistant to prepare for conducting an aortic compression."

Evelyn also called for the doctor and blood was taken for grouping and cross-matching. When her assistant's technique was not effective, Evelyn took over and, after another 20 minutes, she assessed that the bleeding had finally stopped.

Following a blood transfusion and observation in the ward for three days, "both mother and baby were discharged home in a healthy state," Evelyn added, happily.

Evelyn Bash-Amankwah during a follow-up supportive supervision visit. (Photo courtesy of Jhpiego.)

Jharkhand Hosts State Consultation on Improving Maternal and Child Health

11 September 2013

USAID's Dr. Nancy Godfrey addresses participants during the consultation. (All photos courtesy of MCHIP.)

To accelerate progress toward attaining Millennium Development Goals 4 and 5—and to reduce under-five mortality per the Call for Action Initiative[29]—the Government of India (GOI) has prioritized 184 districts across the country's 29 States for focused maternal and child health interventions. These poor performing areas, known as High Priority Districts (HPDs), include 11 districts in Jharkhand, [30] a State that has become critical to the implementation and realization of this Reproductive Maternal Newborn Child Health + Adolescence (RMNCH+A) approach.

RMNCH+A employs a novel mechanism whereby development partners are assigned States for coordinating activities. In Jharkhand, USAID has been identified as the State Lead Partner (SLP), with a USAID-MCHIP team coordinating the State's activities. And to fast track the implementation of this approach, the Government of Jharkhand (GOJ) in collaboration with USAID organized the recent "State Consultation for Intensification and Harmonization of efforts in High Priority Districts for improved Maternal and Child Health outcomes."

Above from left to right: Dr. Sumant Mishra, Director Health Services, GOJ; Dr. Praveen Chandra, Director in Chief, GOJ; Dr. Manish Ranjan, Mission Director, NRHM, GOJ; Dr. Rakesh Kumar, Joint Secretary (RCH), GOI; Dr. V.S. Salhotra, Deputy Commissioner (RCH), GOI; Nancy Godfery, Director Health Office, USAID/India; and Dr. Genevieve Begkoyan, Chief of Health, UNICEF/India.

The July 19th event provided a critical platform to discuss and deliberate on child survival and development in the State. Attended by about 200 delegates, participants represented a spectrum of health policy planners and implementers. This included participants from the Ministry of Health and Family Welfare, deputy commissioners of four HPDs , state and district health officials from GOJ, national and state level RMNCH+ A experts from development partners, civil society members, nongovernmental organizations, medical colleges, and professional medical bodies such as the Indian Medical

Association. GOI was represented by a high-level delegation, with Dr. Rakesh Kumar (Joint Secretary [RCH], Ministry of Health and Family Welfare) leading the discussions and deliberations.

Dr. Kumar (photo right) provided an overview of the RMNCH+A strategy, emphasizing the need for a comprehensive approach and technical harmonization among the partner organizations. The strategy puts forth the need for a holistic approach that includes not only increasing coverage of key child survival interventions, but also the related social

[29] http://www.who.int/pmnch/media/ news/ 2013/20130207_call_to_action_india/en/index4.html
[30] The GOI has identified 11 such HPDs: Dumka, Godda, Gumla, Latehar, Lohardaga, Pakur, Palamu, Sahibganj, Saraikela, Simdega, and West Singhbhum in Jharkhand.

determinants such as girls' education, adolescent health, maternal under-nutrition, and environmental factors, he said.

Dr. Manish Ranjan (photo right), Mission Director of the GOJ's National Rural Health Mission (NRHM), spoke about the progress and challenges of RMNCH+A in the State. Jharkhand has demonstrated steady progress in curbing child deaths, he pointed out—with both the infant mortality rate (38/1,000 live births) and neonatal mortality rate (24/1,000 live births) being lower than the national average (44/1,000 live births, and 31/1,000 live births, respectively). Similarly, the rate of decline of the under-five mortality rate (U5MR)—55/1,000 children in age group 0–5—has been faster than the other Empowered Action Group (EAG) states. During 2011–2012, Jharkhand's U5MR declined at an average rate of 6.8%, from 59 in 2011 to 55 in 2012. Moreover, the rural-urban gap in child mortality has narrowed, reflecting improved equity in health care. However, despite this current progress, nearly 19,000 neonates continue to die within the first 28 days and 30,000 infants die within one year. The State also has wide inter-district variations in health indicators, with the 11 HPDs faring poorly across the spectrum.

Dr. Nancy Godfery, Director of USAID/India's Health Office Sector, stressed the need for partnership building and development partners to come together to support the GOI in their shared goal to reduce maternal and child deaths. And Dr. Genevieve Begkoyan, UNICEF's Chief of Health for India, spoke about the role of UNICEF in providing assistance and support to GOI for implementation of the RMNCH+A strategy in the State.

During the consultation, the Deputy Commissioners of Dumka, Godda, and Simdega districts, and the Civil Surgeon of West Singhbhum, presented on the existing challenges on RMNCH+A and the intervention measures to be adopted for effective implementation of the strategy in the districts.

A highlight of the event was the release of the "Jharkhand Child Survival Score Card"[31] developed by the GOJ with technical support from USAID-MCHIP. Modeled on the National Child Survival Score Card, it provides a comprehensive review of performance of the districts based on Annual Health Survey data across 9 outcome and 12 process indicators encompassing the life cycle approach. Interestingly, the ranking system introduced in the Score Card brought forward the fact that all the HPDs were clubbed together in the bottom half, thus further underscoring the need for focused and specific intervention in these areas.

The consultation provided a platform for the launch of the RMNCH+A strategy and presented a historic opportunity for the State to foster and accelerate progress in reducing childhood illness and death.

[31] http://www.mchip.net/sites/default/files/mchipfiles/report%20card.jpg

A "Precious Life" Is One of Many Saved by MCHIP Training in Jharkhand, India

By Dr. Syed Belal, MCHIP/India

Amina and Lukhman with their daughter, Razia. (Photo courtesy of MCHIP.)

Palojori, India—Alima and Lukhman will never forget the day a skilled birth attendant (SBA) saved the life of their daughter, Razia. It was not always certain that their daughter would survive after her birth at the Primary Health Centre at Palojori, but thanks to Manju Devi, an SBA trained by MCHIP in essential newborn care and resuscitation, their story has a happy ending.

When Alima's labor pain started, a community health worker brought her to the facility. This was Alima's second pregnancy, and it had gone smoothly so far. However, when she gave birth, the newborn did not cry or breathe.

Manju, who was assisting the delivery, quickly took action. She informed Alima of the situation, cut the baby's cord, and started resuscitating the newborn. And when simulation and suction did not work, she used a bag and mask for resuscitation. Thanks to her skilled efforts, little Razia started crying after a few seconds. A precious life had been saved!

Alima and Lukhman come from Dumaria village, which falls in the Palojori block of Deoghar district. Palojori is one of the remote blocks in Deoghar, situated nearly 65 kilometers away from a main town. A tribal dominated population with subsistence farming as its main occupation, much of the workforce migrates to other states in search of jobs. It has its only Primary Health Centre at Palojori, which serves a large population. It was recently upgraded to a Community Health Centre.

Palojori CHC was identified as one of MCHIP's demonstration sites and, since October 2011, a number of capacity-building activities have been undertaken. These efforts were made to establish the center as a learning site for high-quality newborn care and other health services—not only for the district, but for the entire state of Jharkhand.

The training for providers includes essential newborn care and resuscitation, followed by regular supportive supervision to ensure that they have acquired mastery over the newly acquired skills. It was due to this training that Manju knew exactly what to do when Razia did not breathe after birth.

All the staff members (auxiliary nurse-midwives) who conduct deliveries are trained in essential newborn care, including hands-on resuscitation practice on baby mannequins and regular practice sessions at skills stations. This mentoring support helps them gain the necessary confidence to do resuscitation procedures whenever required.

Today, Razia—whose name means "the chosen one"—is healthy and thriving. A coy smile appears on Alima's face as she carries her precious baby in her lap and describes in her own language how she and her husband have cared for the three-month-old to help her grow and stay healthy. Razia was brought to the CHC for a follow up visit by her parents, where the provider reassured them that all is well with their baby.

And Razia is not alone. Many more babies are getting a second chance at life with the help of the trained providers at Palojori CHC. Between November 2011 and September 2012, 20 babies were helped to breathe through simulation, suction, or bag and mask.

These trained providers are now encouraging their peers to learn and deliver. Their stories of success are spreading to the community, slowly motivating members to come for institutional deliveries. There is a growing confidence that in case of any emergency, the staff at the facilities will save their babies.

Tamina Bibi and her husband Majid decided to give birth to their first born at the facility and are glad they did:

"We are happy that we took the decision to go for the delivery at the hospital. Had we opted for a home delivery, we could have lost our only child as the traditional attendant would surely have declared our child dead as he did not cry at birth and did not breathe either. It is only due to the machine used in the hospital that we are able to have our first child after 12 years of marriage!"

Family Planning Counselor in India Helps Women Avoid Her Own Hardships

By Indrani Kashyap, MCHIP/India

Chandra Bisht lets a woman touch and feel a demo IUD to explain it better. (Photo courtesy of Jhpiego.)

Haldwani, India—Nineteen-year-old Kamala[32] came to the Haldwani Women's Hospital looking for Chandra Bisht, the hospital's family planning (FP) counselor. "She was carrying her nine-month-old in her lap, and the moment I helped her sit, tears started rolling down her eyes," recalls Chandra.

Worry and fatigue clearly written on her face, Kamala said she was pregnant again and her husband, the sole earning member of her family, had been out of a job for many months. In her position, Chandra has seen many such cases—of women becoming mothers too early, of repeated pregnancies, and of a complete lack of awareness about the risks of closely spaced pregnancies on the health of mothers and children.

"This is a government hospital and most of the people who come here are poor, with little or no education. The need to counsel them on the benefits of postpartum family planning (PPFP) is very high," Chandra said.

She spoke to Kamala and her husband about various FP methods that they could use immediately after Kamala gave birth. This would give her control over her own fertility, Chandra said, preventing her from getting pregnant again unless she wished to, and giving her the necessary time to heal and focus on her family. She discussed the benefits of the postpartum intrauterine contraceptive device (PPIUCD), a safe and long acting (up to 10 years) FP method, which can be inserted immediately after delivery. A reversible option, the PPIUCD can also be removed whenever required.

"I assured [Kamala] that if she faced any problems, I would be there to help," Chandra said, noting that the couple chose to use a PPIUCD after their discussion. "I feel happy when a woman so in need of FP gets convinced and adopts an FP method."

Chandra was hired and trained by USAID's flagship Maternal and Child Health Integrated Program (MCHIP) to strengthen PPFP services in India. In the state of Uttarakhand, 13 other counselors were also hired and trained in counseling skills, and have made a tremendous impact on the uptake of PPFP services where they are stationed. This success prompted the State government to employ these counselors under the National Rural Health Mission (NRHM), and now 13 additional counselors have been hired and are being trained by MCHIP.

In less than two years as a counselor at the hospital, Chandra is changing the perception of PPFP, proof that good counseling can have a positive impact on FP uptake. During her tenure, the number of women at the hospital accepting PPIUCDs every month has increased from an average of 29 to 81. Those who know her give much of this credit to Chandra's abilities to listen well—to the women themselves as well as their families—and to communicate in the local language. And because the Women's Hospital at Haldwani is surrounded by mountains, many women come only for delivery and not during the antenatal period. Therefore, Chandra takes every opportunity to communicate with women and their families about PPFP each time they come in.

"If a client gets followed-up well, she will talk about her positive experience to her family and friends. Such feedback will increase the demand for PPFP, including PPIUCD, as these women would listen to a satisfied client more than us," she said.

And Chandra understands these women's needs and concerns well. She grew up in the same district and faced many of the same challenges in her own life: "I got married very early, right after high school and became a mother soon after. My marriage broke down and I had to return to live with my mother. I had to face several hardships. I had the responsibility of this little child and no source of income. I educated myself while doing odd jobs and eventually became a teacher."

Chandra's own hardships have made her determined to help the women of her community live better lives. And many other FP counselors who come from humble households feel similarly. At a recent State gathering, one such counselor said: "We get to know the lives of the women in the community and the challenges they face on a daily basis more closely.

[32] Name changed

Counseling these women to adopt FP methods that will help improve their conditions has increased our self-worth."

The Indian Government is recognizing the important role that counselors play in providing information and helping women and their families to understand the health benefits of FP. As a result, the Government is now expanding their scope of work across the country to include other important areas of maternal and child health.

Ms. Anuradha Gupta, Additional Secretary and Mission Director, NRHM, Government of India writes: "It has been observed that good practices related to mothers, newborns, child health and family planning are adopted and continued when clients make decisions by themselves based on accurate information. Effective counseling is a means, which empowers clients to seek what is best for them and to exercise their rights to good quality maternal, newborn, child health, and FP services."

It takes many factors to make a success of a public health program. In India, where more than 55,000 women die due to childbirth every year, and where more than 1 million babies die before reaching their first birthdays, strengthening PPFP services has become a major health priority. And counselors like Chandra are playing an increasingly vital role in helping women and their families get the information they need to improve their lives.

Market Contraceptive Program: Expanding Family Planning Services Outside of the Health Facility in Liberia

By Comfort Gebeh, Marion Subah, Nyapu Taylor, and Alishea Galvin

Marwo Weagai, a Grand Bassa Market family planning peer provider. (Photos courtesy of Jhpiego.)

Grand Bassa County, Liberia—In the past, if a woman of reproductive age in Grand Bassa County was interested in learning more about her family planning (FP) choices, the only option was to travel to the health facility and wait for hours to see the health care provider. Most Liberian women are too busy supporting their families to take the time to receive counseling on FP methods even though they may be interested. According to the latest Demographic Health Survey (LDHS 2007), the contraceptive unmet need in Liberia is 36%, with a total fertility rate of 5.2. Moreover, the maternal mortality rate is 994/100,000—one of the highest in the world.

With funding from USAID, MCHIP has been working to increase FP services in Liberia since 2010. In addition to strengthening the skills of FP providers and integrating FP and immunization services at selected health facilities, the Program is looking to identify effective approaches to increase FP services and awareness through community-based distribution.

The Market Contraceptive Project aims to increase access and utilization of FP services—counseling, contraceptive distribution, health promotion, and referrals—in market settings through volunteer market vendors who are trained to be FP peer providers. In Grand Bassa, the training focused on increasing awareness, providing condoms, referring new clients for counseling and methods, and refilling supplies of pills for continuing acceptors without problems. The peer providers are linked to nearby health facilities for supplies, reporting and client referrals. In Buchanan, MCHIP has trained 22 market FP peer providers in four markets in Buchannan city and one in Compound Three District, Grand Bassa County.

Marwo Weagai, a Grand Bassa Market FP peer provider (see photo below), was candid about her misperceptions and lack of knowledge related to FP: "I like and enjoy this program, because it has increased my knowledge on family planning." She says this program is so important that she has continued to champion her knowledge on FP methods outside the market by speaking with her female peers, who then visit her in the market for contraceptives.

By the age of 18 years, 48% of Liberian girls have begun having children (LDHS 2007), and this percentage could be higher in some counties. For instance, according to the UN 2008 Common Country Survey, Grand Bassa County has a teenage pregnancy rate of more than 68%. Among all women of childbearing age, 25% of deaths are associated with maternal complications. Thus, consistent access to FP services can save lives.

Marwo says, "This makes me feel very good, because I am helping my country to reduce the teenage pregnancy, prevent women from dying because of childbirth since many women and girls are having children too soon and too close . As I speak to you, because of the program, I have counseled all my younger sisters and they have accepted an FP method. Every morning, when I come and put my market on the table, I go around talking to my peers on FP, those who are interesting and are continuous users come for refills, and new clients are encouraged to go to any government health facility of their choice for FP services."

Clients and members of the Marketing Association discuss the program with MCHIP staff.

During a supportive supervision visit at the Monrovia Junction market in Buchanan, two satisfied clients came to thank MCHIP staff for this market contraceptive program: “We are grateful, because this program is really good for us. It helps us to space our children and it also makes it easier for us to get our refill without take much of our time because we are busy people.” Other market FP peer providers have noted that the program is helping women to prevent unwanted pregnancy and unsafe abortion.

There are a total of five markets in Grand Bassa—four in Margibi and eight in Montserrado—that are participating in the program. To date, the market contraceptive program has served more than 1,500 clients in Grand Bassa, Margibi and Montserrado markets through this approach.

MCHIP’s support to this intervention included training market peer providers and Ministry of Health and Social Welfare health facility providers, ongoing supportive supervision, and data collection for routine monitoring.

MCHIP Prepares Students in Lesotho for "Real Life" Conditions through Clinical Placements

Tsepiso Jomane decided to become a nurse as a girl when she witnessed firsthand the shortage of nurses in the community where she grew up. "When my grandmother fell ill, we took her to the local clinic," she said. "She was discharged before she regained her health due to a shortage of staff and space in the clinic. She had ulcers and was unable to care for herself, but she still had to leave."

The 21-year-old is now a third year student at Lesotho's Roma School of Nursing, located about 34 kilometers (21 miles) from the capital. And as a student at one of four nursing schools in the country supported by MCHIP, Jomane was chosen to participate in a rural clinical placement.

MCHIP places nursing and midwifery students like Jomane in primary care clinics to strengthen their capacity through exposure to "real life conditions," with an emphasis on having students gain experience in clinical decision-making. Traditionally, high numbers of students have been placed in district hospitals for their clinical rotations, which has contributed to a lack of a varied clinical experience. Moreover, the lack of rotations in more rural settings has resulted in low community health skills and test scores among senior students.

In addition, many of these health centers experience challenges in recruiting and retaining nurses. By exposing and preparing students for these health centers roles, MCHIP and partners hope graduating nurses will be confident in their work and more willing to be recruited and retained in these essential positions.

Jomane was placed in rural Nazareth Clinic for a month-long clinical placement. "The experience was valuable because I got to see all corners of health services. I worked in pharmacy, immunization, HIV counseling and treatment, and the under-five clinic," she said. "The experience was difficult, but worth it. I learned to be independent. When there's a problem, I had to know how to act. There was no doctor to call, no one to refer to. Now when I see a patient, I feel I immediately have a plan of action instead of waiting for someone else. This experience has given me the power to take care of people."

Jomane also noted a deepened relationship with her peers, preceptors, and patients: "One of the biggest growth experiences I had was the new relationships I formed with clinic staff, who became my supporters, coaches, and teachers."

When asked what she plans to do after graduation, Jomane said without hesitation that she plans to find a job at a rural clinic. "I've learned that I really like working with the community," she added. "During my clinical placement rotation, I led a community health education group. I was able to create a safe space for people to talk about how HIV had impacted their lives. I feel confident now that I can help people."

Nursing student Tsepiso Jomane at Roma College of Nursing.

To date, a total of 205 students (including nurse assistants, general nurse students, and midwife students) from the MCHIP-supported nursing schools have been exposed to primary health care clinical placements. In an initial evaluation of the placements—conducted to guide improvement for the next academic year—82% of the students stated that the placements enhanced their clinical skills, and 81% said the experience has made them feel confident working in a (rural) primary care clinic.

In the 2013–2014 academic year, MCHIP and these four schools will support an estimated 60 nursing assistant students, 244 general nursing students, and 101 midwifery students (for a total of 405 students). And while a continued goal of these clinical placements is to ensure that students meet their clinical learning competencies, a wonderful benefit has been the increased interest among graduates in accepting rural clinical placements.

Culturally Sensitive Approach to Male Circumcision Reaps High Demand in Lesotho

By Delia Helie, Peace Corps Volunteer attached to Jhpiego/Lesotho

Walking up to Carewell Clinic, I see scores of men and adolescent boys sitting outside under the sun, standing in small groups under tents, and purchasing fruit and sweets from the vendors who have set up outside the facility. All of these men and adolescents are here for the same reason—voluntary medical male circumcision (VMMC) for HIV prevention.

Inside the clinic, a line of men and adolescent boys is sitting quietly. I approach a well-dressed man in a sea of uniformed high school students. His name is Hlalele and he is just beginning the VMMC process. He has already gone through related group and individual counseling and is awaiting his screening, after which he will undergo the VMMC procedure.

The 24-year-old man grew up in Lesotho's capital, Maseru, completed high school, and now works as a waiter at one of Lesotho's large hotels, a job that he enjoys very much. However, on the advice of his older brother, he has taken the day off to visit Carewell Clinic for the free VMMC services offered through the Lesotho Ministry of Health (MOH) and MCHIP. Jhpiego implements MCHIP's VMMC program with funding from PEPFAR.

"My brother came to Carewell and got circumcised. He said the doctors and nurses did a good job and it decreases the chances of getting HIV and it will be easier to keep myself clean. And my brother said it was a good service that wasn't too painful," he says confidently.

Hlalele is one of hundreds of men and adolescent boys seeking VMMC services daily throughout Lesotho. In contrast to other countries—where rapid scale-up of circumcision services has encountered problems due to lack of demand, cultural sensitivities, or insufficient integration with existing health systems—the MOH and MCHIP have implemented a step-by-step approach that is proving successful. In just 18 months, 33,000 men have been medically circumcised, with continuous demand for services. Through strong leadership from the Lesotho MOH, the MCHIP VMMC program works within the existing health system, and respects cultural sensitivities regarding traditional rites of initiation to adulthood. This approach has been the key to the program's success.

To meet the high demand for services, the MOH and MCHIP have opened 13 facilities, including at MOH, Christian Health Alliance for Lesotho (CHAL), and private facilities in eight of Lesotho's 10 districts. All doctors, nurses, and counselors providing VMMC participate in a two-week training on the WHO/UNAIDS/Jhpiego manual for male circumcision using local anesthesia. Service provision is available two days a week (including Saturdays) in nine facilities, and daily in four high-volume sites.

With the success of the VMMC program, MCHIP has committed to ensuring high-quality, comprehensive services for all men and adolescent boys in Lesotho. These services include provision of HIV prevention messaging and condoms, linkages with care and treatment, and additional sexual and reproductive health education.

Moreover, VMMC uptake in Lesotho has the ability to change the course of the epidemic: modeling shows that for every five male circumcisions completed, one infection will be averted and millions of dollars are saved in care and treatment costs. The challenges now are keeping demand high and fully integrating VMMC into the national HIV prevention plan.

Before Hlalele went in for his screening, he proudly expressed his wish for all Basotho men to be circumcised: "It is temporary pain that will benefit all men. All men should do it!"

Photo by Diego Garcia

Hlalele, a beneficiary of Jhpiego's VMMC program.

Mothers in the Philippines Space Births to Address Unacceptably High Maternal Mortality

By: Donna Miranda, MCHIP/Philippines

"If I didn't know that I could use family planning (FP) right after giving birth, I would have kept worrying about getting pregnant again soon," says Gladys Bulawan, a 20-year-old first-time mother who lives with her sister in Batangas City.

"Seeing [my sister] barely managing with four kids I could see how hard it is to raise a child. Even while I was still pregnant, my husband and I decided that it's best to plan our family early that is why I decided to have an IUD immediately after giving birth."

By considering FP, Gladys and her husband have made a critical, healthy choice for their family. In the Philippines—where maternal mortality *increased* from 162 to 221 between 2006 and 2011[33]—a major contributor to the high number of maternal deaths was lack of access to effective FP services.

Compared to its neighbors in Southeast Asia, the country faces unique challenges with respect to policy and political support for FP and reproductive health services. One of the gaps identified is the lack of access to contraceptive choices, particularly long-acting or permanent methods available immediately postpartum. This is especially true for many Filipino women living in low-resource settings who have limited access to health facilities and resources to avail of quality health care. Use of immediate postpartum IUD (PPIUD) and tubal ligation are indeed viable options for women who want to space or limit child bearing since it could be made available while women are still in the hospital or birthing facility.

To address this gap, MCHIP is working with the Philippines Department of Health (DOH) to create an enabling environment for postpartum FP/IUD (PPFP/PPIUD), and to establish resources and capacity for service delivery and training for PPFP/PPIUD adoption and scale-up. The Program works in 10 geographical areas to develop Centers of Excellence (COEs) as model service delivery sites that offer postpartum FP services, including PPIUD, and act as technical/training resource for the Centers for Health Development (regional DOH offices). The COEs were selected by the DOH and are strategically located to provide coverage to the three island regions in the Philippines. All sites have high-volume delivery hospitals with interest, capacity, and commitment to integrate IUD with postpartum services.

[33] 2011 Family Health Survey.

As a result, by August 2013:

- More than 80 service providers trained in PPFP/PPIUD;
- Over 3,000 PPIUD insertions performed by MCHIP-trained providers, helping to fill the gap in unmet need for FP by increasing access to women in postpartum; and
- Over 88,000 women receiving essential maternal, newborn and child health services with integrated FP services.

Batangas Medical Center (BatMC) has been identified as one of the most promising COE candidates, and MCHIP has worked for the past two years to help staff integrate PPFP services into their existing essential maternal and child health program. The facility's success is attributed to the commitment of BatMC's providers and leadership to adopt and scale-up PPFP/PPIUD services in their facility. Key to the demand for PPFP services at BatMC are the availability of round-the-clock services, effective counseling of mothers from pregnancy through the postpartum period, and positive "word of mouth" stories spread by mothers in the community.

Photo: Gladys Bulawan with her first born. (courtesy of Jhpiego)

Gladys learned about the PPIUD at a weekly class for mothers routinely conducted at her local health center. She discussed the FP option with her husband, who agreed with the decision to use a PPIUD. Since the adoption of PPFP-PPIUD services at BatMC, other DOH-retained facilities such as barangay health centers in the locality have been actively informing mothers like Gladys of other long-

acting reversible FP methods now available to them. Gladys is just one of the mothers in Batangas City who decided to give birth at BatMC because of the she wanted to use PPIUD.

"Now, I am assured that I can give my baby all the attention, care, and support that he will need in the first three to five years of his life," she says. "When he turns five, I plan to get a job so that I can help out with the family's finances. I was told by my doctor that I could have the IUD removed anytime I feel like I'm ready to have another child."

In Rwanda, Greater Availability of Misoprostol Prevents Postpartum Hemorrhage and Saves Lives

by Dr. Musoni Pascal, Beata Mukarugwiro, and Susan Moffson

Ephiphanie with her daughters: 9-month-old Patiente and 3-year-old Lea. (Photo courtesy of Jhpiego.)

Twenty-five-year old Epiphanie felt her labor begin and immediately called Immanaculee, the community health worker (CHW) assigned to 100 households in the Bugosa village in the Gakenke district of Rwanda. Immanaculee had educated Epiphanie on the importance of regular prenatal care visits and encouraged her to deliver at the health center. These were key messages the CHW had been taught by trainers from USAID's flagship Maternal and Child Health Integrated Program (MCHIP). Since 2009, MCHIP-trained CHWs have been teaching women like Ephiphanie that their odds of a safe delivery are much better in a health facility (with a midwife or doctor) than at home, where they often don't have access to essential medicine or trained assistance when complications arise.

Soon after she received the call, Immanaculee accompanied Epiphanie on the hilly five kilometer (more than three mile) trek to the health center. Because the contractions were coming very quickly, they decided it would be quicker to walk instead of waiting for local transport, which is a makeshift hammock carried by four men. But the baby would not wait. So Immanaculee found a hidden area along the way and covered the spot with the colorful cloths traditionally wrapped around women's waists. There, she helped Epiphanie deliver a healthy baby girl who she named Patiente.

Right after the baby was born, Immanaculee remembered the training she had received from MCHIP and gave Epiphanie three tablets of a lifesaving drug known as misoprostol. Misoprostol has been proven highly effective at preventing excessive bleeding after birth, known as postpartum hemorrhage (PPH). PPH is the leading cause of death for pregnant women globally, including in Rwanda, where an astounding 45% of women who perish during childbirth die from PPH. Weeks before the birth, Immanaculee had counseled Ephiphanie about the possible mild side of effects of misoprostol, but the mother chose to take the medicine anyway, knowing it could save her life.

Recognizing that deaths caused by PPH can be prevented if women have access to the right medicine, since September 2012, the Rwandan government and MCHIP have been collaborating on an innovative pilot program in four districts. As part of the program, MCHIP trainers teach CHWs like Immanaculee how to educate women to recognize the danger signs of life-threatening complications. MCHIP also trains these CHWs to give women misoprostol just after birth if they are not able to deliver in a facility.

Every pregnant woman is at risk for PPH. As a result, the World Health Organization recommends that women receive a uterotonic medicine—such as misoprostol—to prevent PPH. While another drug, oxytocin, is the best drug for preventing PPH, it requires refrigeration and must be injected with a needle and syringe by a skilled health worker, such as midwife or doctor. Misoprostol, by contrast, does not need to be refrigerated and comes in pill form. As such, it is ideally suited for preventing PPH at home births and in resource-poor settings like Rwanda due to its stability, ease of use, effectiveness and safety.

Map showing MCHIP intervention areas in Rwanda.

Importantly, MCHIP trainers also teach CHWs to help women plan in advance to give birth in a health facility. The Program's Maternal Health Advisor in Rwanda, Dr. Beata Mukarugwiro, said CHWs are highly effective at promoting these types of key messages to encourage safe deliveries. However, despite the government's concerted efforts, there are still women who chose to give birth at home, she admitted. Having worked in a hospital maternity ward

for more than 12 years, Dr. Beata described the women who would come to the hospital suffering from PPH after delivering at home: "They would arrive in shock and we would try to resuscitate them and give them blood transfusions. Many came too late and did not survive. The first two hours after delivery are critical for the mother to prevent excessive bleeding."

Given the mountainous terrain in Rwanda, which is known as "the land of a thousand hills," women like Epiphanie living in isolated areas often find it difficult to give birth in a facility for transport, cost or other reasons. Regardless of why women give birth at home, Dr. Beata is convinced that the government's efforts to make misoprostol available are very important. "Ten to 20 percent [of women] who don't give birth in a facility need to live if they suffer from PPH," she said.

Ephiphanie was very pleased with her experience with misoprostol and grateful that she was able to take this essential drug. "I still remember the tragic day when we lost my neighbor who died during childbirth from excessive bleeding," she said. "I wish the drug was available in our village to save her life." Since her daughter's birth, Ephiphanie has been teaching other mothers in her village about the importance of preparing in advance for childbirth and taking misoprostol immediately after the birth if delivering outside a health facility.

And with MCHIP support, Immanaculee is continuing her critical work to ensure that women who give birth at home have access to the vital medicine they need. Through this Rwandan pilot program—and many other activities being carried out globally[34]—MCHIP is successfully empowering women and their health care providers to prevent PPH. To date, more than 700,000 women giving birth have received lifesaving medicine to prevent PPH thanks to USAID/MCHIP-supported programs.

[34] http://www.mchip.net/ Postpartum%20Hemorrhage

Improved Health Worker Skills Increase Community Confidence in Referral System and Hospital Care

Nurse Dipura managing a sick child at Gutaurare Rural Health Center in Mutare District. (Photo credit: MCHIP.)

Concerned about her son's fever, fast breathing, and diarrhea, 33-year-old mother of three Rudo Manyika (not her real name) took her five-year-old son to Gutaurare Rural Health Centre (RHC)in Mutare District. The boy, named Innocent, arrived to the center the same day that his mother noticed his symptoms, and was met by Dipura, an MCHIP-trained primary care nurse.

Dipura noticed immediately that the boy was grunting in his mother's arms and took action—assessing Innocent's vital signs and noting that the boy's weight and temperature were within reasonable range, his immunizations were up to date, and he was not anemic.

Due to Innocent's rapid breathing, the nurse quickly diagnosed him with severe pneumonia and/or very severe disease. He then administered the appropriate pre-referral treatment and sent Innocent to the nearest hospital for further management.

However, while counseling Rudo on the referral, Dipura noticed the mother's hesitancy to take her son to the hospital. She cited concerns about leaving her other children alone at home and about being in a hospital environment. Thankfully, with skills learned in an MCHIP-supported in-service training on Integrated Management of Newborn and Childhood Illnesses, Dipura was able to convey the importance of hospital care to Rudo, who eventually accepted his guidance.

With nine years of professional experience already, Dipura attended the May 2013MCHIP training, which he described as "really important." The training boosted his confidence in assessing, classifying, and treating all sick young infants and children that come his way, he said, and taught him the importance of strengthening the referral system, enabling sick children—like Innocent—to receive higher-level care when needed.

"We are now better at managing sick young infants and children and treating them using the standard guidelines," he added.

Dipura's effective counseling paid off and helped to save Innocent's life. In following up on the boy's condition, Dipura learned that Innocent was kept at Mutare Provincial Hospital for nearly two weeks. His mother and extended family were very happy with the successful treatment he received, Rudo expressing her newfound confidence in hospital care.

And her positive experiences with the referral system and at the hospital is having a ripple effect—influencing her neighbors, who used to share similar negative opinions on referral to a hospital. Rudo is now a strong advocate for early treatment-seeking behavior and for following the referral advice of health workers.

Nurse Dipura showing off the tools of his trade—IMNCI chart booklet and job aids. (Photo credit: MCHIP)

Annex F: List of Communications Events and Publications

EVENT MATRIX AND PHOTOS

EVENT	DATE	LOCATION	CO-SPONSORS	NOTES
MCHIP AIDS Walk	October	Washington, D.C.	D.C. AIDS Walk and others	
Strengthening National Malaria Control Efforts through Community-Based Strategies: The President's Malaria Initiative's Malaria Communities Program	October	Washington, D.C. (CORE Group Fall Meeting)	President's Malaria Initiative	Pre-Meeting Event at CORE Group Fall Meeting. Event highlighted the contributions of seven Malaria Communities Program (MCP) grantees to national malaria control efforts.
Kangaroo Mother Care Orientation Workshop	October	Washington, D.C. (CORE Group Fall Meeting)		Pre-Meeting Workshop at CORE Group Fall Meeting. Focused on best practices, positioning techniques, and a discussion of challenges to scaling up the lifesaving technique in hospitals and community settings.
In Search of Impact and Value for Money: Can financial incentives significantly and sustainably increase provisions and use of maternal health services?	October	Beijing, China	Broad Branch Associates	Satellite event at Second Global Symposium on Health Systems Research.
"Getting Real" Through NGO Partnerships with Policymakers and Researchers to Test Innovative, Scalable Solutions to Implementation Challenges: Community Health Systems Research on Reaching Neglected Populations in LAC, Africa, and Asia	October	Beijing, China		Satellite event at Second Global Symposium on Health Systems Research.
Nutrition Brown Bag Series	October, November, January, March	Washington, D.C.		Series included: "Integrating Child Development and Nutrition Interventions among Infants in Rural India: Lessons from the Field," "The Relationship between Weight and Length in Early Childhood," "Delayed Cord Clamping to Improve Iron Status in Children," and "Maternal Anemia and Blood Loss at Childbirth—Findings from Zanzibar, Tanzania."
Launch of Community Case Management Supplement in the *American Journal of Tropical Medicine and Hygiene*	November	Atlanta, Georgia	John Snow, Inc.	Hosted in conjunction with American Society of Tropical Medicine and Hygiene Conference.
MCHIP Presence at International Conference on Kangaroo Mother Care	November	India	Saving Newborn Lives	

EVENT	DATE	LOCATION	CO-SPONSORS	NOTES
World Prematurity Day Social Media Campaign	November	Online	Led by Saving Newborn Lives and other partners	Online campaign on prematurity and newborn health, including blog series and extensive social media efforts.
mHealth Happy Hour Tweet-Up Celebrating Mobile Devices in Healthcare Delivery	December	Washington, D.C.	ICT4D, TechChange, mHealth Working Group, MAMA, FrontlineSMS, and Plan International USA	Planned in conjunction with the mHealth Conference.
Booth at mHealth Conference	December	Washington, D.C.	Jhpiego	
Newborn Alliance Meeting	December	Santo Domingo, Dominican Republic	Centers of Excellence, Neonatal Alliance, MOH	Meeting on newborn health priorities.
Maternal and Newborn Health Services and Measurement Meeting	January	Arusha, Tanzania		M&E pre-meeting to the Global Maternal Health conference
Child Survival Call to Action	February	Mahabalipuram, India	Govt. of India, UNICEF	MCHIP India team served as Secretariat.
Orientation for Voluntary Medical Male Circumcision Site Operation Best Practices	March	Washington, D.C.	PEPFAR	
PEPFAR Voluntary Medical Male Circumcision Webinar Series	March, June, August	Washington, D.C.	PEPFAR	First in a series of PEPFAR Voluntary Medical Male Circumcision webinars and associated satellite viewing parties.
Orientation for VMMC Site Operation Best Practices	March	Washington, D.C.	PEPFAR	Dissemination event held to orient and share this new resource.
PVO/NGO Learning Exchange Series	March	Washington, D.C.		Webinar series on PVO/NGO experiences and topics.
MCHIP Booth at Interaction Conference	April	Washington, D.C.		
Global Meeting on Guidance on Implementing Effective Programs to Prevent Pre-Eclampsia and Anemia to Improve Maternal and Newborn Outcomes	April	Johannesburg, South Africa	Spring, Micronutrient Initiative	Pre-Global Newborn Health Conference Nutrition Symposium.
Global Newborn Health Conference	April	Johannesburg, South Africa	Save the Children, UNICEF, Gates Foundation, JSI, Laerdal, Jhpiego, GE, Elma, Every Woman Every Child, A Promise Renewed	Four-day global conference hosting approx. 450 participants focused on accelerating the scale-up of maternal and newborn health interventions to reduce mortality.
Program Learning & Communications Workshop	April	Johannesburg, South Africa		Program learning and communications update for MCHIP field staff attending the Global Newborn Conference.
Country Work Meeting for Newborn Action Plans	April	Johannesburg, South Africa		Hands on workshop for invited country teams following the Global Newborn Health Conference.

EVENT	DATE	LOCATION	CO-SPONSORS	NOTES
Regional Operations Research Workshop	April	Ghana		PVO/NGO-led event.
PPIUD Meeting	April	Zambia		
Booth at CORE Group Spring Meeting	April	Baltimore, Maryland		
Booth at Women Deliver Conference	April	Kuala Lumpur, Malaysia		
Committing to Newborn Health in the Latin American and Caribbean Region	June	San Salvador, El Salvador	LAC Neonatal Alliance	Annual Meeting of the Latin America and Caribbean Neonatal Alliance.
Taking stock of the Child Survival Call to Action: Are we on track to end preventable child deaths?	June	Washington, D.C.	PATH	One year following the Child Survival Call to Action, checking in on progress made and highlighting innovations in child health.
What does it take to scale up MNCH interventions: Discussion of the MCHIP experience from the field	June	Washington, D.C.		Presentation to colleagues at USAID regarding scale-up of various MNCH interventions, followed by a town hall style discussion.
U.S. Global Leadership Coalition Conference Booth	June	Washington, D.C.		
Malaria in Pregnancy Session at SARN Annual Consultative Meeting	July	Johannesburg, South Africa	Roll Back Malaria MIP Working Group	
Kangaroo Mother Care—A catalytic approach to achieve MDG4 in the LAC region	September	Washington, D.C.		Event/Webinar highlighting experiences of various Neonatal Alliance countries around the implementation and scale-up of KMC.
Postpartum Hemorrhage Program Implementation Workshop	September	Washington, D.C.	Engender Health, PSI, VSI	Workshop to provide organizations with the knowledge and tools for successful implementation of PPH prevention programming.
World Contraception Day Tweet Chat	September	Online	Women Deliver, Pathfinder, FP2020, and others	Cohosted advocacy campaign on Twitter to celebrate World Contraception Day.
Improving Access, Saving Lives: Essential Maternal Health Medicines	September	Online	Family Care International, PATH, Jhpiego	Cohosted Twitter discussion on maternal health commodities.

The MCHIP team poses for a photo at the halfway mark of the D.C. AIDS walk.

Guests celebrate the Community Case Management Supplement Launch in the in the *American Journal of Tropical Medicine and Hygiene*.

Steve Hodgins gives a brief presentation about his contribution in the inaugural issue of *Global Health: Science and Practice* at the publication's launch event.

Distinguished opening ceremony panelists at the Global Newborn Health Conference.

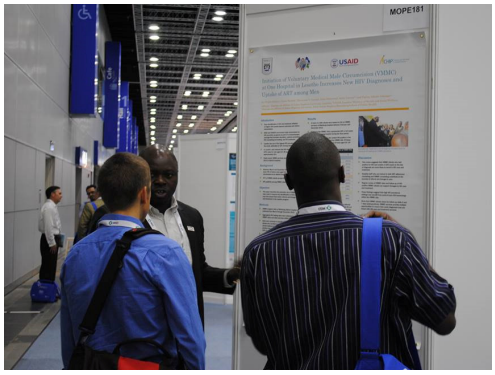
Her Dignity, Graca Machel, invigorates the audience at the Global Newborn Health Conference by highlighting the importance of investing in interventions that prevent newborn mortality.

Participants at the Global Newborn Health Conference take turns "standing for newborns."

Participants were able to get up close and learn more about specific health innovations at the Child Survival event on Capitol Hill.

Congresswoman Lois Capps voices her support for global child health at the Taking Stock of the Child Survival Call to Action event.

Participants gather for a group shot at the PPIUD meeting in Zambia.



Virgile Kikaya presents a poster on linking men who test HIV+ in VMMC to care and treatment at the International AIDS Society Conference in Kuala Lumpur.

Sheena Currie hosts an interactive demonstration of the MamaNatalie at the PPH Prevention and Implementation workshop in September. Two more regional workshops will follow in PY6.

Participants at the LAC Newborn Conference in San Salvador, El Salvador.

Dr. Saswati Das (in blue dress), MCHIP Senior Advisor in Clinical Services and Training, recently facilitated a capacity-building activity to establish first-ever quality assurance standards at the Habiganj District Hospital. This health facility is supported by the USAID-funded MaMoni project, an initiative led by MCHIP to improve the health of women and their babies in Bangladesh.

PUBLISHED RESEARCH FINDINGS

OUTLET	TEAM	TITLE
BMC Pregnancy and Childbirth	Maternal Health	Misoprostol for postpartum hemorrhage prevention at home birth: An integrative review of global implementation experience to date http://www.biomedcentral.com/1471-2393/13/44/abstract
BMC Pregnancy and Childbirth	Maternal Health	An integrative review of the side effects related to the use of magnesium sulfate for pre-eclampsia and eclampsia management http://www.biomedcentral.com/1471-2393/13/34
Global Health: Science and Practice	Newborn	Chlorhexidine for umbilical cord care: game-changer for newborn survival? http://www.ghspjournal.org/content/1/1/5.extract.html?etoc
PLOS Medicine Collection on Measuring Coverage for MNCH	M&E	Measuring Coverage in MNCH: Testing the Validity of Women's Self-Report of Key Maternal and Newborn Health Interventions during the Peripartum Period in Mozambique http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0060694
HIV Nursing Matters	HIV	Voluntary Medical Male Circumcision and Adolescents: An opportunity for nurses to contribute to an HIV free generation http://www.sahivsoc.org/upload/documents/HIV%20Nursing%20Matters%20Vol%204%20No%201.pdf
Global Health: Science and Practice	HIV	"Man, what took you so long?" Social and individual factors affecting adult attendance at voluntary medical male circumcision services in Tanzania http://www.ghspjournal.org/content/1/1/108.abstract
The Journal of Urology	HIV	Penile Measurements in Tanzanian Males: Guiding Circumcision Device Design and Supply Forecasting http://www.jurology.com/article/S0022-5347(13)03532-5/abstract
The American Journal of Tropical Medicine and Hygiene	Child Health	Special Supplement on Integrated Community Case Management http://www.ajtmh.org/content/87/5_Suppl.toc
International Health	Immunization	Why children are not vaccinated: a review of the grey literature http://www.sciencedirect.com/science/article/pii/S1876341312000496
Health Policy and Planning	PVO/NGO	Community-based intervention packages facilitated by NGOs demonstrate plausible evidence for child mortality impact http://heapol.oxfordjournals.org/content/early/2013/02/22/heapol.czt005.short?rss=1
Médecine et Santé Tropicales	M&E	Quality of care to prevent and treat postpartum hemorrhage and pre-eclampsia/eclampsia: an observational assessment in Madagascar's hospitals http://www.jle.com/fr/revues/medecine/mst/e-docs/00/04/8A/80/resume.phtml
13th World Congress on Public Health Book	Immunization	Addressing equity and reaching the underserved and unreached in India http://www.mchip.net/node/1824
Journal of Health Communication	Immunization	Communication for Polio Eradication: Improving the Quality of Communication Programming Through Real-Time Monitoring and Evaluation http://www.mchip.net/sites/default/files/Communic%20M&E%20paper%20JHC.pdf
Journal of Infectious Diseases	Immunization	Integrated Delivery of Health Services During Outreach Visits: A Literature Review of Program Experience Through a Routine Immunization Lens http://www.mchip.net/sites/default/files/Integrated%20Delivery%20of%20Health%20Services%20During%20Outreach%20Visits.pdf
Health Policy and Planning	PVO/NGO	Community-based intervention packages facilitated by NGOs demonstrate plausible evidence of child mortality impact http://heapol.oxfordjournals.org/content/early/2013/02/22/heapol.czt005.short?rss=1

OUTLET	TEAM	TITLE
Global Health: Science and Practice	Family Planning	Operations research to add postpartum family planning to maternal and neonatal health to improve birth spacing in Sylhet District, Bangladesh http://www.ghspjournal.org/content/1/2/262.abstract
Vaccine	Immunization	Moving Forward with Strengthening Routine Immunization Delivery as part of Measles and Rubella Elimination Activities http://www.sciencedirect.com/science/article/pii/S0264410X12017458
Vaccine	Immunization	Applying an Equity Lens in the Decade of Vaccines http://www.sciencedirect.com/science/article/pii/S0264410X12017392
Vaccine	Immunization	New vaccine introductions: Assessing the impact and the opportunities for immunization and health system strengthening http://www.sciencedirect.com/science/article/pii/S0264410X12015927

Annex G: 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)

	DEFINITION AND DISAGGREGATION	BASELINE DATA (2008 OR EARLIER)	FY2009/PY1 DATA	FY2010/PY2 DATA	FY2011/PY3 DATA	FY2012/PY4 DATA	FY2013/PY5 DATA
1. Number of MCHIP countries demonstrating reductions in maternal mortality since the last survey	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. **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; and use or adaptation of methods to acquire adequate sample sizes, such as the Sampling at Service Sites method.	▪ 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 **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.	N/A	N/A	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. **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; and use or adaptation of methods to acquire adequate sample sizes, such as the Sampling at Service Sites method.	▪ 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 **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.	

	DEFINITION AND DISAGGREGATION	BASELINE DATA (2008 OR EARLIER)	FY2009/PY1 DATA	FY2010/PY2 DATA	FY2011/PY3 DATA	FY2012/PY4 DATA	FY2013/PY5 DATA
2. Number of MCHIP countries demonstrating reductions in newborn and under-5 mortality (U5MR) since the last survey	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 5. This includes contributions by CSHGP grantees. **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.	**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 Data Source: WHO/UNICEF 2005 **U5MR** ▪ Bangladesh – 88 (CSHGP, CRWRC		**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 Data Source: WHO/UNICEF 2010 **U5MR** ▪ Bangladesh – 81 (CSHGP, CRWRC 2004–2010)	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 5. This includes contributions by CSHGP grantees. **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.	**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 Data Source: WHO/UNICEF 2005 **U5MR** ▪ Bangladesh – 88 (CSHGP, CRWRC	**U5MR** Nepal – 30 Uganda – 137 Ethiopia – 121 India – 116

	DEFINITION AND DISAGGREGATION	BASELINE DATA (2008 OR EARLIER)	FY2009/PY1 DATA	FY2010/PY2 DATA	FY2011/PY3 DATA	FY2012/PY4 DATA	FY2013/PY5 DATA
		2004–2010) ▪ Cambodia – 101 (CSHGP, IRD 2006–2010) ▪ 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)		▪ 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)		2004–2010) ▪ Cambodia – 101 (CSHGP, IRD 2006–2010) ▪ 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)	

	DEFINITION AND DISAGGREGATION	BASELINE DATA (2008 OR EARLIER)	FY2009/PY1 DATA	FY2010/PY2 DATA	FY2011/PY3 DATA	FY2012/PY4 DATA	FY2013/PY5 DATA
3. Estimated number of lives saved among children under 5 in USAID MNCH focus countries as a result of MCHIP-supported interventions, Including CSHGP and MCP-supported grants in these countries[35]	This will be disaggregated for CSHGP grantees versus achievements of other MCHIP country programs. These 10 focus countries include the five countries where MCHIP will scale up an integrated package of high-impact MNCH interventions. **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.			▪ 19, 990 ▪ Bangladesh – 200 (CSHGP, CRWRC 2004–2010) ▪ Cambodia – 100 (CSHGP, IRD 2006–2010) ▪ DR Congo – 3,000 (CSHGP, CRS 2005–2010) ▪ 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)	This will be disaggregated for CSHGP grantees versus achievements of other MCHIP country programs. These 10 focus countries include the five countries where MCHIP will scale up an integrated package of high-impact MNCH interventions. **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.		▪ 41,858 ▪ Nepal – 3,504 (CSHGP, HKI 2008–2012) ▪ Uganda – 18,188 (CSHGP, ERD 2008–2012) ▪ Ethiopia – 8,784 (CSHGP, Save the Children 2007–2012) ▪ India – 11,382 (CSHGP, World Renew 2007–2012)

[35] 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.

	DEFINITION AND DISAGGREGATION	BASELINE DATA (2008 OR EARLIER)	FY2009/PY1 DATA	FY2010/PY2 DATA	FY2011/PY3 DATA	FY2012/PY4 DATA	FY2013/PY5 DATA
4. Percentage of children aged 12–23 months who received three doses of DPT vaccine	Numerator: Number of children aged 12–23 months receiving three doses of DPT vaccine Denominator: Total number of children aged 12–23 months surveyed	▪ Bangladesh – 90.1.% (MICS Report 2006) ▪ Bangladesh – 35.9% (CSHGP, CRWRC 2004–2010) ▪ Benin – 76% (WHO/UNICEF, 2003) ▪ Bolivia – 81% (WHO/UNICEF, 2003) ▪ Cambodia – 78.0% (CSHGP, IRD 2006–2010) ▪ DR Congo – 11.6% (CSHGP, CRS 2005–2010) ▪ Ethiopia – 56% (WHO/UNICEF, 2003) ▪ Ghana – 83.5% (MICS 2006) ▪ Guinea – 43% (WHO/UNICEF, 2003) ▪ India – 64% (WHO/UNICEF, 2003) ▪ India – 33.9% (CSHGP HOPEWW 2006–2010) ▪ Indonesia – 27.4% (CSHGP Mercy Corps 2006–2010) ▪ Liberia – 62% (WHO/UNICEF, 2003)	▪ Zimbabwe- 66.6% (MICS 2009)	▪ Bangladesh[36] – 94%* (CSHGP, CRWRC 2004–2010) ▪ Benin – 83% (WHO/UNICEF 2009) ▪ Bolivia – 85% (WHO/UNICEF 2009) ▪ Cambodia[37] – 81.2% (CSHGP, IRD 2006–2010) ▪ Cambodia – 84.8% (DHS 2010) ▪ DR Congo[36] – 50.2%* (CSHGP, CRS 2005–2010) ▪ Ethiopia – 79% (WHO/UNICEF 2009) ▪ Ghana – 94% (WHO/UNICEF 2009) ▪ Guinea – 57% (WHO/UNICEF 2009) ▪ India – 66% (WHO/UNICEF 2009) ▪ India[37] – 51.5% (CSHGP HOPEWW 2006–2010) ▪ Indonesia[37] – 40.2% (CSHGP Mercy Corps 2006–2010)	▪ Benin – 85% (WHO/UNICEF) ▪ Nepal – 91.7% (DHS 2011) ▪ Uganda – 71.5% (DHS 2011)	▪ Kyrgzstan – 80.6% (DHS Preliminary 2012) ▪ Nepal – 95.6% (CSHGP, CARE 2007–2011) ▪ Benin – 73.7%	Nepal – 96.8% (CSHGP, HKI 2008–2012) Uganda – 75.6% (CSHGP, ERD 2008–2012) Ethiopia – 71.5% (CSHGP, Save the Children 2007–2012) India – 55.4% (CSHGP, World Renew 2007–2012)

[36] 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.
[37] 2006 Rapid CATCH indicator definition: Percentage of children age 12–23 months who received a DPT 3 vaccination before they reached 12 months.

	DEFINITION AND DISAGGREGATION	BASELINE DATA (2008 OR EARLIER)	FY2009/PY1 DATA	FY2010/PY2 DATA	FY2011/PY3 DATA	FY2012/PY4 DATA	FY2013/PY5 DATA
		▪ Liberia – 30.6% (CSHGP, MTI 2006–2010) ▪ Mozambique – 85.9% (CSHGP, FH 2005–2010) ▪ Nigeria – 26% (WHO/UNICEF, 2003) ▪ Nigeria – 29.6% (MICS 2006) ▪ Pakistan- 58.5% (DHS 2006-07) ▪ Philippines- 85.6% (DHS 2008) ▪ Rwanda – 86% (WHO/UNICEF, 2003) ▪ Senegal – 52% (WHO/UNICEF, 2003) ▪ South Sudan – n/a (WHO/UNICEF, 2003) ▪ Tajikistan - 86.3% (MICS 2005) ▪ Tanzania – 85% (WHO/UNICEF, 2003) ▪ Timor-Leste – n/a (WHO/UNICEF, 2003) ▪ Uganda – 76.7% (CSHGP, HealthPartners 2005–2010) ▪ Ukraine – 99%x ▪ Yemen- 61% (MICS 2006) (WHO/UNICEF, 2003) ▪ Zambia – 32.6% (CSHGP, SAWSO		▪ Liberia – 64% (WHO/UNICEF 2009) ▪ Liberia[37] – 87.6%* (CSHGP, MTI 2006–2010) ▪ Malawi –k 93.0% (DHS 2010) ▪ Mozambique[36] – 69.1% (CSHGP, FH 2005–2010) ▪ Nigeria – 42% (WHO/UNICEF 2009) ▪ Rwanda – 97% (WHO/UNICEF 2009) ▪ Senegal – 86% (WHO/UNICEF 2009) ▪ South Sudan – n/a (WHO/UNICEF 2009) ▪ Tanzania – 85% (WHO/UNICEF 2009) ▪ Timor-Leste – 64.2% (DHS 2009–10) ▪ Ukraine – 90% (WHO/UNICEF 2009) ▪ Zimbabwe – 73% (WHO/UNICEF 2009) ▪ Uganda[36] – 60.4% (CSHGP, HealthPartners 2005–2010) ▪ Zambia[36] – 55.8%* (CSHGP, SAWSO			

	DEFINITION AND DISAGGREGATION	BASELINE DATA (2008 OR EARLIER)	FY2009/PY1 DATA	FY2010/PY2 DATA	FY2011/PY3 DATA	FY2012/PY4 DATA	FY2013/PY5 DATA
		2005–2010) ▪ Zambia – 79.7% (DHS 2007) ▪ Zimbabwe – 75% (WHO/UNICEF, 2003) **Note on WHO/UNICEF data:** Data for MCHIP countries with population-based surveys and immunization activities.		2005–2010)			
5. Percentage of children aged 0–59 months with diarrhea receiving oral rehydration	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) Denominator: Total number of children aged 0–59 months with diarrhea in the 2 weeks prior to the survey	▪ Bangladesh – 57.1% (CSHGP, CRWRC 2004–2010) ▪ Cambodia – 37.9% (CSHGP, IRD 2006–2010) ▪ Cambodia – 73.1% (CSHGP, IRD 2006–2010) ▪ DRC – 42.3% (UNICEF, 2007) ▪ Egypt- 30.4% (DHS 2008) ▪ India – 74.3% (CSHGP HOPEWW 2006–2010) ▪ India – 34.9% (CSHGP HOPEWW 2006–2010) ▪ Indonesia – 49.0% (CSHGP Mercy Corps 2006–2010) ▪ Indonesia – 77.8% (CSHGP Mercy Corps	▪ Kenya – 42.6% (DHS, 2008–09) ▪ Zimbabwe – 34.9% (UNICEF,2009)	▪ Bangladesh[38] – 72.3% (CSHGP, CRWRC 2004–2010) ▪ Cambodia[38] – 38.5% (CSHGP, IRD 2006–2010) ▪ India[38] – 72.4%* (CSHGP HOPEWW 2006–2010) ▪ Indonesia[38] – 43.1% (CSHGP Mercy Corps 2006–2010) ▪ Liberia[38] – 84.1% (CSHGP, MTI 2006–2010) ▪ Mozambique[38] – 93%* (CSHGP, FH 2005–2010) ▪ Tanzania – 50.4% (DHS, 2010)		▪ Niger – 49.7% (CSHGP, Relief 2007–2011) ▪ *denominator = 0–23 months ▪ Rwanda – 32.5% (CSHGP, Concern 2006–2011) ▪ Zimbabwe – 73.7% (2010–11 DHS) ▪ Rwanda – 48.1% (2010 DHS)	Nepal – 64.6% (CSHGP, HKI 2008–2012) Uganda – 58.5% (CSHGP, ERD 2008–2012) Ethiopia – 60.9% (CSHGP, Save the Children 2007–2012) India – 58.5% (CSHGP, World Renew 2007–2012)

[38] 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).

	DEFINITION AND DISAGGREGATION	BASELINE DATA (2008 OR EARLIER)	FY2009/PY1 DATA	FY2010/PY2 DATA	FY2011/PY3 DATA	FY2012/PY4 DATA	FY2013/PY5 DATA
		2006–2010) ▪ Kenya – 33.3% (UNICEF , 2003) ▪ Liberia – 43.2% (CSHGP, MTI 2006–2010) ▪ Liberia – 74.2% (CSHGP, MTI 2006–2010) ▪ Mozambique – 66% (CSHGP, FH 2005–2010) ▪ Tanzania – 53.0% (UNICEF, 2005) ▪ Zimbabwe – 46.7 (UNICEF, 2006) **Note on WHO/UNICEF data:** Data are included for MCHIP countries with child health activities that had population-based surveys before or during MCHIP.					
6. Percentage of children aged 0–59 months with suspected pneumonia taken to an appropriate health care provider	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 care provider Denominator: Total number of children aged 0–59 months with suspected pneumonia in the 2 weeks prior to the survey	▪ DRC – 41.9% (2007 DHS) [5yrs] ▪ Egypt – 79% (DHS 2008) ▪ Kenya – 53.0% (2003 DHS) ▪ Rwanda – 23.7% (UNICEF, 2005) ▪ Rwanda – 28.6% (2007–08 Interim DHS) ▪ Tanzania – 60.6% (2004–05 DHS) ▪ Zimbabwe – 24.8%	▪ Kenya – 57.3% (2008–09 DHS)	▪ Rwanda – 50.2% (2010 Preliminary DHS) ▪ Tanzania – 71% (2010 DHS) ▪ Cambodia[39] – 66.7% (CSHGP, IRD 2006–2010) ▪ India[39] – 69.0% (CSHGP HOPEWW 2006–2010) ▪ Indonesia[39] – 75.0% (CSHGP Mercy Corps	▪ Zimbabwe – 47.4% (2010–11 Preliminary DHS	▪ Cambodia – 39.1% (2010 DHS) ▪ Rwanda – 66.3% (CSHGP, Concern 2006–2011) ▪ Tanzania – 91.1% (CSHGP Wellshare 2006–2011) ▪ *denominator = 0-23 months	Nepal – 38.8% (CSHGP, HKI 2008–2012) Uganda – 74.6% (CSHGP, ERD 2008–2012) Ethiopia – 46.6% (CSHGP, Save the Children 2007–2012) India – 91.6% (CSHGP, World Renew 2007–2012)

[39] 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.

	DEFINITION AND DISAGGREGATION	BASELINE DATA (2008 OR EARLIER)	FY2009/PY1 DATA	FY2010/PY2 DATA	FY2011/PY3 DATA	FY2012/PY4 DATA	FY2013/PY5 DATA
		(2005–06 DHS) ▪ Zambia – 81.3% (CSHGP, SAWSO 2005–2010) **Note on WHO/UNICEF data:** Data are included for MCHIP countries with child health activities that had population-based surveys before or during MCHIP.		2006–2010) ▪ Liberia[39] – 90.8%* (CSHGP, MTI 2006–2010) ▪ Zambia[39] – 89.4% (CSHGP, SAWSO 2005–2010)			
7. Percentage of children aged 0–59 months with suspected pneumonia receiving antibiotics	Numerator: Number of children aged 0–59 months with suspected pneumonia in the 2 weeks prior to the survey receiving antibiotics Denominator: Total number of children aged 0–59 months with suspected pneumonia in the 2 weeks prior to the survey	▪ DRC – 41.9% (DHS 2007) ▪ Egypt- 57.9% (DHS 2008) ▪ India – 69% (DHS 2005-06) ▪ Indonesia* – 65.9% (DHS 2007) ▪ Kenya* – 43.5% (DHS 2003) ▪ Lesotho – 58.8% (DHS 2004) ▪ Mali – 38.1% (2006) ▪ Rwanda – 28.0% (DHS 2007–08) ▪ Senegal* – 40.6% (DHS 2005) ▪ Tanzania* – 56.6% (DHS 2004) ▪ Yemen – 37.9% (MICS 2006) ▪ Zimbabwe –24.9% (DHS 2005–06) *Treatment of acute respiratory infection (ARI) and/or fever	▪ Kenya – 55.9% (2008–09 DHS) ▪ Rwanda – 50.2% (2010 Preliminary DHS) **Note for DHS data:** Data for MCHIP countries child health activities and population-based surveys. The DHS in some countries with MCHIP child health activities did not include ARI treatment data. *Lesotho 2009 data available only in data set, not in report.	▪ Malawi – 70.3% (2010 DHS)		▪ Zimbabwe – 31% (2010–11 DHS) ▪ Senegal – 49.9% (2010–11 DHS)	

	DEFINITION AND DISAGGREGATION	BASELINE DATA (2008 OR EARLIER)	FY2009/PY1 DATA	FY2010/PY2 DATA	FY2011/PY3 DATA	FY2012/PY4 DATA	FY2013/PY5 DATA
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	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 Denominator: Total number of women who had a live birth occurring in the same period	▪ Bangladesh – 20.6% (2007 DHS) ▪ Burkina Faso – 17.6% (2003 DHS) ▪ Egypt - 66% (DHS 2008) ▪ India – 37.0%; (2005–06 DHS) ▪ India – 53% (CSHGP HOPEWW 2006–2010) ▪ Indonesia – 81.5% (2007 DHS) ▪ Kenya – 52.3% (2003 DHS) ▪ Kenya – 32% (CSHGP, AMREF 2005–2010) ▪ Kenya – 28% (CSHGP, HealthRight 2006–2010) ▪ 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) ▪ Pakistan – 28.4%	▪ Kenya – 47.1% (2008–09 DHS) ▪ Lesotho – 70.4% (2009 DHS) ▪ Madagascar – 49.3% (2008–09 DHS)	▪ Malawi – 45.5% (2010 DHS) ▪ Rwanda – 35.4% (2010 Prelim DHS) ▪ India[40] – 68%* (CSHGP HOPEWW 2006–2010) ▪ Kenya[40] – 49%* (CSHGP, AMREF 2005–2010) ▪ Kenya[41] – 28% (CSHGP, HealthRight 2006–2010		▪ Zimbabwe – 64.8% (2010-11 DHS) ▪ Nepal – 50.1% (2011 DHS) ▪ Nepal – 84.1% (CSHGP, Plan 2007–2011) ▪ Nepal – 65.8% ▪ (CSHGP, CARE 2007–2011) ▪ Tanzania – 55.0% (CSHGP Wellshare 2006–2011) * denominator = 2 years prior to survey	Nepal – 70.8% (CSHGP, HKI 2008–2012) Uganda – 36.1% (CSHGP, ERD 2008–2012)

[40] 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.
[41] Percentage of mothers of children 0–11 months who attended ANC at least four times during most recent pregnancy.

	DEFINITION AND DISAGGREGATION	BASELINE DATA (2008 OR EARLIER)	FY2009/PY1 DATA	FY2010/PY2 DATA	FY2011/PY3 DATA	FY2012/PY4 DATA	FY2013/PY5 DATA
		(DHS 2006-07) ▪ Philippines – 77.8% (DHS 2008) ▪ Paraguay – 90.5 (2008 RHS) ▪ Rwanda – 23.9% (2007–08 Interim DHS) ▪ Zambia – 60.3% (DHS 2007) ▪ Zimbabwe – 71.1% (2005–06 DHS) **Note on DHS data:** Data for MCHIP countries' maternal health activities and population-based surveys.					
9. Percentage of women who received intermittent preventive treatment for malaria during their last pregnancy	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 Denominator: Total number of women surveyed at risk for malaria who delivered a live baby within the last 2 years	▪ 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 ▪ Zambia – 87.2% (DHS 2007) ▪ Zimbabwe – 37.9% (2005–06 DHS) ▪ Kenya – 4% (CSHGP, HealthRight 2006–		▪ Burkina Faso – 11% (2010 Preliminary DHS) ▪ Malawi – 55% (2010 DHS) ▪ Rwanda – 13.3% (2010 Preliminary DHS) ▪ Kenya[42] – 13%* (CSHGP, HealthRight 2006–2010) ▪ Kenya – 66.5% (MIS 2010) ▪ Zambia[43] – 87.7% (CSHGP, SAWSO 2005–2010)	▪ Mozambique – 20.5% (2011 Preliminary MIS) ▪ Uganda – 62.2% (DHS 2011) ▪ Zimbabwe – 23.2%(2010–11 Prelim DHS)[44]	▪ Tanzania – 57.3% (CSHGP Wellshare 2006–2011)	

[42] Percentage of mothers of children 0–11 months who received IPT at least twice during ANC.
[43] Percentage of mothers of children 0–23 months who received IPT for malaria during their last pregnancy (confirmed by maternal health card).
[44] Percentage of last births in the 2 years preceding the survey for which the mother got intermittent preventive treatment (IPTp) during an antenatal visit.

	DEFINITION AND DISAGGREGATION	BASELINE DATA (2008 OR EARLIER)	FY2009/PY1 DATA	FY2010/PY2 DATA	FY2011/PY3 DATA	FY2012/PY4 DATA	FY2013/PY5 DATA
		2010) ▪ Kenya – 41.5% (DHS 2008–09) ▪ Zambia – 83.8% (CSHGP, SAWSO 2005–2010) **Note:** Data for MCHIP countries with malaria activities and recent population- based surveys and:					
10. Percentage of live births attended by skilled health personnel (doctor, nurse, midwife, or auxiliary midwife)	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) 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.)	▪ Dominican Republic – 97% (DHS 2007) ▪ Egypt- 78.9% (DHS 2008) ▪ 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	▪ Kenya – 45.2% (2008–09 DHS) ▪ Lesotho – 61.5% (2009 DHS) ▪ Madagascar – 43.3% (2008–09 DHS)	▪ Burma –70.6% (MICS 2009-10) ▪ Malawi – 71.4% (2010 DHS) ▪ Rwanda – 69% (2010 Preliminary DHS) ▪ Bangladesh[45] – 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	▪ Ethiopia – 10% (2011 Preliminary DHS) ▪ Nepal – 36% (2011 Preliminary DHS) ▪ Zimbabwe – 66.2% (2010–11 Preliminary DHS)	▪ Nepal – 77.6% (CSHGP, Plan 2007–2011) ▪ Nepal – 52.1% (CSHGP, CARE 2007–2011) ▪ Niger – 52.8% (CSHGP, Relief 2007–2011) * denominator = 2 years prior to survey	Nepal – 29.7% (CSHGP, HKI 2008–2012) Uganda – 64.4% (CSHGP, ERD 2008–2012) Ethiopia – 15.0% (CSHGP, Save the Children 2007–2012) India – 64.3% (CSHGP, World Renew 2007–2012)

[45] 2000+ and 2006 Rapid CATCH indicator definition: Percentage of children age 0–23 months whose births were attended by skilled personnel.

	DEFINITION AND DISAGGREGATION	BASELINE DATA (2008 OR EARLIER)	FY2009/PY1 DATA	FY2010/PY2 DATA	FY2011/PY3 DATA	FY2012/PY4 DATA	FY2013/PY5 DATA
		DHS) ▪ Zimbabwe – 67.3% (2005–06 DHS) ▪ 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% (CSHGP Mercy Corps 2006–2010) ▪ 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) ▪ Pakistan – 38.8% (DHS 2006-07) ▪ Philippines - 62.2% (DHS 2008) ▪ Uganda – 47.4% (CSHGP, HealthPartners 2005–2010)		2005–2010) ▪ Kenya[46] – 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% (CSHGP, SAWSO 2005–2010)			

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

	DEFINITION AND DISAGGREGATION	BASELINE DATA (2008 OR EARLIER)	FY2009/PY1 DATA	FY2010/PY2 DATA	FY2011/PY3 DATA	FY2012/PY4 DATA	FY2013/PY5 DATA
		▪ Yemen – 35.7% (MICS 2006) ▪ Zambia – 41.6% (CSHGP, SAWSO 2005–2010) ▪ Zambia - 46.5% (DHS 2007) **Note for DHS:** Data for MCHIP countries' maternal health activities and population-based surveys.					
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	▪ Dominican Republic – 20% (DHS 2007) ▪ Egypt – 27.6% (DHS 2008) – Urban-37.1% – Rural- 22.0% ▪ Ethiopia – 1.0% (2005 DHS) – Urban: 9.4% – Rural: 0.3% ▪ Kenya – 4.0% (2003 DHS) – Urban: 9.4% – Rural: 4.0% ▪ Lesotho – 5.1% (2004 DHS) – Urban: 8% – Rural: 4.6% ▪ Liberia – 3.5% (2007 DHS) – Urban: 5.4% – Rural: 2.6% ▪ Madagascar – 1.0% (2003–04 DHS) – Urban: 2.2% – Rural: 0.8%	▪ Kenya – 6.2% (2008–09 DHS) – Urban: 11.3% – Rural: 5.1% ▪ Lesotho – 6.7% (2009 DHS) – Urban: 11.4% – Rural: 5.2% ▪ Madagascar – 1.5% (2008–09 DHS) – Urban: 5.7% – Rural: 0.9%	▪ Malawi – 4.6% (2010 DHS) – Urban: 8.3% – Rural: 4.2%	N/A	▪ Ethiopia – 1.5% (2011 DHS) – Urban: 8.1% – Rural: 0.5% ▪ Zimbabwe – 4.5% (2010-11 DHS) – Urban:7.8 % – Rural: 3.1% ▪ Nepal – 4.6% (2011 DHS) – Urban: 15.3% – Rural: 3.5% ▪ Rwanda – 7.1% (2010 DHS) – Urban: 15.9% – Rural: 5.9%	

	DEFINITION AND DISAGGREGATION	BASELINE DATA (2008 OR EARLIER)	FY2009/PY1 DATA	FY2010/PY2 DATA	FY2011/PY3 DATA	FY2012/PY4 DATA	FY2013/PY5 DATA
		▪ Malawi – 3.1% (2004 DHS) – Urban: 4.4% – Rural: 2.9% ▪ Mozambique – 1.9% (2003 DHS) – Urban: 5.3% – Rural: 0.5% ▪ Nepal – 2.7% (2006 DHS) – Urban: 8.4% – Rural: 1.9% ▪ Nigeria – Kano-.6%, Katsina-.1%, Zamfara - 0.1% (2008 DHS) – Urban (nat'l): 3.7% – Rural (nat'l): 1% ▪ Pakistan – 7.3% (DHS 2006-07) – Urban: 12.9% – Rural:4.9% ▪ Philippines – 9.5% (DHS 2008) – Urban: 13.8% – Rural: 5.3% ▪ Rwanda – 2.9% (2007–08 Interim DHS) – Urban: n/a – Rural: n/a ▪ Zambia – 3.0% (DHS 2007) – Urban: 6.2% – Rural: 1.6% ▪ Zimbabwe – 4.8% (2005-06 DHS) – Urban: 8.7% – Rural: 3.2%					

	DEFINITION AND DISAGGREGATION	BASELINE DATA (2008 OR EARLIER)	FY2009/PY1 DATA	FY2010/PY2 DATA	FY2011/PY3 DATA	FY2012/PY4 DATA	FY2013/PY5 DATA
		Note: Data for MCHIP countries maternal health activities and population- based surveys.					
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 period may differ between surveys.)	▪ Dominican Republic – 74% (DHS 2007) ▪ Egypt- 55.9% (DHS 2008) ▪ India – 25% (CSHGP HOPEWW 2006–2010) ▪ Kenya – 20% (CSHGP, HealthRight 2006–2010) ▪ Liberia – 33.7% (CSHGP, MTI 2006–2010) ▪ Pakistan – 28.8% (DHS 2006-07) ▪ Yemen- 29.6% (MICS 2006) ▪ Zambia – 43.8% (CSHGP, SAWSO, 2005–2010 ▪ Zambia – 56.5% (DHS 2007) **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		▪ India[47] – 34% (CSHGP HOPEWW 2006–2010) ▪ Kenya[48] – 66%* (CSHGP, HealthRight 2006–2010) ▪ Liberia[49] – 87.0%* (CSHGP, MTI 2006–2010) ▪ Burma – 75.8% (MICS 2209-10) ▪ Zambia[50] – 71.6%* (CSHGP, SAWSO, 2005–2010)	▪ Bangladesh - 47.1% (DHS 2011)	▪ Ethiopia – 81.6% (CSHGP, GOAL 2007–2011) * denominator = 0-23 months ▪ Malawi – 94.7% (CSHGP, Save 2006–2011) * denominator = 0–11 months ▪ Nepal – 79.9% (CSHGP, Plan 2007–2011) * denominator = 0–5 months ▪ Niger – 95% (CSHGP, Relief 2007–2011) * denominator = 0–23 months	

[47] Percentage of newborns who were put to the breast within 1 hour of delivery.
[48] Percentage of children aged 0–5 months who were exclusively breastfed within the first hour after birth.
[49] Percentage of newborns who were put to the breast within 1 hour of delivery and did not receive prelacteal feeds.
[50] Percentage of children 0–23 months who were breastfed within 1 hour of birth.

	DEFINITION AND DISAGGREGATION	BASELINE DATA (2008 OR EARLIER)	FY2009/PY1 DATA	FY2010/PY2 DATA	FY2011/PY3 DATA	FY2012/PY4 DATA	FY2013/PY5 DATA
		than all children; anticipate having updated MICS data from the current round of MICS surveys in PY4.					
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)	▪ Bangladesh – 27% (DHS 2007) ▪ Dominican Republic –.1% (2007 DHS) ▪ Egypt- 64.6% (DHS 2008) ▪ Ethiopia – 4.6% (2005 DHS) ▪ Kenya – 10.0% (2003 DHS)[51] ▪ Kenya – 23% (CSHGP, AMREF 2005–2010) ▪ 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) ▪ Pakistan – 36.4% (DHS 2006-07) ▪ Philippines – 76.9% (DHS 2008) ▪ Paraguay – n/a ▪ Zambia – 38.7%	▪ Kenya – 42.1% (2008–09 DHS) ▪ Lesotho – 47.9% (2009 DHS) ▪ Madagascar – 46.3% (2008–09 DHS) ▪ Kenya[52] – 58%* (CSHGP, AMREF 2005–2010)	▪ Malawi – 43% (2010 DHS)	▪ Nepal – 44.5% (DHS 2011)	▪ Ethiopia – 6.7% (2011 DHS) ▪ Zimbabwe – 27.1% (2010–11 DHS)	

[51] 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.
[52] Percentage of mothers 0–5 months who attend postnatal care within 2 days of delivery.

	DEFINITION AND DISAGGREGATION	BASELINE DATA (2008 OR EARLIER)	FY2009/PY1 DATA	FY2010/PY2 DATA	FY2011/PY3 DATA	FY2012/PY4 DATA	FY2013/PY5 DATA
		(DHS 2007) ▪ Zimbabwe – 30.3% (2005–06 DHS) **Note on DHS data:** Data for MCHIP countries with population-based surveys and newborn health activities.					
14. Percentage of babies who received a postnatal care visit within 2 days of birth	Numerator: Number of 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	▪ Bangladesh – 27% (DHS 2007) ▪ Cambodia – 21.3% (CSHGP, IRD 2006–2010) ▪ Dominican Republic- 82.1% (2007 DHS) ▪ Egypt- 7.8% (DHS 2008) ▪ 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) ▪ Pakistan – 39.4% (DHS 2006-07) ▪ Zambia 38.7% (DHS 2007) **Note:** Data for other MCHIP countries from		▪ Cambodia[53] – 67.0%* (CSHGP, IRD 2006–2010) ▪ India[53] – 46.3% (CSHGP HOPEWW 2006–2010) ▪ Indonesia[53] – 43.0% (CSHGP Mercy Corps 2006–2010) ▪ Kenya[54] – 54.7%* (CSHGP, HealthRight 2006–2010) ▪ Liberia[53] – 40.3%* (CSHGP, MTI 2006–2010)	▪	▪ Malawi – 30.9% (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	Nepal – 26.6% (CSHGP, HKI 2008–2012) Uganda – 46.2% (CSHGP, ERD 2008–2012) Ethiopia – 13.9% (CSHGP, Save the Children 2007–2012) India – 60.3% (CSHGP, World Renew 2007–2012)

[53] 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.
[54] Percentage of mothers of infants 0–5 months who received neonatal care within 2 days of delivery.

	DEFINITION AND DISAGGREGATION	BASELINE DATA (2008 OR EARLIER)	FY2009/PY1 DATA	FY2010/PY2 DATA	FY2011/PY3 DATA	FY2012/PY4 DATA	FY2013/PY5 DATA
		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.					
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 *Data for contraceptive prevalence rate are from DHS, which uses this definition: percent married women 15–49 using any form of contraception at the time of the survey.*	▪ Bangladesh – 55.8% (DHS 2007) ▪ Egypt- 60.3% (DHS 2008) ▪ 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 DHS) ▪ 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.	▪ Kenya – 45.5% (2008–09 DHS)	▪ Malawi – 47.4% (2010 DHS) ▪ Rwanda – 52% (2010 Preliminary DHS) ▪ Zimbabwe – 58.5% (2010 Preliminary DHS)	▪ Ethiopia – 28.6% (2011 Preliminary DHS) ▪ Nepal – 49.7% (2011 Preliminary DHS)	N/A	Nepal – 29.4% (CSHGP, HKI 2008–2012) Uganda – 21.6% (CSHGP, ERD 2008–2012)

	DEFINITION AND DISAGGREGATION	BASELINE DATA (2008 OR EARLIER)	FY2009/PY1 DATA	FY2010/PY2 DATA	FY2011/PY3 DATA	FY2012/PY4 DATA	FY2013/PY5 DATA
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	▪ Bangladesh – 57.2% (2007 DHS) ▪ Burkina Faso – 70.3% (2003 DHS) ▪ Dominican Republic – 90% (DHS 2007) ▪ Egypt – 43.7% (DHS 2008) ▪ 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% (5 yrs) (2008 DHS) ▪ Pakistan – 43.3% (DHS 2006-07)*iron only ▪ Philippines – 82.4% (DHS 2008) ▪ Paraguay – n/a (2008 RHS) ▪ Rwanda – 41.7% (2007–08 Interim	▪ Lesotho – 46.5% (2009 DHS) ▪ Kenya – 69.6% (2008–09 DHS) ▪ Madagascar – 58.0% (2008–09 DHS)	▪ Malawi – 91.2% (2010 DHS) ▪ Burma – 83.6% (MICS 2009-10)	▪ Nepal – 79.5% (DHS 2011)	▪ Ethiopia – 35.1% (CSHGP, GOAL 2007–2011) ▪ Nepal – 79.5% (2010 DHS) ▪ Nepal – 82.3% (CSHGP, Plan 2007–2011) ▪ Rwanda – 73% (2010 DHS) ▪ Zimbabwe – 49.5% (2010–2011 DHS)	

	DEFINITION AND DISAGGREGATION	BASELINE DATA (2008 OR EARLIER)	FY2009/PY1 DATA	FY2010/PY2 DATA	FY2011/PY3 DATA	FY2012/PY4 DATA	FY2013/PY5 DATA
		DHS) ▪ Zambia – 90.4% (DHS 2007) ▪ Zimbabwe – 41.4% (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,[55] regulations, and 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.)	26 (See list of policies by country and technical area at the end of this matrix.)

[55] 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.

	DEFINITION AND DISAGGREGATION	BASELINE DATA (2008 OR EARLIER)	FY2009/PY1 DATA	FY2010/PY2 DATA	FY2011/PY3 DATA	FY2012/PY4 DATA	FY2013/PY5 DATA
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)	3 (DRC, Kenya, Senegal)
19. Number of people trained through USG-supported programs*	This indicator will be disaggregated by training topic and for CSHGP and MCP contributions as needed. Training topics include: MNH, child health and nutrition, malaria, FP/RH, HIV/AIDS (PMTCT, male circumcision), and M&E/operations research.	0	1,935 (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) 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.)	69,148 MNH: 34, 609 (core: 1,695, field: 32,914, HBB: 12,766) CH/N:13,207 (core: 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: 1,049) (Note: These are training participants and not unique individuals.)	118,130 MNH: 31,570 (core: 30,592, field: 978, HBB: 11,674) CH/N:44,448 (core: 244, field: 44,204) Malaria:2,548 (core: 22, field: 2,526) FP/RH:25,978 (core: 29, field: 25,949) HIV/AIDS: 1,236 (core: 0, field: 1,236) MER: 12,762 (core: 1, field: 12,761) (Note: These are training participants and not unique individuals.)

	DEFINITION AND DISAGGREGATION	BASELINE DATA (2008 OR EARLIER)	FY2009/PY1 DATA	FY2010/PY2 DATA	FY2011/PY3 DATA	FY2012/PY4 DATA	FY2013/PY5 DATA
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	Kenya – 100% Mozambique – 100% Zambia – 100%
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)	7 (Ghana, Guinea, Madagascar, Malawi, Mali, Mozambique, Zambia)
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 baseline. This will be disaggregated by country and type of facility (e.g., dispensary/ health post, health center, hospital).	0	0	117	1,990 (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)	278 (Dominican Republic, Ethiopia, Guinea, Liberia, Malawi, Mali, Mozambique, Zambia, Zimbabwe)

	DEFINITION AND DISAGGREGATION	BASELINE DATA (2008 OR EARLIER)	FY2009/PY1 DATA	FY2010/PY2 DATA	FY2011/PY3 DATA	FY2012/PY4 DATA	FY2013/PY5 DATA
23. Number of countries with introduction of high-impact MNCH interventions through MCHIP-supported activities and CSHGP grants in MCHIP-supported countries**	This includes: ▪ 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 facility settings)** ▪ Newborn infection management ▪ Oral rehydration therapy/zinc ▪ Community case management/	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.)	PPH - 1 Asphyxia – 4 NB infect. - 2 KMC – 4 PNC/ENC – 0 ORT/Zinc – 2 CCM/Pneu. – 0

	DEFINITION AND DISAGGREGATION	BASELINE DATA (2008 OR EARLIER)	FY2009/PY1 DATA	FY2010/PY2 DATA	FY2011/PY3 DATA	FY2012/PY4 DATA	FY2013/PY5 DATA
	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: ▪ 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.)	PPH - 5 PNC/ENC - 2 ORT/Zinc - 0 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)	4 (Kenya, Malawi, Mali, Zimbabwe)

	DEFINITION AND DISAGGREGATION	BASELINE DATA (2008 OR EARLIER)	FY2009/PY1 DATA	FY2010/PY2 DATA	FY2011/PY3 DATA	FY2012/PY4 DATA	FY2013/PY5 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, PAC, postpartum care, and 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)	647,652 (Ethiopia, Liberia, Mali, Mozambique, Philippines, Zambia)
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.[56]	0	New for Year 3	New for Year 3	404,807 (Bangladesh, Guinea, India, Malawi, Mozambique, Nigeria)	572,783 (Bangladesh, Guinea, India, Mali, Mozambique)	865,075 (Bangladesh, Bolivia, Guinea, India, Kenya, Liberia, Mali, Mozambique, South Sudan)

[56] 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 1 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 lifespan is realized.

	DEFINITION AND DISAGGREGATION	BASELINE DATA (2008 OR EARLIER)	FY2009/PY1 DATA	FY2010/PY2 DATA	FY2011/PY3 DATA	FY2012/PY4 DATA	FY2013/PY5 DATA
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: ▪ Medically trained doctor, nurse, or midwife. It does NOT include traditional birth attendants (TBAs). Data will be disaggregated by country.	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, Zimbabwe)	375,683 (Bangladesh, Bolivia, Egypt, Ethiopia, Guinea, Kenya, Liberia, Madagascar, Mali, Mozambique, Rwanda, South Sudan, Zambia, 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)	240,116 (Bolivia, Guinea, Liberia, Madagascar, Mali, Mozambique, Rwanda, Zambia)
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%	India - 100% Kenya - 94% Liberia – 53% Madagascar – 80% Malawi – 100% Mali - 86% Mozambique - 98% Rwanda – 59% South Sudan – 32% Zambia – 90% Zimbabwe - 92%

	DEFINITION AND DISAGGREGATION	BASELINE DATA (2008 OR EARLIER)	FY2009/PY1 DATA	FY2010/PY2 DATA	FY2011/PY3 DATA	FY2012/PY4 DATA	FY2013/PY5 DATA
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	50,205 (Pakistan)
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		Zimbabwe – 92% Mali – 95%	Ethiopia – 100% India – 100% Kenya – 3% Malawi – 100% Mali – 4% Zambia – 82% Zimbabwe – 91%
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)	29,873,230 (India, Kenya, Pakistan, South Sudan, 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 ▪ Newborn cases: 1,889 ▪ Child cases: 49,854 ▪ Under-5 cases: 3,999	521, 105 (DRC, Malawi, Rwanda, Zimbabwe)	22,712 (Ethiopia, Guinea, Mali, Zimbabwe)	139,319 (Egypt, Guinea, Mali, Pakistan, Zimbabwe)

	DEFINITION AND DISAGGREGATION	BASELINE DATA (2008 OR EARLIER)	FY2009/PY1 DATA	FY2010/PY2 DATA	FY2011/PY3 DATA	FY2012/PY4 DATA	FY2013/PY5 DATA
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 — 1,167	4,864	46,461 (DRC, Rwanda, Zimbabwe)	45,204 (Guinea, Mali, Zimbabwe)	93,220 (Ethiopia, Guinea, Mali, Pakistan, 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)	5 (Bangladesh, Guinea, 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)	7 (Bangladesh, Kenya, Liberia, Mali, Mozambique, Nepal, Rwanda)
38. Number of studies[57]	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	0	34	48 ▪ 22 CSHPG ▪ 10 Malaria Communities Program ▪ 16 MCHIP	46 ▪ 21 MCHIP ▪ 25 CSHGP (See the table following this matrix for a list of studies.)	**50** ▪ 33 MCHIP (See the table following this matrix for a list of studies.) ▪ 17 CSHGP (eight midterm evaluations nine final evaluations)	65 ▪ 39 MCHIP (See the table following this matrix for a list of studies.) ▪ 26 CSHGP (nine midterm evaluations, seven final

[57] 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.

	DEFINITION AND DISAGGREGATION	BASELINE DATA (2008 OR EARLIER)	FY2009/PY1 DATA	FY2010/PY2 DATA	FY2011/PY3 DATA	FY2012/PY4 DATA	FY2013/PY5 DATA
	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 of implementing the particular activity. This includes midterm and endline evaluations conducted by CSHGP grantees.						evaluations, seven baseline studies, three OR studies
39. Number of innovations or promising practices of CSHGP grants documented and supported by SO3	Demonstration of innovations and promising practices includes: ▪ 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	0	5	11	6 (6 innovation grants started in YR3)	23 active Innovation awards	20 active Innovation projects

	DEFINITION AND DISAGGREGATION	BASELINE DATA (2008 OR EARLIER)	FY2009/PY1 DATA	FY2010/PY2 DATA	FY2011/PY3 DATA	FY2012/PY4 DATA	FY2013/PY5 DATA
	integration/integrated packages, cost, effective delivery modalities, analysis for scalable components, equity ▪ Documentation of successful projects						
40. Number of CSHGP grantee innovations or promising practices incorporated into MCHIP country programs	Demonstration of innovations and promising practices include: ▪ 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, and equity; SO3 organized TAG, for example on equity ▪ Documentation of successful projects	0	0	0	None	Total of 3: 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 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. World Renew (formerly CRWRC) and MCHIP have a	

	DEFINITION AND DISAGGREGATION	BASELINE DATA (2008 OR EARLIER)	FY2009/PY1 DATA	FY2010/PY2 DATA	FY2011/PY3 DATA	FY2012/PY4 DATA	FY2013/PY5 DATA
						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).	
41. Number of CSHGP-developed tools, reference materials and guides utilized to inform MCHIP country-level activities	Disaggregated by specific tool, reference material and guide. Examples are: KPC survey, including Rapid CATCH indicators; KPC TOAST curriculum (Training of Survey Trainers); Lives Saved calculator; Technical Reference Materials; MAMAN package; Sustainability framework; Program Design Monitoring and Evaluation course (PDME).	0	1	1	1 (Equity guidance use for start-up of MCHIP Zimbabwe)	**Total of 3:** 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. 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)	

	DEFINITION AND DISAGGREGATION	BASELINE DATA (2008 OR EARLIER)	FY2009/PY1 DATA	FY2010/PY2 DATA	FY2011/PY3 DATA	FY2012/PY4 DATA	FY2013/PY5 DATA
						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.
- EBF coverage was assumed to be the same for children less than one month old and for those one to five months old although LiST allows users to enter different rates for the two age groups.
- All grantees conducted their baseline surveys within the first three 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:

Helen Keller International (HKI)/Nepal was implemented in three districts in Far West Nepal: Kailali, Baitadi, and Bajura. Nutritional status, specifically chronic malnutrition and anemia among children, improved significantly in Kailali District and among the Dalit (disadvantaged) population in Baitadi. There was no change in these indicators for Bajura or for Baitadi Operations Research district, where exposure to project activities was limited to two years and external factors may have affected nutritional status. Because of the short timeframe of the expansion project in Bajura, the baseline and endline surveys had to be conducted in opposite seasons, with the final survey done during the rainy season, which is a limitation in assessing prevalence of illnesses and both quantity and type of vegetables grown. For the OR district of Baitadi, HKI over-sampled for the endline to make it feasible to analyze their data separately for the impact indicators. Indicators modeled in LiST include: IYCF, DPT3, SOAP, and ITN. Under-five, infant, and neonatal mortality rates were used from Nepal's 2011 DHS as baseline mortality rates.

The Episcopal Relief and Development (ERD)/Uganda project was carried out in two sub-counties (Amuru and Odek) in Northern Uganda, where a majority of the population was in the process of relocating from Internally Displaced Persons (IDP) camps back to their villages. A comparison of the baseline and endline KPCs (using the LQAS methodology) shows that most of the important indicators improved. This improvement was achieved even though ERD had only two and a half years to implement their program. Noteworthy gains were made in increasing

the percentage of deliveries by skilled attendants (from 38% to 63.7%) and decreasing moderate and severe malnutrition (from 35.5% to 16.4%). Indicators modeled in LiST include: SBA and FEVER. Under-five, infant and neonatal mortality rates were used from Uganda's 2011 DHS as baseline mortality rates.

Save the Children/Ethiopia was implemented is the Southern Nations and Nationalities People's Region in the districts of Shebedino (Sidama Zone) and Lanfero (Silti Zone). The sampling frame for the baseline survey comprised the entire population of the two districts. It was a random cluster household survey with 600 respondents (300 per district). Indicators modeled in LiST include: SOAP and Vitamin A. Under-five, infant, and neonatal mortality rates were used from Ethiopia's 2011 DHS as baseline mortality rates.

World Renew/India implemented the Parivartan Child Survival Project in rural Sahibganj district of Jharkhand State, targeting the entire district. Baseline and endline KPC surveys used 30-cluster random sampling to obtain a sample of 300 mothers of children under two years of age chosen from throughout the district. Several items on the baseline KPC were omitted from the final KPC survey due to difficulty in getting valid data (child receiving treatment for fever with an effective anti-malarial drug and treatment for diarrhea with zinc supplements). Indicators modeled in LiST include: SBA, PNC, IYCF, Vitamin A, FEVER, CS, SOAP, and ITN. Under-five, infant, and neonatal mortality rates were used from India's 2005–2006 DHS as baseline mortality rates.

Table 6. Details for Indicators 23 and 24 on high-impact MNCH interventions (Number of countries and country names)

INDICATOR	YEAR 1 RESULTS	YEAR 2 RESULTS	YEAR 3 RESULTS	YEAR 4 RESULTS	YEAR 5 RESULTS	TOTAL TO DATE	LOP TARGET
High Impact Maternal Health Interventions							
Maternal Anemia Control	0	1 Bangladesh or Indonesia	1 Rwanda	2 Zimbabwe, Kenya	0	4	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	4 South Sudan, Yemen, Burma, Pakistan	19	10
PE/E Prev./Treatment Introduced	0	2 Nepal, Mozambique	2 Tanzania Zimbabwe	5 Bangladesh, Ethiopia, Indonesia, Bolivia, Paraguay	6 Pakistan, Guinea, Zambia, India, Yemen, Rwanda	15	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	5 Yemen, Burma, Philippines, Pakistan, Zambia	30	20

INDICATOR	YEAR 1 RESULTS	YEAR 2 RESULTS	YEAR 3 RESULTS	YEAR 4 RESULTS	YEAR 5 RESULTS	TOTAL TO DATE	LOP TARGET
PPH Treatment Introduced	2 Nigeria, DRC	7 Mali, Kenya, Malawi, Mozambique, Madagascar, Liberia, India	2 Zimbabwe, Nepal	3 Paraguay, Bolivia, Ethiopia	1 South Sudan	15	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	4 Burma, Pakistan, South Sudan, Yemen, Paraguay	25	8
Newborn handwashing promoted		3 Indonesia, Bangladesh, India	1 Kenya	0	1 Dominican Republic	5	8
Newborn infection management introduced	0	3 Bangladesh, Nigeria, Dominican Republic	1 Paraguay	0	2 Liberia, Madagascar	6	8
Community KMC	1 Bangladesh	2 Malawi, Indonesia	2 Ethiopia, Mozambique	0	0	5	8
KMC introduced/expanded	0	7 Malawi, Bangladesh, Nigeria, DRC, Mali, Dominican Republic, Nicaragua	8 Rwanda, Indonesia, Guatemala, Honduras, El Salvador, Paraguay, Zimbabwe, Mozambique	0	4 Philippines, Burma, South Sudan, Yemen	19	15
PNC/ENC expanded	0	2 Bangladesh, DRC	9 India, Nigeria, Malawi, Ethiopia, Zimbabwe, Mozambique, Mali, Guinea, Rwanda	0	2 Pakistan, South Sudan	13	10
PNC/ENC introduced	0	5 India, Malawi, Mali, Nigeria, Dominican Republic	3 Azerbaijan, Indonesia, Paraguay	4 Kenya, Tanzania, Colombia, Mozambique	0	12	15

INDICATOR	YEAR 1 RESULTS	YEAR 2 RESULTS	YEAR 3 RESULTS	YEAR 4 RESULTS	YEAR 5 RESULTS	TOTAL TO DATE	LOP TARGET
High Impact Child Health Interventions							
Expansion of ORT/Zinc	1 Senegal		2 DRC, Rwanda	3 Kenya, Mali, Zimbabwe	0	6	6
Introduction of ORT/Zinc	2 Kenya, Mali		1 Zimbabwe	3 DRC, Rwanda, Senegal	2 Zambia, Guinea	8	8
Expansion of CCM or Pneumonia Control	2 DRC, Senegal		1 Rwanda	2 Mali, Zambia	2 Guinea, Ethiopia	7	7
Intro. of CCM or Pneumonia Control	2 Kenya, Mali		0	1 Guinea	0	3	5
Immunization Interventions							
RI and Polio	3 DRC, India, Kenya		3 Nigeria Afghanistan, Pakistan	3 Ukraine, Kyrgyzstan, Tajikistan	2 Uganda, Yemen	11	7
New vaccines/Innovative technologies	1 Rwanda		5 DRC, Kenya, Benin, Zimbabwe, Tanzania	4 Senegal, Malawi, India, Timor-Leste	1 Uganda	11	7
RED+ (RED plus MNCH/FP)	1 Liberia		3 Kenya, India, Zimbabwe	0	0	4	3
District RI planning/Management capacity	5 DRC, India, Kenya, Nigeria, South Sudan		2 Rwanda, Zimbabwe	5 Senegal, Malawi, Uganda, Tanzania, Timor-Leste	1 Yemen	13	8
Resources leveraged for RI	8 DRC, India, Kenya, Timor-Leste, Zimbabwe, Madagascar, Nigeria, South Sudan		1 Tanzania	4 Senegal, Malawi, Rwanda, Uganda	1 Yemen	14	6
One Year RI Coverage Increased	6 (Years 1 and 2: Rwanda, South Sudan, India, Madagascar, Nigeria, Timor-Leste)		1 Kenya	5 DRC, Malawi, Tanzania, Timor-Leste, Zimbabwe	2 Senegal, Uganda	14	7

Table 7. Details for Indicators 38 and 17

Indicator 38: Number of Studies		
Geographic Area	Number	Additional Notes
Dominican Republic	1	KMC Strategy and Newborn Health Services for the improvement of the post-partum follow-up of children exposed prenatally to the Human Immunodeficiency Virus and their families, in four hospitals in the Dominican Republic.
Egypt	1	SMART Program Baseline Study
Ethiopia	2	These are literature review on cultural barriers on MNH service utilization and documentation of promising practices
Kenya	7	iCCM, Immunization, East Pokot baseline, Igembe North baseline, PPH, Baringo North baseline, nutrition study
Liberia	2	Increasing Access to Evidence Based Interventions for Prevention of Postpartum Hemorrhage at Birth in 2 Districts in Liberia, Integration of Family Planning and Immunization Services in Liberia
Madagascar	1	Prevention of Postpartum Hemorrhage in Madagascar: Increasing Access to Evidence-Based Interventions
Malawi	2	HBB Evaluation and Post Introduction Evaluation (for new Vaccines introduced)
Mali	4	Matrone Implant Study, Qualitative study of low utilization of community care , Endline study, Effectiveness of community health fairs
Mozambique	1	Post-Partum Family Planning Systematic Screening Study
Nepal	1	Evaluation of a program to prevent pre-eclampsia and eclampsia through calcium supplementation for pregnant women in Nepal
Pakistan	5	2 for Sindh: Baseline Assessment of Health Program, DHS analysis and SBMR baseline 3 for FATA: Baseline Assessment Of FATA-KP Health Programme, Gender Analysis FATA-KP Health Program (FKHP), Social and Behaviour Change Communication FATA-KP Health Program (FKHP)
Rwanda	1	Prevention of Postpartum Hemorrhage in Rwanda
Senegal	1	Immunization coverage survey
South Sudan	1	Prevention of Postpartum Hemorrhage in South Sudan
Tanzania	3	The Integrated HTC VMMC study is completed; the Early Infant Male circumcision study, Adult male study are awaiting approval from the National Institutional Review Board
Zimbabwe	6	cPQI second assessment, SBM-R 3rd and 4th assessment, Chimanimani head count, Data Quality Assessment, PCV 13 Post Introduction Evaluation, Assessment of IMNCI tools
Total	39	

Indicator 17: Number of National Policies, Guidelines, and Strategies Developed Using USG Funds.[58]			
Geographic Area	Number	Technical Area(s)	Additional Notes
Bolivia	2	Maternal and newborn health (1) FP/RH (1)	SBM-R was made part of the national CQI strategy. By Ministerial Resolution No. 1472 (2013), the MSD (MOH) mandated that all Level 2 and 3 health care services must apply the CCQI methodology. This institutionalized the QI process throughout the entire country.
DRC	1	Child health and nutrition	Measles elimination policy
Guinea	1	Maternal and newborn health (1)	PMTCT
India	6	Maternal and newborn health (4) Child Health and nutrition (1) FP/RH (1)	Facility Based Newborn Care Operational Guide - Guidelines for planning and Implementation, MOHFW 2011; A Strategic Approach To Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A) In India, MOHFW 2013; Maternal and Newborn Health Toolkit, MOHFW 2013; Guidelines on use of Injection Gentamicin by ANMs - For management of Sepsis in Young Infants under specific situations, MOHFW 2013; Multi dose open vial policy; 1 policy including Road Map for strengthening ANM/ GNM training school to improve the quality of nursing and midwifery education, Career Path for in-service cadre of ANM GNM personnel working in the public health department and Strengthening of State Directorate/Nursing Cell/ Supervisory Structure
Liberia	2	Maternal and newborn health (2)	Policies related to introduction of chlorhexidine and use of misoprostol for PPH
Mali	3	Maternal and newborn health (2) FP/RH (1)	Facility-based integrated package training curriculum for matrons at secondary health centers - Relais training package
Mozambique	1	Maternal and newborn health (1)	National strategy for the prevention and management of PPH
Senegal	1	Child Health and nutrition (1)	Use of measles activities to strengthen RI
Zambia	1	Maternal and newborn health (1)	Zambia Newborn Health Framework 2013
Zimbabwe	8	Maternal and newborn health (5) Malaria (1) Child health and nutrition (2)	These are Quality Assurance/Quality Improvement Policy, Maternal and Perinatal Mortality Audit Guidelines, KMC training package, EmONC training package, Integrated Supportive Supervision Guidelines Malaria Community Case Management(MCCM) training package IIP training package, IYCF policy
Total	26		

[58] 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.

Annex H: Country Accomplishments

	SERVICE DELIVERY	CAPACITY BUILDING	POLICY	QUALITY IMPROVEMENT	COMMUNITY
Bangladesh	▪ Proportion of deliveries by skilled birth attendants (SBAs) has been increased through ensuring 24/7 delivery care at union level facilities. ▪ Special care newborn unit has been established at sub-district level. ▪ Funds leveraged and eight additional clinics renovated (11 clinics renovated to date). ▪ Integrated five telecom operators, reached 100,000 subscribers in July 2013 with MAMA messages, and reached over 10 million with launch of the Aponjon national media campaign.	▪ 744 HBB trainers trained and more than 6,127 SBAs trained in HBB in 14 districts and two cities. ▪ 1,091 facilities and 1,563 SBAs equipped with bag and mask, and 407 facilities receiving HBB training sets. ▪ 1,489 field workers and supervisors received MNH/FP/N training.	▪ Concluded data collection, completed the draft report from the Healthy Fertility Study and disseminated the findings at national dissemination meeting in Dhaka.	▪ HMIS has been strengthened to provide real-time population-based estimates of key indicators, enabling program managers to plan and monitor coverage in an efficient manner. ▪ SBM-R tools adapted to local context for use in orienting district stakeholders.	▪ Oriented Village Health Teams (VHTs) in all five districts at for total of 10,135 participants (6,137 women and 3,998 men). ▪ Of these, VHTs in Rukungiri were oriented in Q4, totaling 2,630 (1,702 women and 928 men). ▪ 94% of 2,245 villages in Habiganj now have Community Action Groups (CAGs). ▪ MNH/FP/N awareness campaigns carried out in 253 villages.

	SERVICE DELIVERY	CAPACITY BUILDING	POLICY	QUALITY IMPROVEMENT	COMMUNITY
Dominican Republic	▪ Enrolled 73% of all eligible newborns in KMC in HSVP and 50.3% in MSLM.	▪ Expanded KMC Programs to two new CdEx Hospitals. ▪ 45 hospital staff members trained in KMC. ▪ Facilitated HBB training of 267 physicians and nurses in the 10 USAID Maternal and Child Centers of Excellence. ▪ Conducted the first HBB training of facilitators, which generated interest in HBB from the CdEx Hospitals. ▪ Focused on strengthening data collection for program indicators ▪ Tested an automated database for KMC.	▪ Advocated for the inclusion of newborn health indicators in the MOH national surveillance system. ▪ Drafted an analysis of an assessment of the quality of treatment of newborn infections in three facilities; findings will be disseminated during closing workshop. ▪ Conducted a baseline assessment on the effectiveness of the national PMTCT guidelines for diagnosis and pre- and post-counseling (post-test) of the HIV-positive pregnant woman. ▪ Identified a gap found on the screening coverage of pregnant women seen in ANC (3%–18%).	▪ Hosted a meeting on priority interventions in newborn health, which led to the adaptation of a tool for conducting baseline assessments of newborn services related to prevention and treatment of infections in ten hospitals. ▪ Developed a new strategy to improve links between newborn health services (particularly KMC) and services for the prevention (PMTCT) and treatment of HIV/AIDS. ▪ Developed a strategy to improve links to HIV/AIDS services in the CdEx hospitals.	
DRC	▪ Provided technical support for new vaccine introduction in six additional provinces (Kasai Orientale, Kasai Occidentale, Maniema, Katanga, Equateur, and Province Orientale), including by: contributing to an assessment to identify and address gaps in readiness for vaccine introduction; supporting advocacy efforts to mobilize additional resources at the health zone and provincial levels; and promoting	▪ Co-facilitated training of 34 provincial EPI and health zone staff on cold chain and logistics. ▪ Adapted MLM training tools for health zone staff. ▪ Conducted supportive supervision visits to seven health zones, addressing issues such as improving cold chain and EPI management tools; supporting and following up on data quality self-assessments and/or routine data quality audits; and supervising SIAs against poliomyelitis. ▪ Provided technical support to EPI to adapt training presentations on new vaccine introduction for trainers at the provincial and health zone levels.	▪ Supported the EPI team in finalizing measles SIA proposal (to target children aged six months to 14 years) to GAVI. ▪ Provided technical support for revision of national EPI policies and guidelines (which had not been updated for more than a decade), as well as EPI data management tools. ▪ Contributed technical expertise toward	▪ Supported EPI at the national level, during monthly ICC meetings, in monthly provincial immunization data analysis and validation. ▪ Supported seven health zones in four provinces (Kinshasa, Sud Kivu, Bas Congo, and Katanga) in conducting data quality self- assessments and routine data quality audits, and in developing data quality improvement action	▪ Provided technical support to provincial ICCs to adapt key messages around PCV13 introduction for mothers and health workers, in anticipation of the 3rd African Immunization Week in April 2013.

	SERVICE DELIVERY	CAPACITY BUILDING	POLICY	QUALITY IMPROVEMENT	COMMUNITY
	improved injection safety and waste management and disposal.	▪ Supported two provinces (Orientale and Sud Kivu) in planning RI activities and SIAs, and in validating provincial and health zone micro-plans in collaboration with national EPI and partners. ▪ Supported trainings of 20 provincial staff from four provinces, and 46 health zone staff from 1 province, on best practices for SIAs against measles.	revising DRC measles elimination strategy, developing a road map for measles activities, and assisting in strategic planning for measles campaign in September and November 2013, in close collaboration with DRC Ministry of Health, WHO, UNICEF, Sabine Vaccine Institute, and other key technical stakeholders, during a three-day workshop. ▪ Supported finalization of a measles activity road map, which was presented and validated at a June 2013 National Coordinating Committee meeting.	plans based on findings. ▪ Provided technical support to EPI and partners to improve quality of SIAs/ campaign against poliomyelitis in five health zones, which led to mapping low-coverage villages and hard-to-reach populations for subsequent targeting. ▪ Provided technical support to improve measles campaign (SIAs) quality in Equateur province, including: supporting the provincial coordination office and two health zones in campaign coordination; providing supportive supervision; and conducting a convenience survey to help identify and then vaccine/re-vaccinate underserved populations.	
Egypt	▪ 12 "umbrella" and 100 local Community Development Associations implemented MNCH activities and secured funding for new initiatives with MCHIP support. ▪ 38,000 women and children receiving free health services from project-supported mobile clinics.	▪ 3,196 doctors, nurses and CHEWs trained on key interventions (M&ENC, HBB, KMC, exclusive breastfeeding, nutrition counseling, and growth monitoring). ▪ National institutions and medical schools spreading MCH-N activities beyond the project impact areas.	▪ Trials of Improved Practices (TIPS) raised stakeholder awareness of stunting as a very real and present problem in Egypt. ▪ MOH support (unofficial) for nutrition and neonatal interventions garnered.		▪ Evidence-based BCC materials and tools on MNH and nutrition topics produced and disseminated to/thru CDAs.

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Ethiopia	▪ ANC 4+ visits increased from 5.9% to 18%; deliveries by SBA increased from 8.6% to 22.6%. ▪ Tested 24,942 pregnant women for HIV at ANC, L&D and counseled and tested 8,446 (34.8%) with their partners in 44 sites. ▪ Introduced PPFP/IUCD in 26 facilities; PPIUCD counseling for 9,541 and insertion services for 543 mothers.	▪ Built FMOH and RHB capacity in developing MNH/PMTCT and FP policies, guidelines, and training materials. ▪ Supported facilities to increase demand generation for MNH services. ▪ Strengthened referrals and linkages with PHCU through regular pregnant mothers and PHCU meetings. ▪ Supported Ethiopia Midwives Association to lead the professionalization of midwifery in the country. ▪ HEW skills in managing cases improved in Oromia and Afar regions.	▪ Identified nine promising practices in MNCH for potential scale-up by FMOH. ▪ Operations research on the effectiveness of community-based KMC on-going in 10 districts.	▪ Improved quality of MNH services in all 119 facilities using PQI. ▪ Introduced culturally sensitive, women-friendly care services in MCHIP-support health facilities.	▪ Supported the provision of iCCM services working from 924 health posts in two zones of Oromiya and 53 health posts in Afar Region.
Ghana		▪ 42 midwifery clinicians and four tutors trained in selected BEmONC interventions and achieving competency. ▪ 58 preceptors from six midwifery training schools trained on mentoring/coaching skills and followed up. ▪ 82 tutors from 35 schools provided technical updates in TB, HIV/AIDS, malaria, and family planning (average score on post-test was > 80%). ▪ Six training sessions conducted and 132 tutors updated in new nutrition topics. ▪ Six skills labs at Jirapa, Goaso, Pramso, Mampong, Twifo Praso, and Hohoe health facilities fully equipped. ▪ Twifo Praso skills lab commissioned on September 20, 2013 by the Deputy Minister of Health.	▪ Strategic inputs to the curriculum revision process of the Nursing and midwives Council (NMC) of Ghana ensuring that the technical updates implemented are sustained.	▪ mMentoring study completed, included sending SMS messages and quiz questions to 21 tutors and preceptors and conducting structured mentoring via phone. ▪ Analyzed results will be shared with stakeholders and presented at the International Confederation of Midwives (ICM) conference in June 2014.	

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Guinea	▪ 62 facilities now offer implants, 108 offer IUD, and 18 offer PPIUD.	▪ Trained 1,080 CHWs and community association members in messages for FP, PPFP, PAC, MNCH, and IMNCI. ▪ Conducted innovative outreach to five salons in Conakry. ▪ Continued implementation of SBM-R in midwifery school. ▪ Supported the development of a skills lab for pre-service education that focuses on FP and MH. ▪ Supported the revision of national HMIS indicators and tools ▪ Supported health managers through LQAS and supervision visits.		▪ Integrated SBM-R into 10 new facilities (total facilities = 48). ▪ Achieved SBM-R recognition in 11 facilities.	
India	▪ Supported the integration of PPFP into routine MNCH services and revitalized immediate PPIUCD insertions.	▪ Built the capacity of the MOHFW's National Immunization Program, the state health departments, and their many Indian and external partners toward achieving and sustaining full immunization coverage by 12 months of age for at least 80% of India's children. ▪ Developed a scalable model for ENC at the facility level for sub-district health facilities.	▪ Strengthened and expanded the foundation of PSE at the national level by supporting the initiative of the Indian Nursing Council (INC) and the Government of India (GoI). ▪ Set up state nodal centers of excellence and upgraded ANMTC clinical training capacity in Jharkhand and Uttarakhand. ▪ Supported Child Survival Call to Action Summit by working with six sub-committees, serving as secretariat for the summit, and coordinating with GoI and all development partners.		

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Kenya					
Nutrition	▪ Introduced Baby Friendly Community Initiative (BFCI) package in Igembe North. ▪ Developed, finalized, and printed the nutrition BCC materials for ORT corners.	▪ Provided TA to the Igembe North DHMT to form six MIYCN community support groups. ▪ Identified complementary local recipes for diet improvement through community support groups in collaboration with the Ministry of Agriculture.	▪ Provided TA to develop the national MIYCN policy and strategy and to finalize the national MIYCN operational guidelines.		
Immunization	▪ > 75% of the children received the first dose of pentavalent 1 within 2 weeks of the scheduled date. ▪ 70% of the caregivers adhered to the four-week interval between doses. ▪ >70% of the children had completed their pentavalent schedule by the time they were 32 weeks old.	▪ Finalized the pre-service EPI curriculum for nursing schools. ▪ Updated the immunization policy guidelines to include PCV 10 and Measles vaccine second dose.	▪ Scaled up the RED approach to Igembe North, Tigania East, and Tigania West districts.		
Reproductive Health	▪ Reviewed DHS data and found: – New ANC clients increased from 36.3% to 46.9%. – Mothers who completed four ANC visits increased from 12.6% to 16.4%. – ANC clients counseled for HIV increased from 73.8% to 96.3%. – Eligible ANC clients issued ARVs increased from 68% to 100%.	▪ Trained 20 service providers on MNH service delivery standards based on the SBM-R approach from four district hospitals. ▪ Provided TA and participated in development of a six-day EmONC training package. ▪ Trained 73 service providers in EBC for APHIAPlus programs.	▪ Conducted an assessment on newborn hand washing with soap and identified poor messaging by health care workers to mothers. ▪ Provided TA to incorporate newborn components/messages into iCCM and FP/MIYCN guidelines and in the harmonized EmONC curriculum and Learning Resource Package.	▪ Implemented the RED approach for PMTCT in Igembe sub-county.	▪ Scaled up PMTCT community units to cover 100% of Igembe North sub-county (formation of 20 CUs).

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MIYCN/FP		▪ Trained 18 SPs, seven CHEWs, and 77 CHWs in six sites and affiliated community units on FP/MIYCN integration. ▪ 55% of SPs demonstrated knowledge and skills in promotion of FP and exclusive breastfeeding. ▪ 87.5% of CHWs convey MIYCN/FP messages at the community level.			
PPH Study, MNH Surveillance			▪ Conducted a PPH study in Nairobi slums that mapped health facilities, collected baseline data from nine health facilities, and trained onsite trainers, service providers and CHWs on eight key PPH-FP topics. ▪ Conducted MNH surveillance in four hospitals on data collection and utilization for decision making, introduced baby's notes page in all four hospitals, and instructed how to correctly fill out and use partographs and Maternal and Perinatal Death Surveillance and Response forms.		
FP		▪ Supported 363 CHWs in Bondo, 554 CHWs in Igembe, and 35 in East Pokot to conduct home visits, counsel families on FP options, and make referrals to health facilities for uptake of methods. ▪ Provided MOH-recommended monthly stipend of KSh 2000 (about 23$) to CHWs. ▪ Supported 25 integrated outreaches (FP services and commodities) in hard-to-reach areas every month.			

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PMTCT		▪ Trained DHMT and CHEWs on the PMTCT community strategy.			
Malaria	▪ Registered 3,212 pregnant women and referred 47% for ANC.	▪ Trained CHWs in 12 out of targeted 14 malaria endemic counties on MIP performance standards. ▪ Mentored 1,284 out of targeted 1,200 facility in-charges and district focal persons on MIP performance standards.			
AIDS/STI Control			▪ Assisted with development of National community PwP orientation package for HIV managers/supervisors at the community and the facility levels.		▪ Raised awareness of use of condoms and living positively by working with most-at-risk populations (MARPs). ▪ Collaborated with NASCOP and NACC to reach these cohorts and give them PwP messages to reduce and, if possible, avert new HIV infections. ▪ Provided TA to NASCOP to develop national community PwP reporting framework and M&E tools.
Lesotho	▪ >31,000 male circumcisions were conducted in 13 hospitals and clinics.	▪ Trained 74 new providers to competency in VMMC skills training, early infant male circumcision (EIMC) skills training, and training of trainers. ▪ Collaborated with the MOH to maintain a productive relationship in which the MOH is actively involved in the VMMC program. ▪ Conducted QA supportive supervision, procured pharmaceuticals, and provided service providers.	▪ Conducted a study on client views to assess why clients ("early adopters") choose to come for VMMC services. ▪ Conducted a literature review to expand understanding of gender issues and opportunities in VMMC.		

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Liberia	▪ Planned and implemented "District Contraceptive Days" in nine districts in Montserrado, Grand Bassa, and Margibi counties in collaboration with MOHSW. ▪ Counseled 6,862 clients on FP in all modern contraceptive methods and provided free FP services for the method of their choice.	▪ Completed the FP/EPI integration pilot project in Bong and Lofa countries: – Found a substantial increase in the number of new contraceptive users (90% increase in Bong, 73% increase in Lofa). – Immunization data gave a mixed picture at pilot facilities. – Trained 23 National Trainers on KMC from five hospitals where KMC is being introduced.	▪ Drafted and finalized the "USAID's Liberia Family Planning Roadmap to Support the MOHSW in Reducing Unintended Pregnancies." ▪ Participated in the Chlorhexidine Working group where the Chlorhexidine for Cord Care and National Implementation Guideline was developed and later approved by MOHSW. ▪ Completed Phase 1 of the PPH Project which achieved uterotonic coverage of 53% of all estimated deliveries (facility and home births combined), led to increase in ANC visit and facilities births, and showed that an intervention focusing on PPH prevention for both facility births and home births is feasible to implement. ▪ Conducted a PPH Project dissemination meeting for stakeholders.		▪ Designed and printed counseling cards/booklets for the *Home-Based Maternal Newborn Health Care Training Manual* adopted from the WHO training manual on community-based maternal and newborn care for CHWs.

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Madagascar		▪ Trained 169 providers, including from faith-based organizations, on MNCH. ▪ Increased the capacity of 341 CHWs to provide essential maternal and newborn care. ▪ Involved 532 people in information sharing meetings which included advocacy for quality of care, equity, access for better care for women and newborns, and community-based distribution of misoprostol. ▪ Distributed 1,822 posters and job aids. ▪ Trained 149 CAs and 44 ASs in PPH prevention and misoprostol distribution.	▪ Revised MNCH pre-service curriculum adopted by 13 private training institutions.		▪ Reached 12,075 community members by CHW group talks and visits. ▪ Distributed misoprostol to 1,124 women who self-administered the drug during home delivery (80% of women enrolled in the study). ▪ 85.4% of women who took misoprostol reported being favorable of the drug.
Malawi Immunization	▪ Introduced Rotavirus vaccine in November 2012.	▪ Conducted Rotavirus Post-Introduction Evaluation in July 2013. ▪ Sponsored Malawi's participation in WHO Regional workshop on EPI curriculum revision. ▪ Trained 88 trainers and 1,450 vaccinators/trainers on Immunization in Practice (in 23 districts. ▪ Conducted a training needs assessment of the EPI unit, three zonal offices, six districts, and six training centers/institutions.	▪ Developed the first National EPI Policy. ▪ Revised the EPI Field Guide. ▪ Revised the cMYP for Immunization.	▪ Participated and funded the EPI comprehensive review in 14 districts. ▪ Printed immunization monitoring charts and reporting tools. ▪ Participated in supportive supervision visits.	
Malawi VMMC					

	SERVICE DELIVERY	CAPACITY BUILDING	POLICY	QUALITY IMPROVEMENT	COMMUNITY
Mali (PSI)	▪ Provided 24,388 women of reproductive age with access to implants and IUDs. ▪ Distributed 345,222 injectables. ▪ Distributed 911,399 oral contraceptives. ▪ Tested 17,926 people for HIV, in line with its' combination prevention approach. ▪ Distributed 13,218,118 male condoms. ▪ Provided families with more than 3,023,600 units of safe drinking water products, and 86,116 lifesaving oral rehydration salts for young children.				
Mali	▪ During LARC Campaign, 448 women received implants and two received free IUDs.	▪ Trained 65 skilled providers in LARC training in Kita district ▪ Finalized and validated Relais training manual. ▪ Trained 20 master trains on TOT. ▪ Trained 158 DTC and 408 ASC on rollout in all MCHIP districts. ▪ Trained 246 health providers (108 skill providers and 138 matrons) in Kita and Diema on HBB approach.	▪ Developed BCC strategy and BCC program rollout at national and district levels through advocacy, workshops, radio, and other media outlets.		▪ 7,900 community members participated in health fairs across all seven MCHIP districts. ▪ 5,922 individuals received preventive health services including WASH, nutrition, and FP.

	SERVICE DELIVERY	CAPACITY BUILDING	POLICY	QUALITY IMPROVEMENT	COMMUNITY
Mozambique		▪ Supported the MOH to conduct three regional PPIUCD trainings in collaboration with Pathfinder, resulting in the training of a total of 57 health professionals (50 MNCH nurses, two surgical technicians, two gynecologists/obstetricians, one surgeon, and two general medicine physicians) from hospitals, health centers, training centers, and DPS. ▪ Supported the MOH to conduct a Training of Trainers (TOT) in HBB which resulted in 40 trainers trained from all 11 provinces. ▪ During this training, the provincial trainers developed a series of next steps, including presentation of the HBB methodology to the Provincial Health Directors and Medical Chiefs as a way to improve neonatal mortality indicators. ▪ These 40 trainers then trained 260 health workers in Nampula, Cabo Delgado, and Inhambane provinces.	▪ Organized and led the National Quality and Humanization of Care Meeting in November 2012. ▪ Approximately 250 participants attended the meeting, including members of Quality and Humanization of Care Committees from the health facility, district, provincial, and national levels. The meeting demonstrated active participation by all attendees, including religious leaders, community leaders, and traditional medicine practitioners, representatives from the League of Human Rights, health workers, and partners. ▪ This meeting mobilized the active support and collaboration from several USG partners such as EGPAF, ITECH, CHASS, Pathfinder, and others.	▪ Worked with health facility staff to conduct a total of 293 technical assistance/supportive supervision visits to 95 MMI facilities.	

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Namibia		▪ Reviewed and revised Health Extension Program (HEP) training materials, including monitoring and evaluation tools and forms. ▪ Developed draft standard operations procedure (SOP) for the HEP and conducted a rapid assessment of the HEP at pilot intervention sites. ▪ Developed HEP indicators in coordination with the HIS team. ▪ Provided STTA and TOT to facilitate the HEW training in Kunene Region ▪ Liaised between MOHSS, USAID, C-Change and other IPs. ▪ Provided training on workplan implementation to KTPTF for a pregnancy prevention program in Kavango region. ▪ Finalized teen pregnancy prevention brochure. ▪ Conducted initial assessment and developed VMMC scope of work. ▪ Developed an MCHIP-specific plan to support the VMMC scale-up efforts in Zambezi.	▪ Held stakeholder workshop in February 2013 on strengthening and integrating Namibia's national HIS system. ▪ Provided technical assistance to the TWG in reviewing the HIS Strategic Framework with key staff in the MOHSS.		
Nepal		▪ Assisted C-Change to facilitate the HEW refresher training, and developed draft SOP for the HEP and conducted a rapid assessment of the HEP at pilot intervention sites.			
Philippines	Introduced KMC in two government hospitals.	▪ Developed a service delivery manual for PPFP/PPIUD to supplement the current *Philippine Clinical Standards Manual on Family Planning*, approved and endorsed by the DOH. ▪ The supplement is expected to aide FP service providers with updated information on PPFP technologies, strengthen the adaptation and scale-up of PPFP-PPIUD services in health facilities, and increase stakeholder buy-in among the cadre of FP service providers.	▪ PPIUD included officially in the *Clinical Practice Guidelines on Family Planning* allowing providers to add another choice in the method mix.		

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Rwanda	▪ Initiated four VMMC services in the Rwanda National Police health facilities. ▪ 977 men circumcised. ▪ Administered misoprostol to women in both health facilities and at home in four districts. ▪ Among those women who give birth at home, 76% of those enrolled in the study took misoprostol. ▪ Among women who gave birth in health clinics, 86% received a uterotonic.	▪ Trained 60 providers on VMMC surgical procedures and counseling. ▪ Developed IEC materials and job aids for HIV prevention and VMMC.	▪ Conducted MIP prevalence study in six districts. ▪ Documented best practices and bottlenecks to program implementation in Rwanda through analysis of the status of prevention and control of malaria. ▪ Evaluated the impact of malaria control interventions on all causes of under-five mortality, in partnership with ICF/Macro, PMI, and RBM.		
Senegal	▪ Conducted MenAfriVac vaccine campaign for one- to 29 year-olds in 35 districts in eight regions with highest risk of MenA meningitis spread. ▪ 95% of target population reached in most health districts (based on immunization cards, immunization history reported by individuals). ▪ 91–94% coverage: In 12 of a total 35 districts (in eight regions). ▪ Only seven districts with coverage <80% (based on immunization cards alone).	▪ Participated in EVM assessment and national logistics inventory. ▪ Contributed to National Immunization Coverage Survey. ▪ Contributed to RI strengthening ▪ Supported regular technical Inter-Coordinating Committee (ICC) meetings at central level. ▪ Supported planning for PCV13 introduction and MR catch-up campaign.	▪ Launched Inter-University Diploma on Vaccinology initiative, collaborating with University of Dakar to integrate principles of WHO MLM training course into medical curriculum. ▪ Participated in decision-making process, reviewed comprehensive Multi-Year Plan (cYMP), and developed draft vaccine introduction plans for rotavirus vaccine and MR as 2nd dose of measles vaccine (through ICC Technical Committee).		

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South Sudan	▪ Protected 94% of births from PPH. ▪ 99% of women who had misoprostol and delivered at home took misoprostol. ▪ Increased facility birth rate.	▪ Advanced the finalization, printing, and plans for launching the FP Policy, RH Policy, and RH Strategy. ▪ Convened FP Technical Working Group meetings with stakeholders. ▪ Supported the MOH to review proposals for RH activities by implementing partners. ▪ Reviewed data on behalf of RH Directorate as it was collected from the national EmONC needs assessment. ▪ Assisted the HIV Division to meet its reporting requirements. ▪ Assisted the HIV Division to meet other data requirements: HIV/AIDS 2013–2017 strategic plan, proposal development (TFM), ART scale-up plan (test and treatment cascade), and PMTCT scale-up plan. ▪ Assisted HIV Division to complete surveys.	▪ Prepared for the update of the FP Technical Guidelines.	▪ Reviewed data collection and reporting tools for HIV/AIDS.	
Tanzania Immunization	▪ Participated in rapid district cold chain inventory (conducted through multi-agency collaboration in 130 districts, with 105 vaccine stores identified as having a shortage of refrigerators). ▪ Installed cold rooms in 19 regions in advance of new vaccine introduction.	▪ Trained 37 District Immunization and Vaccine Officers from five regions on vaccine management. ▪ Trained 361 national and zonal level health staff on new vaccine introduction. ▪ Co-organized and supported vaccine launch and key communication messages and materials. ▪ Updated training, monitoring, and reporting tools. ▪ Conducted National MLM TOT and preparation for follow-up trainings ▪ Acted as advisors in ICC and training, logistics, and communication sub-committees ▪ Supported the IVD annual review and regional micro-planning meetings. ▪ Identified eight lower performing districts across three regions. ▪ Conducted and completed situational assessments in focus districts to identify gaps in RI.	▪ Revised the immunization policy to include two new vaccines (PCV and Rotavirus). ▪ Changed the immunization schedule to accommodate these new vaccines (i.e., from 4, 8, 12 weeks to 6, 10, 14 weeks).	▪ Conducted post-introduction follow-up, including: – Supervision visits conducted in regions. – Incorporated new vaccines in IVD annual plan and in monitoring and reporting. – Revised PIE tool may be piloted. – Identified supportive supervision needs in under-vaccinated areas.	

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Tanzania VMMC	▪ Conducted 114,545 VMMCs in three regions (surpassing the FY13 target of 100,000 VMMCs).			▪ Conducted quality assurance visits to each static site on quarterly basis. ▪ Identified recurrent gaps in service provision and found joint solutions with the facility management for improved services.	
Timor-Leste	▪ Increased Penta 3 coverage from 59% to 84% from Q3 2011 to Q3 2013 in IPL districts; decreased from 67% to 66% in other districts.		▪ Served as a key partner in national immunization initiatives: GAVI HSS proposal development; introduction of pentavalent vaccine; recent leading role during stock-out of measles vaccine.		
Uganda		▪ Trained 198 operational health workers in QI-RED in the five MCHIP districts (141 women and 57 men). ▪ Supported training in QI-REC methodology in all five MCHIP districts, totaling 391 participants (204 women and 187 men). ▪ During Q4, this included 315 participants (164 women and 151 men) in Iganga, Kabale, and Rukungiri.	▪ Supported MOH/UNEPI to review the EPI draft policy and process it for approval through MOH structures and consensus with other stakeholders. ▪ Completed a policy costing and impact assessment and report, and drafted a Cabinet memo for the Minister's endorsement and submission to Cabinet for approval; the policy will guide EPI system management and implementation throughout Uganda.	▪ Supported five districts in routinely analyzing local data, information used in district quarterly review meetings (QRM), and providing feedback to district and sub-county leaders as well as HFs; EPI locally -generated data is aggregated to facilitate assessment of sub-county, health sub-district (HSD), and district performance.	▪ Oriented Village Health Teams (VHT) in all five districts at a total of 10,135 participants (6,137 women and 3,998 men).

	SERVICE DELIVERY	CAPACITY BUILDING	POLICY	QUALITY IMPROVEMENT	COMMUNITY
Yemen	▪ Commenced procurement of KMC equipment for Al Wahda Hospital in Aden.	▪ Contracted MIYCN-TIPs site investigator, developed protocol, completed local orientation, piloted instruments, and conducted data collector's training in Dhamar. ▪ Revitalized RH TWG, MCHIP acting as Secretariat. ▪ Conducted competency-based training of 12 midwives on assisting normal birth. ▪ *Capacity building of 21 High Institute for Health Science (HIHS) staff from eight governorates on Standards-Based Management and Recognition (SBM-R) to support quality rollout of updated community midwifery education program and use of competency-based training. ▪ Conducted technical update of 112 service providers on PPFP. ▪ Conducted competency-based clinical training of 17 service providers.	▪ Completed the Yemen Maternal, Newborn and Child Health Situation Analysis. ▪ Conducted a KMC needs assessment of Al Wahda Hospital in Aden. ▪ Conducted gap analysis of RI services in Dhamar and Sana'a in coordination with UNICEF, WHO, and MOPHP. ▪ *Conducted gap analysis of MNH services at Dhamar Hospital.		
Zambia		▪ Developed the National PPH Prevention In-Service Training Package, which standardizes Zambia's approach to the scale-up of misoprostol and situates misoprostol within broader PPH prevention strategies, including facility delivery with AMTSL. ▪ Trained over 90% of skilled labor and delivery providers in Mansa District in EmONC.	▪ Established HBB as standard national protocol for newborn resuscitation training through inclusion in the National Newborn Framework, facilitating integration into national training curricula.	▪ Implemented district-led clinical mentorship program to provide monthly on-site mentorship to all 30 facilities which provide labor and delivery services in Mansa District, ensuring retention and application of skills in EmONC, HBB, and FP.	

	SERVICE DELIVERY	CAPACITY BUILDING	POLICY	QUALITY IMPROVEMENT	COMMUNITY
Zimbabwe	▪ Strengthened immunization services through supportive supervision (SS) and on-the-job training of health workers (HWs), and through RI activities in all seven districts in Manicaland (RED).	▪ Trained 156 HWs in BHFI from Mutambara and Rusitu Hospitals ▪ Conducted HBB training in newborn resuscitation for 176 maternity ward HWs from 17 SBM-R sites, KMC training for 55 HWs. ▪ Trained 162 HWs in IMNCI including post-training follow-up (PTFU) and SS. ▪ Trained 22 HWs in MCCM, with PTFU. ▪ Trained 306 VHWs in community IYCF. ▪ Trained 275 VHWs in community MNCH services (twice the annual target).	▪ Finalized guidelines and policies: QA/QI Policy, National IYCF Policy, Draft RH Policy; National MPMA guidelines and death notification forms; Implementation Matrix for National Food and Nutrition Security Policy.	▪ Ongoing implementation of MNCH service delivery quality improvement activities (using SBM-R), including SS visits made to 100% of SBM-R-supported health facilities, modular training for HWs and PTFU, and support for commodities/supplies to SBM-R-supported and other health facilities.	