MCHIP YEAR FIVE SEMI-ANNUAL REPORT ADDENDUM

Reporting Period: October 2012 – March 2013

Country Summaries and Success Stories

Table of Contents

Country Summary: Bangladesh 1
Success Story: Bangladeshi Celebrity Draws Media Attention to Program Efforts during Site Visits 8
Country Summary: Bolivia 9
Success Story: MCHIP and the LAC Neonatal Alliance Promote Priority Newborn Health Interventions 14
Country Summary: Dominican Republic 15
Country Summary: Egypt 20
Success Story: Director of Community Development Association Puts her SMART Training to Good Use 25
Country Summary: Ethiopia 27
Success Story: Rural Health Center Makes Mothers' Needs a Priority 36
Country Summary: Ghana 38
Success Story: Basic Emergency Obstetric and Newborn Care Training in Ghana Builds Confidence to Save Lives 41
Country Summary: Guinea 42
Success Story: Guinean Woman's Life Saved by Quick Actions of Health Care Providers 51
Country Summary: India 53
Success Story: MCHIP Prepares State Trainers to Help Strengthen Family Planning Services in India's Most Populous State 59
Country Summary: Kenya 60
Success Story: Zinc Policy Change in Kenya Expands Access, Paves Way for Improved Child Health 74
Country Summary: Kyrgyzstan 75
Country Summary: Lesotho 78
Success Story: Improving Clinical Education Practices in Lesotho: The Role of the Preceptor 84
Country Summary: Liberia 85
Success Story: Market Contraceptive Program: Expanding Family Planning Services Outside of the Health Facility in Liberia 90
Country Summary: Madagascar 92
Success Story: Community Health Worker in Madagascar Instructs on Misoprostol Use to Prevent Postpartum Hemorrhage 97
Country Summary: Malawi 98
Success Story: "Like I Have Been Circumcised at Home": Community-Based Outreach Sites for VMMC in Malawi 104
Country Summary: Mali 106
Success Story: World Malaria Day 2013: Making Lifesaving Treatments Available to Children in Rural Mali 110
Success Story: Malian Midwife Champions Respectful Care for Pregnant Women and their Families 112
Country Summary: Mozambique 114
Success Story: Grandmother of Three in Mozambique Saved through Cervical Cancer Prevention Program 123
Country Summary: Namibia 124
Success Story: Saving Mothers' Lives with Calcium: An Innovative Program in Nepal to Prevent Pre-Eclampsia 127

Country Summary: Pakistan 129
Country Summary: Rwanda 135
Country Summary: Senegal 140
Success Story: MCHIP Supports Successful Mass Meningitis Vaccination Campaign in Senegal 143
Country Summary: South Sudan 144
Success Story: MCHIP Helps Prevent Postpartum Hemorrhage in South Sudan through Innovative Community Project 148
Country Summary: Tajikistan 149
Country Summary: Tanzania 152
Success Story: In Tanzania, MCHIP Supports Simultaneous Launch of Vaccines against Pneumonia and Diarrhea 156
Country Summary: Timor-Leste 157
Country Summary: Uganda 162
Country Summary: Ukraine 166
Country Summary: Yemen 169
Country Summary: Zambia 176
Country Summary: Zimbabwe 179
Success Story: Improving Access to Malaria Treatment in Remote Areas of Zimbabwe 184

Country Summary: Bangladesh

Period: FY 2013, Quarters 1 and 2

Selected Health and Demographic Data for Bangladesh	
GDP per capita (USD)	550.85
Total population	162,220,762
Maternal mortality ratio (deaths/100,000 live births)	194
Skilled birth attendant coverage	18
Antenatal care, 4+ visits	20.6
Neonatal mortality rate (deaths/1,000 live births)	36.7
Infant mortality rate (deaths/1,000 live births)	51.5
Under-five mortality (deaths/1,000 live births)	48 [61]*
Treatment for acute respiratory infection	57.2
Oral rehydration therapy for treatment of diarrhea	85.2
Diphtheria-pertussis-tetanus vaccine coverage (3 doses)	94
Modern contraceptive prevalence rate	47.5
Total fertility rate	2.7
Total health expenditure per capita (USD)	18.43

Sources: World Bank, Bangladesh 2007 Demographic and Health Survey, WHO, UNICEF, Bangladesh Maternal Mortality and Health Care Survey 2010.
*UNICEF <5 mortality ranking (1=highest mortality rate)

Major Activities by Program

- Helping Babies Breathe (HBB) National Scale-Up
- Safe Motherhood via the White Ribbon Alliance (WRA)
- Healthy Fertility Study (HFS)
- Mobile Alliance for Maternal Action (MAMA)
- MaMoni Associate Award
  - MNH/FP
  - Handwashing for newborn survival
  - IYCF
  - Quality Improvement/SBM-R

Program Dates	HBB: April 1, 2011–June 30, 2014 HFS: October 1, 2010–September 30, 2013 WRA: November 16, 2010–March 30, 2013 MAMA: December 9, 2011–September 30, 2013 DHSS: April 1, 201 –September 30, 2013 MaMoni: August 3, 2009–January 31, 2014
2012–2013 Budget	HBB: $1,482,895 (October 1, 2012–September 30, 2013) HFS: $522,000 (October 1, 2012–September 30, 2013) WRA: $350,000 (April 1, 2012–March 31, 2012) MAMA: $1,446,825 (October 1, 2012–September 30, 2013) DHSS: $6,000,000 (April 1, 2012–September 30, 2013) MaMoni: $3,964,862 (October 1, 2012–January 31, 2014)
Mission Funding to Date	October 2008–September 2009: $450,000 October 2009–September 2010: $100,000 October 2010–September 2011: $500,000 October 2011–September 2012: $5,461,142 October 2012–September 2013: $6,023,000 Total: $12,534,142 MaMoni Funding to Date: $12,649,886 (Total ceiling: $13,493,991)

Geographic Focus	HBB: National scale HFS: Sylhet WRA: National level MAMA: National scale DHSS: Habiganj, Noakhali, Laxmipur, National level MaMoni: Sylhet, Habiganj, National level					
Geographic Coverage	No. (%) of provinces	7 (100%)	No. of districts	41	No. of facilities	605
MCHIP In-Country Contact	HBB: Mostaq Ahmed, mostaq.ahmed@savethechildren.org HFS: Salahuddin Ahmed, sahmed773@yahoo.com WRA: Farhana Ahmad, farhana613@gmail.com MAMA: Ananya Raihan, ananya@dnet.org.bd DHSS: Ishtiaq Mannan, Ishtiaq.mannan@savethechildren.org MaMoni: Ishtiaq Mannan, Ishtiaq.mannan@savethechildren.org					
HQ Managers and Technical Advisors	Koki Agarwal, kagarwal@mchip.net; Pat Daly, pdaly@savechildren.org; Rebecca Levine, rlevine@mchip.net; Jaime Mungia, jmungia@mchip.net; Jeff Smith, jsmith@mchip.net; Joseph Johnson, jjohnson@mchip.net;					

Program Objectives

Helping Babies Breathe (HBB)

- Improve capacity of the skilled birth attendants of Bangladesh to resuscitate newborns in the facility and community and thus reduce neonatal mortality and future disability resulting from birth asphyxia:
  - Develop nationally adapted and accepted protocols of newborn resuscitation for all levels of skilled birth attendants.
  - Increase knowledge, skills, and practices of immediate management of birth asphyxia at all levels of skilled birth attendants, both at the facility and in the community.
  - Strengthen systems to monitor the safe delivery practices, including management of birth asphyxia.
  - Increase availability of equipment for newborn resuscitation at all levels and training equipment up to the upazila level.

Healthy Fertility Study (HFS)

- Develop and test an integrated family planning (FP)/maternal and newborn health (MNH) service delivery approach.
- Assess the strengths and limitations of integrating FP with an ongoing community-based MNH care program.
- Assess the impact of the intervention package on exposure to key, intervention-related messages, knowledge of contraceptive methods and the benefits of healthy fertility practices, and contraceptive prevalence, and method mix at different points during the extended postpartum period.
- Assess the impact of the intervention on pregnancy spacing and its outcomes.

White Ribbon Alliance (WRA)

- Raise awareness about the magnitude of maternal and neonatal mortality among policymakers and community leaders to influence them into action.
- Target advocacy efforts at those with decision-making authority in the access, utilization, and quality of MNH care services with a focus on specific “asks.”

- Identify, mentor, and encourage champions for safe motherhood, who will speak out in support of safe motherhood and reach audiences not usually accessible to WRA Bangladesh (WRA, B).
- Identify, document, and share proven local solutions for scaling up and replication.
- Disseminate lessons learned about the myriad of programmatic interventions and approaches known to be effective to reduce maternal mortality, especially those related to community and participatory approaches.
- Facilitate public and private sector accountability to the fulfillment of commitments and investments.
- Strengthen the organizational capacity of the WRA, B.

Mobile Alliance for Maternal Action (MAMA)

- Achieve sustained improvements in health knowledge and practices as well as health-seeking behavior of targeted women and gatekeepers.
- Ensure quality and effectiveness of services.
- Build and manage partnerships.
- Test a finance/business model for sustainability.
- Share learning from the project at national and global levels.

District Health Systems Strengthening (DHSS)

- Improve the national policy environment to support effective implementation of evidence-based maternal and newborn health, family planning, and nutrition (MNH/FP-N) interventions.
- Strengthen essential components of health delivery systems that support MNH/FP-N services at the district, upazila, union, and ward levels.
- Increase access to critical and lifesaving MNH/FP-N interventions at optimal quality of care at community-based service delivery points and from selected existing, strategically located facilities.
- Institute systems that engage community and local government entities at the upazila, union, and ward levels to improve demand and supply for MNH/FP-N.

MaMoni

- Increase knowledge, skills, and practices of healthy maternal and neonatal behaviors in the home.
- Increase appropriate and timely utilization of home- and facility-based essential MNH/FP services.
- Increase acceptance of FP methods and advance understanding of FP as a preventive health intervention for mothers and newborns.
- Improve key systems for effective service delivery, community mobilization, and advocacy.
- Mobilize community action, support, and demand for the practice of healthy MNH behaviors.
- Increase key stakeholder leadership, commitment, and action for MNH approaches.

FY 2013, Quarters 1 and 2: Achievement Highlights

Helping Babies Breathe (HBB) National Scale-Up

- At the policy level, the HBB protocol was incorporated into the community-based skilled birth attendants (cSBA) curriculum for birth asphyxia management. This will ensure that all skilled birth attendants providing services at the community level are trained in newborn resuscitation.
- At the implementation level, MCHIP continued the training of SBAs nationwide:
  - 418 doctors were trained as HBB trainers
  - 2,723 public facility birth attendants were trained (doctors, nurses, family welfare visitors, family welfare assistants, paramedics, and female health assistants)
  - 66 private facility providers were also trained
  - 536 facilities were equipped with newborn resuscitation equipment (bag and mask)
- Since the program began in April 2011, over 15,000 SBAs have been trained in 40 of 64 districts in Bangladesh. Scale-up in the remaining districts is expected to be completed by December 2013.

Healthy Fertility Study (HFS)

- The 30 months postpartum follow-up survey report was shared with USAID/Bangladesh. Selected key findings from the postpartum 30 months survey report were also shared at the annual American Public Health Association:
  - HFS activities were associated with a 26% increase in contraceptive uptake in the intervention arm from baseline (18%) to 30 months postpartum (43.9%); in the comparison area there was 16% increase from baseline (21.1%) to 30 months postpartum (37.2%).
  - Husband abroad/away from home was the main reported reason for not using any method of contraception in the intervention arm (43%), and husband disapproval was the main reason in the control area (39%).
  - The probability of becoming pregnant by 30 months postpartum was significantly lower in the intervention arm compared to the control arm (36.5% in the intervention arm vs. 44.8% in the control arm; $p<0.001$).
- Data collection and data entry for the sub-study on the cost-effectiveness of integrating FP into community-based MNH interventions was completed. Cost-effectiveness activities during the January–March 2013 reporting period encompassed: a) the collection of financial data on program costs; and b) determination of incremental CHW time costs associated with the integration of FP onto an MNH platform through in-depth interviews; and c) data entry and cleaning. Data analyses will span through the next quarter of 2013, with a manuscript slated for emergence by June 2013.
- A data analysis workshop was held at the Johns Hopkins Bloomberg School of Public Health 11–20 February 2013, with the objectives of: a) linking and cleaning the longitudinal data sets, b) reviewing draft manuscripts and finalizing them, and c) outlining and conducting preliminary analyses related to Year 2 manuscripts.

White Ribbon Alliance (WRA)

- A rapid situational analysis to assess the quality of maternal and newborn care in 10 facilities was conducted across five major divisions including Dhaka, Chittagong, Rajshahi, Kulna, and Sylhet. The tools included in the situational analysis included client exit interviews, key informant interviews, and video documentation. Findings from this assessment were used to make recommendations at both the divisional and national levels on how to improve MNH quality of care at the facility level.
- A draft "Client Charter of Rights" was developed for maternal and newborn health and shared with the Directorate General of Health Services and the Directorate General of Family Planning of the Ministry of Health and Family Welfare for their endorsement and inclusion in national policy and guidelines.

Mobile Alliance for Maternal Action (MAMA)

- A nationwide launch was hosted by the MOHFW and USAID on 18 December 2012. It is now providing the first nationwide mobile phone health information service in Bangladesh, with a promise of taking care of mothers and children. The launch was held in Dhaka at Osmani Memorial Hall, through a ceremony inaugurated by Dr. AFM Ruhal Haque, Minister of Health and Family Welfare, Government of Bangladesh, and Mr. Richard Greene, Mission Director of the USAID Bangladesh Mission. The event was attended by more than 500 guests including about 150 high officials from the offices of Ministry of Health and Family Welfare and other government offices and agencies.

- The Media/Above the Line campaign of Aponjon, including TV and radio commercials, newspaper ads, and billboards was launched in January.
- To date, close to 60,000 subscribers are being reached with key ANC, PNC, and FP messaging.

District Health Systems Strengthening

- Situational analyses completed for the two new DHSS districts of Noakhali and Laxmipur and district offices were established and staffed up.
- Key skills trainings for health service providers were conducted including Emergency Triage Assessment and Treatment (ETAT) for newborns.
- Twenty-nine paramedics were recruited and deployed to vacant Family Welfare Visitor positions in both the districts to fill critical gaps in access and availability of health services at the community level.
- Three Family Welfare Centers were identified for installation of 24/7 service delivery and were assessed for renovation.

MaMoni

- Over 13,000 community and facility-based health service providers were trained in various MaMoni interventions and strategies including community-based management of PE/E, ETAT for newborns, postpartum IUCD insertion, and community mobilization.
- Infant and Young Child Feeding (IYCF) was successfully incorporated into the MaMoni package of care (through the training of 255 outreach workers).
- MaMoni collaborated with FANTA III and the Institute of Public Health and Nutrition to launch a special effort to strengthen uptake of iron folic acid (IFA) by postpartum mothers in Madhabpur upazila. Under this initiative, postpartum mothers will receive IFA supplementation through PNC visits by FWA/HA. If found successful, the program will be scaled up in the rest of the district.
- New 24/7 delivery centers introduced and other facilities renovated for improved quality of care.

Ajmiriganj Facility Nurses' Quarters, January 2012

Ajmiriganj Nurses' Quarters after renovations were completed, December 2012

Priorities for Quarters 3 and 4

Helping Babies Breathe (HBB) National Scale-Up

- Continue HBB trainings in five new districts through the training of 1,435 SBAs.
- Conduct district reviews, private health care provider trainings, and refresher trainings in 18 districts.
- Conduct five district advocacy meetings in the five new districts, and 18 district review meetings in those that have already received trainings.

Healthy Fertility Study (HFS)

- Continue analysis of the longitudinal data.
- Finalize the report on assessment of return to fertility messages.
- Finalize the cost-effectiveness report.
- Finalize the postpartum 36-month report.
- Continue with the development of manuscripts.
- Disseminate results at the national level with a stakeholder meeting in September 2013.

Mobile Alliance for Maternal Action (MAMA)

- Develop a Multimedia Training Manual.
- Inaugurate program of "Sponsor a Mother" at Agora.
- Execute in-kind contribution with BEXIMCO Pharma.
- Integrate with TeleTalk.

District Health Systems Strengthening

- Training of community groups in Laxmipur.
- Supervision trainings for first-line supervisors.
- TOT of master trainers' pool on basic MNH/FP-N package: MaMoni MNH FP N package is customized for DHSS, and four master trainers from each of the upazilas will attend the TOT during May.
- Piloting MIS automation in Chunarught: This piece will be piloted in collaboration with ICDDRB and MIS, DGHS.
- Facility assessment survey: This activity has been contracted out. A third party will start this survey in three districts in May 2013.

MaMoni

- Training of paramedics on PPIUCD.
- Training of Union Parishads on MNH issues and their role.
- Renovation of East and West Boro Vakoir Union Hospital & Family Welfare Centers.
- Training of the third batch of private community SBAs.

Bangladeshi Celebrity Draws Media Attention to Program Efforts during Site Visits

by: Areba Panni, MCHIP/Bangladesh

Renowned Bangladeshi singer Samina Chowdhury's recent visits to several MaMoni project sites left her excited about what she saw, and the communities who met her were inspired. As MCHIP's Maternal and Newborn Health (MNH) Ambassador, Samina volunteers her time to bring attention to the Program's efforts.

This fall, she visited a home in Chunarughat Upazila (Habiganj District) to meet with Shamima Akhter, whose newborn girl was resuscitated three weeks earlier by Asma Akhter Khanum, a Family Welfare Assistant. Ms. Kahnum—who received Helping Babies Breathe (HBB) training as well as refresher training—was also at the home, and retold the events that led her to saving Shamima's baby girl.

On her second day in Habiganj, Samina visited additional MaMoni sites to meet staff and service providers, as well as the local community and media, who were eager to discuss MNH issues with her. They left feeling inspired by her kind words, and Samina gained a better understanding of the safe motherhood, newborn health, and family planning interventions taking place at the grassroots level.

Samina's tour of Habiganj is one part of larger efforts by the MCHIP/Bangladesh team to involve the media and celebrities in bringing the Program's messages to the general public. The hope is that frequent media coverage—in newspapers, on talk shows, and in broadcasts—will regularly remind the public of the importance of improving MNH and family planning (FP) outcomes. And this plan seems to be working: Samina's fall tour of Habiganj generated significant coverage in the local press, and reached the national media, as well.

Samina Chowdhury puts on a newborn's cap at Shibpasha Union Health & Family Welfare Center. (Courtesy of Save the Children.)

Samina Chowdhury talks to Nurunnesa, a Family Welfare Visitor, aboard the water taxi at Baniachong. (Photo courtesy of Save the Children.)

Samina's tour included Baniachong, where she saw the water ambulance and met Nurunnesa, a Family Welfare Visitor. The water ambulance, which is used in hard-to-reach areas of Baniachong, brings MNH-FP services to the doorstep of communities lacking easy access. It also acts as emergency transport for mothers and newborns, when needed.

"The water ambulance is an excellent initiative and is extremely important to reach those in the haors [wetlands]," Samina said. "It allows service provision within a sheltered structure that closely resembles a facility."

During a visit to the upgraded Shibpasha Union Health & Family Welfare Center, Samina met the mother who delivered the facility's 100th baby. She also interacted with local government officials, asking about their MNH-FP priorities and, in the evening, met with local journalists. Some had visited MaMoni intervention sites previously and were aware of the MNH-FP services being provided at Habiganj.

This prior knowledge led to an easy discussion on how best to highlight MNH issues through their channels. Samina appealed to the media to continue the media coverage, and, as evidence that she was heard, her visits to the MaMoni sites were covered widely in the local media and highlighted in a national newspaper, as well:

- Artist Samina Chowdhury Visits MaMoni Project Sites
- Singer Samina Chowdhury Visits Various Components of the MaMoni Project at Habiganj
- Samina Stands Beside Pregnant Mothers
- Singer Samina Chowdhury Visits MaMoni Project and Water Ambulance
- Water Ambulance at Haor Areas Impresses Samina Chowdhury
- Samina Chowdhury Visits Mothers and Children

Country Summary: Bolivia

Period: FY 2013, Quarters 1 and 2

Selected Health and Demographic Data for Bolivia	
GDP per capita (USD)	1,758.11
Total population	9,862,860
Maternal mortality ratio (deaths/100,000 live births)	180
Skilled birth attendant coverage	71.1
Antenatal care, 4+ visits	72.1
Neonatal mortality rate (deaths/1,000 live births)	27
Infant mortality rate (deaths/1,000 live births)	50
Under-five mortality (deaths/1,000 live births)	54 [55]*
Treatment for acute respiratory infection	50.9
Oral rehydration therapy for treatment of diarrhea	43.6
Diphtheria-pertussis-tetanus vaccine coverage (3 doses)	85
Modern contraceptive prevalence rate	95.4
Total fertility rate	3.5
Total health expenditure per capita (USD)	84.79

Sources: World Bank, Bolivia 2008 Demographic and Health Survey, WHO, UNICEF.
*UNICEF <5 mortality ranking (1 = highest mortality rate)

Major Activities

- Maternal and newborn health (**MNH**)
- Emergency obstetric and newborn care (**EmONC**) skills
- Postnatal care/**postpartum family planning**
- Family planning and reproductive health
- Postabortion care
- Quality improvement
- Establishment of **capacity development** centers

Program Dates	October 1, 2009–May 2, 2013					
2012–2013 Budget	$900,000					
Mission Funding to Date	$3,480,140					
Geographic Focus	Bolivia, Chuqisaca and La Paz Departments					
Geographic Coverage	No. (%) of provinces	2 (22%)	No. of districts	21	No. of facilities	120
MCHIP In-Country Contact	Patricia Arana, patricia.arana@jhpiego.org					
HQ Managers and Technical Advisors	Jeffrey Smith, jsmith@mchip.net; Patricia Taylor, ptaylor@mchip.net; Connie Lee, Connie.Lee@jhpiego.org; Michelle Goshen, Michelle.Goshen@jhpiego.org					

FY 2013, Quarters 1 and 2: Achievement Highlights

This report highlights achievements for the period October to December 2012. Due to the unexpected termination of the program, effective May 2, 2013, Quarter 2 data are currently incomplete but will be included in the final country report.

Objective 1: Improve the availability and quality of MH, FP/RH, and PAC services in health facilities in the target integrated health networks.

- MCHIP continued to participate in the **Safe Motherhood and Birth Working Group**, which aims to support and advocate for the implementation of public health policies for the reduction of maternal, newborn, and child deaths under the framework of continuous care. The interagency working group, led by the Ministry of Health and Sport (MSD) and also including other governmental entities, international agencies, women's organizations, and scientific associations, is committed to the collaborative improvement and realization of the 2010–2015 Strategic Plan for Maternal, Neonatal and Perinatal Health, focusing on health systems strengthening, quality of care, and intercultural rights.
- In May 2012, the URSSC (Quality and Health Services Networks Unit) of the MSD held a meeting to present a list of immediate actions that need to take place to contribute to the accelerated reduction of maternal and neonatal mortality in Bolivia. MCHIP had committed technical and financial assistance for those actions that are in line with its technical expertise in quality improvement through the implementation of **maternal and newborn health standards**. During Quarter 1, as part of its action plan, the URSSC conducted an evaluation of all partners that committed support. MCHIP was one of the few institutions that had successfully completed its planned activities, in both La Paz and Chuquisaca.
- During Quarter 1, MCHIP initiated **quality improvement processes** in 17 new health facilities in Chuquisaca, and 15 new health sites were established in La Paz, for a total of 32 new sites in the first quarter. This increased the number of health establishments where MCHIP works to an overall total of 110, as of December 2012. The new sites have initiated the joint Continuous Quality Improvement (CQI) and the Standards-Based Management and Recognition (SBM-R) approach, while the original 61 sites in Chuquisaca and 17 in La Paz continue to receive periodic monitoring sessions on their quality improvement processes. A dynamic monitoring process has been established in the majority of the networks, which includes the incorporation of a Quality Improvement Committee that follows up on the implementation of the Annual Operating Plans.

The table below presents the total number of health facilities that have received MCHIP support since FY 2012.

Table 1. Number of Health Facilities Supported by MCHIP

HEALTH NETWORK	FY 2012	FY 2013, Q1	TOTAL
Sucre	41	2	43
Camargo	19	15	34
Tarabuco	0	0	0
Monteagudo	1	0	1
Total Chuquisaca	**61**	**17**	**78**
Los Andes	0	0	0
Red 8	3	9	12
Red 3	14	6	20

HEALTH NETWORK	FY 2012	FY 2013, Q1	TOTAL
Red 5	0	0	0
Total La Paz	17	15	32
TOTAL GENERAL	78	32	110

- During the first quarter of FY 2013, a total of 60 participants, including authorities from SEDES Chuquisaca, health care providers, municipal authorities, and members of the community, were **trained in SBM-R**. In Coripata, Yungas (in the department of La Paz), 20 people participated in an SBM-R training including health providers, municipal staff, and community members from two health facilities.
- The MSD's quality improvement program, with the support of FORTALESSA and PAHO, presented to partners an internal and external communication strategy for quality and for the SAFCI (Family, Community, and Intercultural Health) framework. During the meeting, the MSD also proposed to reenact the **National Quality Committee** with direct support from the Minister of Health. At the municipal level, MCHIP implemented the first Quality Committee meeting with seven municipalities in the Camargo network in Chuquisaca.
- With technical assistance from MCHIP, the SEDES in La Paz and Chuquisaca implemented the use of **two new analytical tools**—a methodology for analyzing the flow of clients and determining where there are problems, particularly with regard to the timely provision of care, as well as a client satisfaction survey. During Quarter 1, in Chuquisaca, these tools were applied in San José, Valle Hermoso, and Villa Abecia Health Centers as well as the Poconas Hospital. In La Paz, they were applied in Coroico and Aymara in Escoma Hospitals.
- At the invitation of the leadership of the Camargo health network, MCHIP, in collaboration with SEDES Chuquisaca, Esperanza Bolivia, UNICEF, and HCP, led the implementation of a **simulated obstetric emergency** in Camargo. After the simulation was complete, the MSD, Chuquisaca Departmental Health Services (SEDES), and the other involved actors participated in an analysis of the strengths and weaknesses of the system and put into place a plan for filling in the gaps. Areas for targeted improvement included the vital participation of community members and local authorities, and the need for well-equipped health facilities, trained staff with a working knowledge of indigenous languages, improved supervision, and teamwork. The leadership of SEDES staff in organizing and directing the simulation activity should also be highlighted. This is an important step toward sustainability of the simulation approach; although initially the SEDES staff participated as a passive observer, today they drive the whole process.
- In Chuquisaca, MCHIP provided technical assistance to selected health facilities by laying the brickwork for the development of the manuals and norms that are a requirement for **accreditation**. The San Pedro Claver Hospital and the Jaime Sanchez Porcel Ob/Gyn Hospital continue to work toward accreditation. They have planned to conduct a follow-up self-evaluation during the month of January; depending on the results, the next step will be a final evaluation by the SEDES in order to receive accreditation. SEDES La Paz selected one health establishment from each network to complete the accreditation process in 2013. The Table below lists the health facilities in Chuquisaca and La Paz selected for accreditation in 2013.

Table 2. Health Facilities Selected for Accreditation in 2013

DEPARTMENT	HEALTH NETWORK	HEALTH FACILITY
Chuquisaca	Sucre	Hosp. Gineco Obstetrico
		Hosp. San Pedro Claver
La Paz	Los Andes	C.S. Palcoco
	Los Andes Manco Kapac	C.S. Germán Buch
	Camacho	C.S Ambaná
	Coroico	Hosp. de Coroico

Objective 2: Strengthen the capacity and competency of health care providers at various levels of care to apply evidence-based practices in MH, FP, and PAC in the target networks.

- From October to December, MCHIP led the **training of 554 health providers**, SEDES and municipal authorities, and community representatives from the five prioritized networks in the Chuquisaca. Technical areas highlighted included MH, FP, PAC, maternal mortality monitoring, and CCQI. Table 3 below details the number of participants trained in six health networks; Azurduy network is included in the table below because staff from this network participated in the Training of Trainers course supported by MCHIP.

Table 3. Number of People Trained, by Health Network

NETWORK	FAMILY PLANNING	CCQI	MATERNAL HEALTH	TOTAL
Camargo	42	63	41	146
Monteagudo	0	3	0	3
Sucre	189	203	0	392
Tarabuco	0	1	0	1
Azurduy	0	3	0	3
Oropeza	0	9	0	9
Total	231	282	41	554

- MCHIP organized a **Clinical Training Skills** workshop with 22 participants in the department of Chuquisaca, led by an MCHIP consultant. Already trained in best practices in maternal health, the participants expressed the importance of clinical training skills in order to replicate MCHIP's technical trainings with peers in their health networks. Before being certified as trained trainers, the cadre was to participate in one more technical update, focusing on FP and infection prevention measures.
- In the Jaime Porcel Ob/Gyn Hospital, four health care providers from the Padilla network completed five-day **internships**, during which they received theoretical and practical training with preceptors from the hospital. The preceptors had been previously tutored by MCHIP trainers.
- Strengthening of infection prevention skills and protocols continues to be enforced within the SEDES of La Paz and Chuquisaca. MCHIP highlighted **handwashing as a key practice for infection prevention** by distributing 1,500 posters detailing appropriate handwashing instructions. These posters are to be displayed in health centers, reiterating the importance of this practice for preventing infections and improving the health of all clients.

Objective 3: Strengthen Capacity Development Centers (CDCs) in FP/RH in hospitals in the target departments.

- In Chuquisaca, the two candidate hospitals—San Pedro Claver Hospital and Jaime Sánchez Pórcel Hospital—are still in the process of receiving accreditation by the MSD. The first to be accredited will become the CDC in Chuquisaca. Equipment for the CDC is currently being stored at the SEDES until the CDC is ready to be furnished.
- In La Paz, the equipment for the Municipal Hospital of the Los Andes network, selected by SEDES La Paz, is ready for delivery on a date to be defined by the SEDES. During Quarter 1, the hospital staff achieved 70% of the knowledge standards for accreditation. The health professionals participating in the series of Training of Trainers courses facilitated by MCHIP support the hospital's work toward accreditation.

Other Activities

- During Quarter 1, MCHIP provided technical assistance for a maternal mortality surveillance workshop in the Sucre 1 network. **Maternal mortality surveillance** committees were an initiative included in the URSSC/MOH's Plan of Immediate Actions to accelerate reductions in maternal and neonatal mortality. MCHIP provided technical and financial support to the work of these committees in both Chuquisaca and La Paz. During the workshop to finalize a report on maternal mortality surveillance, participants also discussed the management of the maternal mortality registry, identified gaps, and developed an action plan, for which follow-up is needed to ensure compliance. Conclusions and recommendations generated during the meeting were disseminated to the hospitals and municipalities where the maternal deaths occurred.
- SEDES Chuquisaca and MCHIP collaborated to **strengthen the Sucre 1 referral system** for the timely provision of services. MCHIP supported the implementation of a workshop to discuss health network operations and determine the referral health centers for each municipality. At the conclusion of the event, the referral hospitals corresponding to each health facility were identified; the results of this discussion will be disseminated to the health networks. The objective of the workshop was to optimize the referral/counter-referral system for the Sucre 1 network, under the leadership of the Director of Health Networks from SEDES Chuquisaca, Dr. Franz Quispe, and the management of the Sucre 1 network. The meeting, which paved the way for measures to improve the referral/counter-referral system for the timely care of obstetric and neonatal emergencies, was well-received by participants.
- **Educational materials and job aids** (including a FP brochure "Knowing to Decide," eligibility criteria disks for the use of contraceptives, the perinatal clinical history, and the partograph) were distributed to various health centers, and poster-sized examples of the perinatal clinical history and the partograph were delivered to hospitals staffed by MCHIP-certified trainers and to selected districts in the Túpac Katari network.

Priorities for Quarters 3 and 4

- As a result of the expulsion of USAID from Bolivia, MCHIP is currently in the process of closing out the program. A termination plan was submitted to USAID/Washington for approval on May 24, 2013. The project office in La Paz will be closed by July 31, 2013.
- The MCHIP team is developing a final report that will include a description of achievements and data through May 2, 2013. The report will be submitted to USAID by July 31, 2013.

MCHIP and the LAC Neonatal Alliance Promote Priority Newborn Health Interventions

by: Dr. Goldy Mazia, MCHIP Newborn Technical Advisor and Molly Miller-Petrie, MCHIP/PATH Program Assistant

Dr. Mazia with Dr. Villamizar (ALAPE) and Drs. Riestra and Michaca (Babies without Borders). Photo courtesy of PATH.

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

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

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

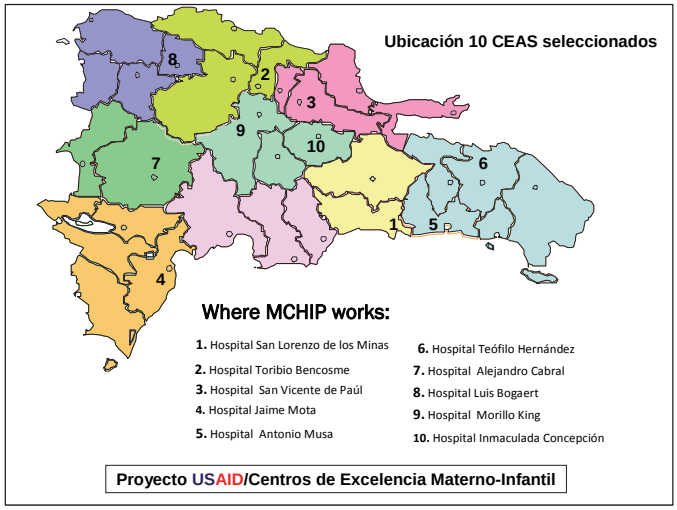
USAID and these Alliance partners have worked to foster a consensus among countries in the region on essential actions for newborn health by developing a Regional Strategy and Action Plan to promote newborn health, with a special focus on the most vulnerable populations. Given the importance of examining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

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

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

Country Summary: Dominican Republic

Period: FY 2013, Quarters 1 and 2



Selected Health and Demographic Data for the Dominican Republic	
GDP per capita (USD)	$9,600 (2012 est.)
Total Population	10,219,630 (July 2013 est.)
Maternal Mortality Ratio (deaths/100,000 live births)	150
Any antenatal care from a skilled provider	99%
Antenatal care, 4+ visits	95%
Delivery with skilled birth attendant	98%
Any postnatal care	91%
Births less than 2.5 kg (low birth weight)	11%
Neonatal mortality rate (deaths/1,000 live births)	17

Sources: DHS 2007; CIA World Factbook; MZ Oestergaard, et al. Neonatal Mortality Levels for 193 Countries in 2009 with Trends since 1990. 2011. PLoS Medicine 8:8; WHO, UNICEF, UNFPA, World Bank. Trends in Maternal Mortality: 1990-2010.

Major Activities

- Kangaroo Mother Care:
  - Implementation and expansion
- "Helping Babies Breathe" (HBB) neonatal resuscitation program:
  - Implementation and expansion
- Quality Improvement of Management of Newborn Sepsis:
  - On-site mentorship, site strengthening
  - Baseline and data base creation
- Improvement of MNH links for prevention and treatment of HIV/AIDS (PMTCT):
  - Baseline assessment
- Education of MNH staff
- National workshop held to present results of currently implemented and priority newborn strategies for scale-up
  - Workshop held, action plans drafted

Program Dates	April 1 2010–31 March 2012, extended through September, 2013					
Geographic Scope	Working in 8/9 Regions, 9/32 provinces in addition to the capital, 10/64 hospitals (mostly regional and referral)					
Geographic Focus	Maternal and Child Health Centers of Excellence Hospitals					
Geographic Coverage	No. (%) of provinces	8 (28%)	No. of districts	9	No. of facilities	10
PY 5 Budget	$231,929 MCH and $300,000 PEPFAR					
Total Mission Funding to Date	$651,400 MCH and $300,000 PEPFAR					
MCHIP In-Country Contact	Nieves Rodriguez, Country Representative, nortiz@path.org Vilma Mejia de Soto, Project Administrator, vsoto@path.org					
HQ Managers and Technical Advisors	Goldy Mazia, gmazia@path.org, Magdalena Serpa, mserpa@path.org, Pat Taylor, pat_taylor@jsi.com, Sarah Marjane, smarjane@path.org, Molly Miller-Petrie, mmiller-petrie@path.org					

FY 2013, Quarters 1 and 2: Achievement Highlights

Program Year 5 has been a year of implementation and expansion for MCHIP. In partnership with the USAID Bilateral the Centers of Excellence Project (CdEx), MCHIP has focused on scale-up of ongoing priority interventions such as newborn sepsis management, Kangaroo Mother Care (KMC) for low birth weight and premature babies, and Helping Babies Breathe (HBB) for birth asphyxia, as well as developed a new strategy to improve links to services for the prevention (PMTCT) and treatment of HIV/AIDS into newborn care. MCHIP was also successful in advocating for the inclusion of newborn health indicators in the Ministry of Health (MOH) national surveillance system.

In December of 2013, MCHIP and CdEx hosted a meeting on priority interventions in newborn health. Stakeholders from the Ministry of Health, UNICEF, PAHO, USAID, and the 10 CdEx Hospitals participated, and each hospital conducted a self-assessment and developed an action plan on newborn health for scale-up following the meeting. MCHIP also took this opportunity to present a tool for conducting baseline assessments of newborn services related to prevention and treatment of infections in facilities with CdEx, which decided to adapt the tool and apply it in all 10 hospitals.

KMC programs were expanded to two new CdEx Hospitals in Quarters 1 and 2. In Hospital Morillo King, 45 staff members, including neonatologists, pediatricians, nurses, and licensed assistants, were trained in KMC by a team that had previously been trained by the KMC training center (Hospital San Vicente de Paul), with support from MCHIP consultant Dr. Nieves Rodriguez. Hospital Antonia Musa received the same training shortly thereafter. Morillo King currently has 22 babies enrolled in the KMC program, and Musa has 45. In Quarter 3 the Kangaroo Mother Care Foundation will conduct a site visit and program review, and a psychologist from KMC training center San Vicente de Paul will travel to the KMC Foundation in Colombia to receive further training to replicate the related specific work.

On March 21, 24 providers at Hospital Alejandro Cabral, including general practitioners, pediatricians, neonatologists, family medicine residents, nurse practitioners, and nursing assistants, were trained by the MCHIP staff and national facilitators on Helping Babies Breathe (HBB). An additional nine trainings, covering all 10 CdEx hospitals, are being carried out in Quarters 3 and 4. MCHIP conducted the first HBB training in the DR in 2012, generating a great deal of interest from the CdEx hospitals as well as primary care facilities and other health institutions, such as those from the Social Security network.

A new strategy to improve links to HIV/AIDS services in the CdEx hospitals was developed by the MCHIP team in Quarter 2. This strategy will focus on utilizing pre-discharge areas from maternity wards and Kangaroo Mother Care programs as sites to identify HIV-positive mothers and exposed babies and ensure their referral and follow-up with the relevant services. A baseline assessment will identify gaps in knowledge of MNH staff regarding HIV/AIDS services so that improvements can be made. Implementation of this strategy will begin in Quarter 3 through identified local consultants.

MCHIP has focused on strengthening monitoring and evaluation in Quarters 1 and 2, and is currently in the process of developing automatized databases for KMC and HBB/ENC indicators with support from the MCHIP M&E team. A site visit will take place in Quarter 3 to implement and train staff to use the databases. A sustainability plan was also drafted in Quarter 2 to ensure project continuity through the bilateral and the MOH, and the team is working with the mission to develop a close-out plan for next year. This is very important considering the USAID MCH programs in the DR are closing next year.

Activity Highlights

Objective 1: Scale up the intervention for quality improvement of prevention and treatment of newborn sepsis in the MCH Centers of Excellence as part of the regional strategy to improve newborn health.

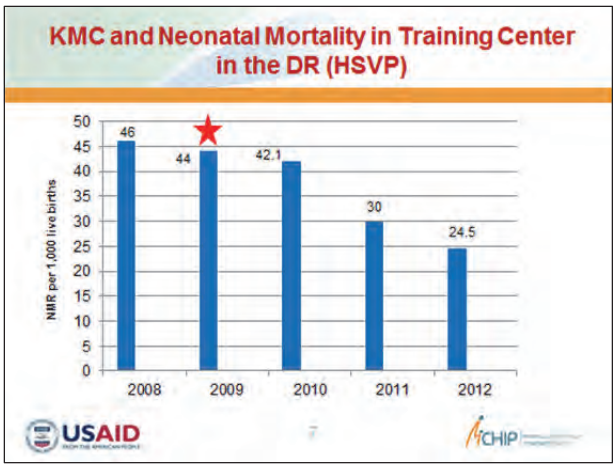
- The MCHIP tool for conducting a baseline analysis of newborn services related to prevention and treatment of infections in facilities was shared with CdEx and implemented in the 10 CdEx hospitals. Relevant results from the baseline, common to most hospitals, identified the following:
  - Non-hygienic practices at childbirth
  - Large human resources gap affecting the quality of care (nurses, doctors, cleaners)
  - Lack of equipment and supplies
  - Reuse of disposable materials
  - Newborn care conducted by unqualified or under-qualified personnel (internal medicine and nursing assistants)
  - Poor quality of antenatal screening increasing neonatal morbidity (no focus on risk prevention, no protocol, unsystematic, unsupervised)
- The database for this baseline assessment is currently under construction and will be finalized in Quarter 3.

Objective 2: Strengthen the implementation of Kangaroo Mother Care strategies in trained Centers of Excellence; continue expansion.

- In the KMC training center (San Vicente de Paul) the newborn mortality rate (NMR) has decreased from 44 deaths/1,000 live births at the time of initiation of the program, to 24 deaths/1,000 live births in 2012. This reduction may be attributed to a reduction in deaths of premature babies, as illustrated by a reduction in the proportion of newborn deaths represented by premature babies from 90% in 2008 to 61% in 2012.
- KMC programs were initiated by MCHIP in two new hospitals in Qs 1 and 2. Hospital San Vicente de Paul continues to serve as a training center and model site for KMC programs in the DR and internationally, and led the training for both hospitals. Forty-five staff were trained and 47 babies are currently enrolled in the newest hospital program at Hospital Morillo King. Hospital Musa currently has 27 babies in the KMC program.

- In coordination with CdEx and hospital management, areas in three hospitals were designed for ambulatory KMC follow-up to ensure that the KMC programs follow the recommendations of the Kangaroo Foundation in Bogotá, adapted to the circumstances and available budget of each hospital. MCHIP and CdEx collaborated to use donated time from a team of architects for the design, and the bilateral is funding the actual areas.

- MCHIP and CdEx hospital Los Minas donated bands and chairs for the startup of the new KMC programs, in addition to providing hard and soft copies of training materials for all participants.
- MCHIP is in the process of upgrading the KMC database to automatize the report of the indicators. This tool will be shared with the LAC KMC network and other interested KMC programs globally.



Objective 3: Implement the "Helping Babies Breathe" (HBB) curriculum in Centers of Excellence.

- On March 21, HBB workshops for health care providers were conducted at Hospital Dr. Alejandro Cabral, San Juan de la Maguana, with the participation of 24 providers (general practitioners, pediatricians, neonatologists, family medicine residents, nurse practitioners, and nursing assistants). Workshops are scheduled and confirmed with all the other CdEx hospitals, to take place between April and July, 2013.
- The HBB/ENC database is currently under construction and will be implemented in Quarter 3. MCHIP is including data collection for indicators during the trainings, and three hospitals are already collecting HBB/ENC data. Other centers in training are committed to reporting on the indicators as well. Their experience was shared at MCHIP's newborn global conference in South Africa on April 15 (together with the KMC data).
- An illustrative example is below:

INDICATOR	RESULTS
Number of trainers trained by type of cadre	41 total Neonatologists: 9 Pediatricians: 4 Obstetrics: 11 Nurses: 4 Nursing assistants: 2 Doctors: 2
Number (and percentage, if available) of babies not breathing at birth who were resuscitated successfully	33

Objective 4: Improvement of links to prevention and treatment of HIV/AIDS services in the MCH Centers of Excellence.

- The MCHIP team developed a new strategy to improve links to HIV/AIDS services in the CdEx hospitals in Quarter 2. This strategy will focus on utilizing pre-discharge areas from maternity wards and Kangaroo Mother Care programs as sites to identify HIV-positive mothers and exposed babies and ensure their referral and follow-up with the relevant services. A baseline assessment will identify gaps in knowledge of MNH staff regarding HIV/AIDS services so that improvements can be made. Implementation of this strategy will begin in Quarter 3 through identified local consultants.

Objective 5: National workshop to present results of currently implemented newborn strategies, ratify commitments and advocate for scaling-up and sustainability of newborn health priority interventions.

- This workshop took place on December 11 with participation from the Ministry of Health, representatives of UNICEF, PAHO, USAID, MCHIP, and the Centers of Excellence project headquarters and hospital staff, where current gaps and opportunities were discussed. As a result of this meeting, each hospital created a workplan with priorities in neonatal health.

Priorities for Quarters 3 and 4

1. HBB trainings will be held in all 10 CdEx hospitals; supervision and monitoring will be conducted by MCHIP in four hospitals.
2. Accompaniment, tracking, and monitoring and evaluation will be conducted by MCHIP in the four hospitals implementing KMC, with emphasis on new programs.
3. MCHIP M&E staff from Bolivia will visit the DR program to support the implementation of the new KMC and HBB databases being created.
4. A training trip will be made to the Kangaroo Foundation in Bogota by a HSVP psychologist, who will then train related staff in the other programs in the country.
5. An assessment visit to the four KMC programs will be conducted by staff from the Kangaroo Foundation, Bogotá, in the next quarter.
6. Activities to integrate HIV/AIDS with current newborn programs will start as soon as consultants are hired.

Donated KMC supplies arrive at the newly initiated KMC Program at San Vicente de Paul.

Participants at the December 11 Priority Newborn Health Interventions Workshop brainstorm gaps and opportunities for improvement.

A KMC father with his child.

Country Summary: Egypt
Period: FY 2013, Quarters 1 and 2

Selected Health and Demographic Data for Egypt	
GDP per capita (USD)	$2,698.00
Total population	81,121,077
Maternal mortality ratio (deaths/100,000 live births)	82
Skilled birth attendant coverage	79
Antenatal care, 4+ visits	66
Neonatal mortality rate (deaths/1,000 live births)	9
Infant mortality rate (deaths/1,000 live births)	19
Under-five mortality (deaths/1,000 live births)	22 [91]*
Oral rehydration therapy for treatment of diarrhea	19
Diphtheria-pertussis-tetanus vaccine coverage (3 doses)	97
Modern contraceptive prevalence rate	60
Total fertility rate	2.8
Percentage of pregnant women who are anemic	44
Percentage of pregnant women who took 90+ IFA tablets	14
Percentage of children under age five stunted (low h for age)	31

Sources: World Bank, WHO, UNICEF.
*UNICEF <5 mortality ranking (1=highest mortality rate)

Major Activities

- Community-based **maternal, newborn and child health/nutrition/family planning** package
- Organizational capacity-building of **community development** associations
- Study on causes of stunting in target governorates
- **Gender**-sensitive programming

Program Dates	October 1, 2011–June 30, 2014					
PY 4 Budget	$5,304,782 (MCH)					
Mission Funding to Date	October 2011–September 2013: $10,400,000					
Geographic Focus	12 Districts in 6 governorates in Lower and Upper Egypt: Qalyubia, Sharqia, Beni-Suef, Asyut, Sohag, Qena					
Geographic Coverage	No. (%) of provinces	6 (22%)	No. of districts	12	No. of facilities	N/A
MCHIP In-Country Contact	Issam Adawi: Issam.Eladawi@savethechildren.org; Ali Abdelmegeid: Ali.Abdelmegeid@savethechildren.org					
HQ Managers and Technical Advisors	Anita Gibson: agibson@mchip.net; Jennifer Shindeldecker: jshindeldecker@mchip.net; Angela Brasington: abrasington@savechildren.org; Rae Galloway: rgalloway@mchip.net; Anne Pfitzer: apfitzer@mchip.net; Vikas Dwivedi: vdwivedi@mchip.net					

FY 2013, Quarters 1 and 2: Achievement Highlights

Objective 1: Improved access to and quality of key maternal, newborn and child health/family planning/nutrition (MNCH/ FP/ Nutrition) services by private facility- and community-based providers.

- During Quarter 2, the SMART team introduced private pharmacists in participating project districts to SMART project objectives and activities through an orientation session. Key MNCH/FP messages that were shared with the intent that pharmacy staff could pass this messaging forward to pregnant women, their husbands, and other family members who entered the pharmacy include: the importance of taking iron-folic acid (IFA) tablets and completing regular antenatal care visits during pregnancy, and the benefits of exclusive breastfeeding and postpartum family planning after the birth. SMART will give maternal and newborn informational brochures and posters to pharmacies as well to encourage messaging to take place.
- During Quarter 2, SMART-trained volunteer doctors and lab technicians, together forming 261 mobile teams, provided MCH services in remote areas of all six governorates, benefiting 11,855 women and 18,366 children. Composed of a gynecologist, a pediatrician, and a lab technician, each mobile team traveled to pre-selected communities once a month to offer free medical care to pregnant women and mothers with children under two—a highly valued service for women previously precluded from their health care by prohibitive cost or distance to the nearest facility.
- IFA tablets are now available at no cost for pregnant women through local community development associations (CDAs) in the target project sites. Previously, only 31% of women regularly took the recommended dosage of iron during their pregnancy. Ensuring tablets are available at convenient locations, increasing awareness of their importance during pregnancy, and providing knowledge to Community Health Workers (CHWs) and other service providers on how women might mitigate unpleasant side effects encountered while taking IFA tablets, should result in increased numbers of women in SMART target sites receiving adequate iron during pregnancy.
- An important aspect of the SMART program is to circulate key MNCH/FP messages broadly in Egypt through partnerships, public presentations, and mass media, as much as possible. SMART collaboration with key sector stakeholders has begun to show results, with the most effective partnerships with medical faculties at eight universities and in six governorate health offices. By training future doctors (obstetricians/gynecologists and pediatricians) on maternal, newborn, and child health practices (for example, essential newborn care (ENC), Helping Babies Breath (HBB), and Kangaroo Mother Care (KMC)), SMART hopes these simple but effective techniques will become standard practice in delivery wards across the country. In addition, many practicing professionals have attended lectures and presentations given by SMART on these topics at various national and international health and nutrition conferences and workshops. SMART developed strong working relationships with Egyptian professional organizations, including the National Neonatology Association, the National Nutrition Institute, the Egyptian Association of Breastfeeding, and the Egyptian Syndicate of Nurses.
- In recognition of the value of SMART interventions, the Ministry of Health has requested that SMART behavior change communication materials (brochures on antenatal care, pregnancy, newborn and postpartum danger signs, and posters on nutrition, child growth, and development) are distributed to all public health centers across Egypt. They have also asked SMART to train 2,000 outreach workers (Raedat Rafiyat) on key messages for pregnant and breastfeeding women.

Objective 2: Increased knowledge and use of key MNCH/FP/nutrition behaviors by women and men.

- 1,200 CHWs were trained on a comprehensive health and nutrition package to provide counseling and education for mothers, fathers, grandmothers, and community leaders. Starting in October 2012, the trained CHWs began home visits to pregnant women and women with underweight or sick children under two, providing referrals to local service providers and offering regular nutrition classes for community groups. By the end of March 2012, 90% of trained CHWs continued to partner with SMART, providing needed community maternal and newborn health and nutrition education.
- In addition to regular home visits, the trained CHWs carry out weekly, biweekly, and monthly nutrition education and cooking demonstration classes for pregnant women, women with children under the age of two, and mothers- and fathers-in-law. Between 30 and 50 people participate in each session. Reports from these sessions reveal that much of the nutritional class information is new for participating community members. Often parents do not realize that their child is stunted. Many of the CHWs have forged close relationships with private service providers in their area to whom they refer women or children with any danger signs or illness. In some governorates, both private and public health facilities have reported an increase in attendance. In addition to home visits, pregnant women are participating in birth preparedness classes organized with women in the same stages of pregnancy routinely meeting together.

Objective 3: Increased capacity of Community Development Associations (CDAs) to implement community-based strategies to improve MNCH/FP/nutrition.

- 135 Umbrella Community Development Association (UCDA) members attended grant and financial management training. Members of the SMART Grants Management team also visited UCDAs in each governorate to build their project documentation and bookkeeping capacity.
- The UCDAs also completed strategic planning, time and resource management, and report writing trainings organized by the SMART project. Several UCDAs have been successful in raising funds from other donors to extend or expand their MNH- FP- nutrition activities, reflecting the beneficial nature of the trainings. In Upper Egypt, two UCDAs in Sohag and one in Asyut have received funding from the Social Fund for Development and World Food Program to replicate SMART key interventions outside the SMART target districts, increasing the number of trained CHWs equipped to support pregnant women and monitor infant growth.

Objective 4: Increased knowledge base of the causes, including gender-specific causes, of stunting and how to implement programs to reduce stunting.

- The stunting study has been initiated with the selection of research methodology and study sites. The team pre-tested detailed interview data collection tools on nutrition for pregnant women, lactating and non-lactating women, and infant feeding care and feeding practices of fathers, grandmothers, and health workers- all of whom greatly influence feeding. The team also piloted three Trials for Improved Practices (TIPs) visits in order to become familiar and comfortable with data collection methodologies for nutrition and behavior, and to develop strategies and recommendations for counseling mothers on small, practical steps they could take to improve infant and young child feeding. The planned stunting study will supply information on which behaviors and feeding practices should be targeted in Egypt and which messages need to be disseminated to address poor nutrition perceptions and practices.

- Four abstracts on SMART's activities and successes were accepted at international professional conferences. One of the abstracts will be presented at the Maternal and Infant Nutrition and Nurture conference in the UK in June. Three others will be presented at the IUNS International Symposium of Nutrition in Grenada, Spain in September 2013. Topics include the following:
  - Operations Research; Triangulation of Data Collection Methods and Analyses to Examine the Rise in Stunting in Lower Versus Upper Egypt
  - It Takes a Village: Developing Key Community-Level Messages to Address the Rise in Stunting in Rural Egypt
  - Using Positive Deviance to Identify Nutritious Recipes for Complementary Feeding and to Reduce Stunting in Rural Egypt
  - Promoting Increased Knowledge of Maternal Health and Nutrition through the Egypt SMART Project: Baseline and Training Results

Objective 5: Improved critical awareness of the impact of gender roles in improving MNCH/FP/nutrition outcomes.

- Raising awareness of gender equity is a common theme in all SMART activities. The newly-hired Senior Gender Advisor drafted a program-wide Gender Equality Strategy, which frames SMART's gender approach across all activities and with implementing partners.
- Training for Trainers (TOT) workshops were held in all governorates for CHW supervisors and UCDA staff, with the strongest participants selected as trainers for the remaining CHWs working in intervention areas across Egypt. From each governorate, 15 trainers were chosen and attended the workshop before delivering a one-day gender awareness-raising workshop in each of the districts. These workshops train CHWs to introduce the concepts of gender roles, social and gender-based inequalities, domestic violence, and women's rights during each routine home visit, an approach called the *Family Solidarity Module*.
- "Gender champions" have been selected in every district and will also be trained on the *Family Solidarity Module* in order to present this method to Community Health Committees and other community members.

Other Activities

- In November 2012, the SMART team participated in the annual Alexandria Health Conference, with four presentations given by SMART staff members and consultants, and a booth presenting SMART accomplishments and strategies. It was an ideal opportunity to introduce the SMART project to a wider audience in the medical field.
- The international World Water Day on 21 March was an occasion to raise awareness of the value of water on the planet. As water scarcity is a key issue in Egypt, and hygiene an important SMART message, the day served as an opportunity for SMART to collaborate with partner CDAs and community CHWs, asking them to emphasize hygiene and smart water use messaging. These messages, which addressed handwashing, conservation of water supplies, and the importance of clean drinking water, were also shared with MCHIP, and put on the central website. (http://www.mchip.net/node/1671).
- Another recent initiative is the partnership between SMART and an NGO called Healthy Egyptians, which recently ran a campaign raising awareness about pneumonia in Egypt (http://youtu.be/q4WPoOZIvlY), with collaboration on additional health campaigns being planned for the future. The next health campaign will address the topic of iron deficiency anemia, which, as mentioned above, is a key priority for the SMART project.

Priorities for Quarters 3 and 4

- With the possibility of extending project activities into mid-2014, there is renewed energy and commitment by field staff and stakeholders. As the main actors to relay nutrition and newborn/child health messages to mothers, CHWs will benefit from planned refresher training, which serves as an excellent venue for sharing of common experiences and providing new information.
- Two main project documents, *Training Guidelines for CHWs and the Service Providers Protocol*, will be published in hard and soft copies, and shared widely with health practitioners in Egypt. SMART will focus on ensuring that key messages are correct and consistent across both public and private sectors.
- Gender workshops have been very popular in the field, and selected trainers are eager to start cascade training. The next step in the gender component is to build the capacity of local Community Health Committees to raise awareness about gender relations in the communities where they work. SMART will continue to search for opportunities to advocate at all levels for better maternal and infant nutrition in Egypt. Accumulation of data from the field, and the early findings of the Stunting Study, will provide evidence for this advocacy, and, it is hoped, influence decision-makers in the Ministry of Health and other key stakeholders.

Director of Community Development Association Puts her SMART Training to Good Use

Many Community Development Associations (CDAs) in Egypt struggle to be sustainable, as their initial funding is spent on start-up costs, and local activities rarely make enough money to pay salaries and ongoing maintenance costs. One of the objectives of the SMART project—a USAID-funded MCHIP project that focuses on improving maternal and neonatal health and nutrition—is to build the capacity of CDAs so they can be more self-reliant. The project works through CDAs in Upper and Lower Egypt, training physicians and community health workers to improve newborn care, nutrition, and the use of modern family planning methods. Stronger CDAs can continue to implement SMART activities in the community after the end of the project.

To strengthen their organizational systems and structures through training and supportive supervision, SMART selected 12 umbrella CDAs in six governorates to form partnerships with up to 10 local CDAs each. At the same time, doctors and community health workers were trained on basic maternal and newborn health interventions that can prevent maternal and neonatal mortality and morbidity.

The CDAs were carefully selected for their potential to incorporate SMART messages and activities into their own programs. And while long-term perpetuation is never guaranteed, a few of the local CDAs have already proven they have the ability to effectively utilize the training and resources they received to achieve SMART objectives—as well as their own improved viability.

One of these is the Women's Association for Health Improvement ("Tahssin El-Seha") established in 2009 in Lower Egypt as a branch of a national organization. Its founder and Director, Ebtisam Ahmed Sayed, is a dynamic young woman determined to help other women in her community. Since opening, the main activities of Tahssin El-Seha have been income generating projects run by and benefitting poor women, mostly widows and divorcees, including:

- Making and selling clothes, tablecloths, and other household linen;
- Decorating and renting out a wedding hall;
- Operating a small catering business;
- Distributing food from the governorate food bank to poor families; and,
- Setting up a revolving loan fund for women to start small businesses with the assistance of the Ministry of Social Affairs.

All of these activities are much needed and appreciated in the communities of Kafr Tesfa, Kafr Marwan, Kafr Ragab, and Kafr Fanoos, but barely cover the operating costs of the CDA.

Ebtisam Ahmed Sayed (center), Director of Tahssin El-Seha, and her team. (Photo courtesy of MCHIP.)

Last year, Tahssin El-Seha decided to add health care to its women empowerment activities, and opened a small outpatient clinic in one room of its office building. It has a rota of general practitioners and obstetricians/gynecologists who provide simple health checkups and referrals to the nearest hospital. And while this is the only private clinic in Kafr Tesfa providing women's health services—pregnancy tests, antenatal care, family planning, and pediatric care—its sustainability was always in doubt.

After Mrs. Ebtisam and Tahssin El-Seha's Project Coordinator attended a SMART training course run on proposal writing, needs assessment, fundraising, budgeting, grants management, and donor compliance, they were inspired and encouraged by the Team Leader to determine what they would need to do to scale up their operations and establish a reliable income stream.

As a result, the CDA team worked on an in-house development plan. Their research showed that with a little investment, the health clinic could be the most lucrative of their activities, and that funding for this may be available. Although Mrs. Ebtisam had written letters for charitable donations before, the funding proposal to the Embassy of Japan in Cairo was the first time she had produced a formal, budgeted document that included local health statistics, potential costs and client numbers, and supporting documents. She consulted with the staff and the Board of Directors of Tahssin El-Seha as well as with the sessional doctors to come up with a list of medical equipment and furniture to expand the clinic operations.

A representative of the Japanese Embassy visited the CDA to assess the suitability of their request and approved the grant, enabling the CDA to prepare a four room apartment for the new location of the expanded polyclinic and hire full-time doctors of different specializations. The development plan included a laboratory and in-house pharmacy for the next phase.

“I am so grateful for SMART training and support, as it has given me confidence and practical skills to use to make our association more active and do more for our community,” said Mrs. Ebtisam in a recent meeting.

“Even though I was nervous, they asked me to run some of the training sessions, so now I can do it by myself," she added. "I can train my staff and our partners and together we can manage to run all these different activities to help poor women. In the SMART workshop, we learned how to write funding proposals so now we can promote Tahssin El-Seha to other donors. I think that Tahssin El-Seha is well established now—everyone knows they can come here and receive help.”

Country Summary: Ethiopia

Period: FY 2013, Quarters 1 and 2

Selected Health and Demographic Data for Ethiopia	
GDP per capita (USD)	357
Total population	84.73
Maternal mortality ratio (deaths/100,000 live births)	676
Skilled birth attendant coverage	10
Antenatal care, 4+ visits	19
Neonatal mortality rate (deaths/1,000 live births)	37
Infant mortality rate (deaths/1,000 live births)	59
Under-five mortality (deaths/1,000 live births)	88
Treatment for acute respiratory infection	27
Oral rehydration therapy for treatment of diarrhea	30.7
Diphtheria-pertussis-tetanus vaccine coverage (3 doses)	37
Modern contraceptive prevalence rate	27
Total fertility rate	4.8
Total health expenditure per capita (USD)	52.0

Sources: World Bank, Ethiopia 2011 Demographic and Health Survey, WHO, UNICEF.

Major Activities

- Integrated maternal, newborn, and child health (MNCH)/prevention of mother-to-child transmission (PMTCT)/family planning (FP):
  - Performance quality improvement (PQI)
  - Strengthening essential maternal and newborn care
  - Postpartum family planning (counseling and postpartum intrauterine contraceptive device [PPIUCD] insertion)
  - Midwifery pre-service education
  - Prevention of mother-to-child transmission (PMTCT)
- Community-based MNCH and FP household and care-seeking practices:
  - Community Kangaroo Mother Care Feasibility Study
  - Integrated community case management (iCCM)
- Strengthening the midwifery profession
- Identifying cultural barriers to accessing MNCH services
  Urban Health Extension Program (core funded)

Program Dates	October 2010–September 2014					
PY 5 Budget	Total: $ 7,815,302 Field Support: $7,612,000 (FP: $1,427,355; HIV: $1,910,404; Malaria: $254,527; MCH: $4,019,714) PY4 Carry forward $3,412,000 Core Support (Urban Health): $203,302					
Total Mission Funding to Date	Obligated amount: $12,184,000 PY 3: $2,840,000 PY 4: $5,144,000 PY 5: $4,200,000					
Geographic Focus	Tigray, Amhara, Southern Nations Nationalities and Peoples (SNNP), Afar, and Oromia Regions					
Geographic Coverage	No. (%) of provinces	4 (44%)	No. of districts	12	No. of facilities	69

MCHIP In-Country Contacts	Hannah Gibson, Project Director: hannah.gibson@jhpiego.org; Nancy Koskei, Program Manager: nancy.koskei@jhpiego.org; Alemnesh Tekleberhan, Maternal Child and Reproductive Health Team Leader: Alemnesh.Tekleberhan@jhpiego.org; Abiy Seifu, MCHIP Advisor: abiy.seifu@savethechildren.org;Belen Belayneh, Program Officer: Belen.Belayneh@jhpiego.org
HQ Managers and Technical Advisors	Anita Gibson, Country Program Manager: agibson@mchip.net; Heather Douglas, Program Officer: heather.douglas@jhpiego.org; Caroline Tran, Financial Administrator: Caroline.Tran@jhpiego.org; Nathalie Albrow, Program Officer: nathalie_albrow@jsi.com; Rachel Taylor/Joanna Michler, Program Officers: rtaylor@savechildren.org, jmichler@savechildren.org; Jennifer Callaghan: jcallagh@jhsph.edu; Joseph de Graft Johnson, jjohnson@mchip.net; Tsigue Pleah, tpleah@jhpiego.net; Sheena Currie, scurrie@mchip.net; Tigistu Adamu, tadamu@mchip.net; Jim Ricca, Jim.Ricca@jhpiego.org; Pat Taylor, ptaylor@mchip.net

FY 2013, Quarters 1 and 2: Achievement Highlights

During FY13, MCHIP has strengthened its partnership with and support to the Federal Ministry of Health (FMOH), Regional Health Bureaus (RHBs), and other partners working to improve MNCH/FP in Ethiopia. This was facilitated through technical and financial support to related programs for MNH communication, relevant in-service training and pre-service education, performance improvements at supported health facilities, and targeted community interventions.

Selected achievements are highlighted below:

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

Communication and Advocacy

MCHIP continues to provide technical assistance to the FMOH and its Technical Working Groups (TWG) on MNH, PMTCT, and FP. Some of the highlights of MCHIP's support to the TWGs are:

- Supported the 2013 Safe Motherhood Campaign through the development of posters and job aids on women-friendly services. The posters have been translated into Amharic, printed, and distributed to all regions, and will be used by providers in health centers and hospitals to guide them on how to provide respectful maternity care and women-friendly care.
- Provided inputs in the review of the campaign strategy for PMTCT demand generation and the development of an inventory of IEC/BCC materials for PMTCT.
- Supported the finalization of the Basic Emergency Obstetric Newborn Care (BEmONC) training package. MCHIP hired a consultant to finalize the training package. The draft was shared with partners for pre-testing, and the FMOH convened a two-day meeting to receive reviewers' input. MCHIP presented its findings during this TWG and the feedback was incorporated into the final package.
- MCHIP actively participated in the National TWG meetings in revising the PMTCT training packages to incorporate the Option B+ treatment approach and job aids, in collaboration with other USG partners. Currently, the revision of training packages and job aids is endorsed and will be rolled out nationally.
- MCHIP facilitated the development of nutrition messages focusing on exclusive breastfeeding, complementary feeding, and maternal nutrition for skilled providers. The messages will assist health care workers during FANC to provide counseling on maternal and newborn nutrition.

MNH Programs Informed on Cultural Barriers to Accessing MNH Care
MCHIP has completed the literature review to identify cultural and behavioral barriers that inhibit women from seeking institutional MNCH care. This review included published and unpublished sources, and reviewed specific cultural and traditional practices in Ethiopia that are considered valuable elements of the birthing tradition as well as practices that are less supportive of institutional delivery. MCHIP has also drafted the report of key informant interviews with providers from seven selected MCHIP-supported health centers; the interviews are to identify how culturally sensitive and women-friendly care can be incorporated into service delivery and be tailored to the regional cultural context.

Documenting Promising Practices in MNH
MCHIP is working through the FMOH Safe Motherhood TWG to identify and document promising practices in MNH. The report of the short-listed and verified promising practices has been compiled and is currently undergoing final review by the FMOH while MCHIP completes final editing. Upon completion, the report will be disseminated by the FMOH, and the FMOH will identify which practices it would like to be scaled up. At the request of the FMOH, the promising practices review exercises extended to FP and reproductive health and were not specifically focused on maternal and newborn health; PMTCT services were excluded because a similar exercise had been conducted at an earlier time. MCHIP is not expected to scale up the selected promising practices. However, for the PQI approach that MCHIP partner Jhpiego submitted, MCHIP is expanding to additional woredas and health facilities and is working closely with the FMOH Medical Services Directorate to have the approach officially endorsed.

Strengthening the Professionalization of the Ethiopian Midwifery Association (EMA)
MCHIP provided technical and financial support to the Ethiopian Midwifery Association (EMA) to hold their annual general assembly meeting on 6 October 2012. One hundred and fifty member midwives from all regions attended. MCHIP made a presentation on evidence-based MNH care to the attendees. During the assembly, the Association nominated three best-performing midwives and gave them an award for their remarkable achievements. The award, initiated by MCHIP in 2011, is aimed to motivate midwives and encourage others to perform well. A Memorandum of Understanding between MCHIP and EMA has finally been developed to continue technical support provided by MCHIP and outline clear expectations between both parties. One of the key deliverables will be building the capacity of the regional chapters of the association.

Intermediate Result 2: Availability, accessibility and quality of high-impact MNH, PMTCT, and FP services improved.

Performance Quality Improvement (PQI)
To expand facility-level improvements in MNCH and PMTCT service delivery, MCHIP has extended its PQI support to a **total 119 facilities** in the four regions at the request of the RHBs. To date, MCHIP has supported PQI trainings for a total of **418** individuals—regional, zonal, woreda, health officials and health workers. When selecting participants for training, MCHIP ensures that woreda and zonal health officers are part of the PQI training to enable them to support the facilities in implementing PQI.

Maternal, Newborn, and Child Health (MNCH)
MCHIP-supported sites have shown improvements in the coverage of antenatal care (ANC) and delivery services provided at the health facility. Improvements can in part be attributed to the improved quality of service.

The graphs and charts below show some of the achievements for ANC first visits and deliveries by a skilled attendant. They compare achievements from this semi-annual period of FY13 with the semi-annual period of FY12 and the remaining targets for the length of project (LOP).

Figures 1 and 2 reflect ANC attendance in MCHIP-supported facilities.

Figure 1. First ANC Visits, October 2011–March 2013

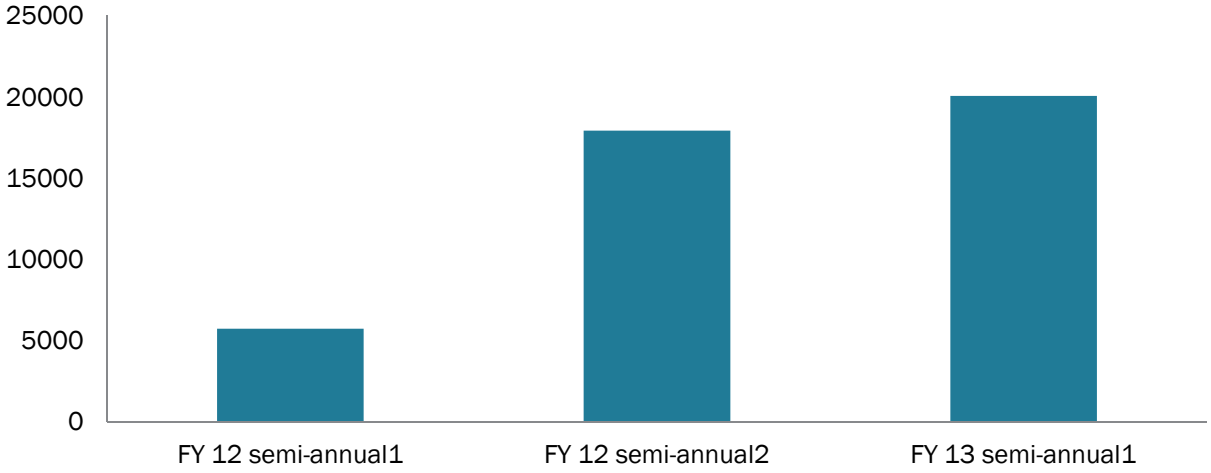
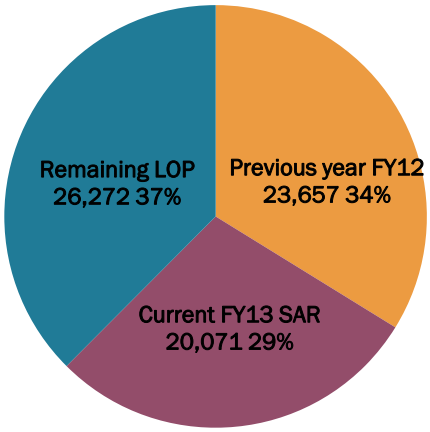


Figure 2. First ANC Visit Achievements



To reinforce and strengthen the transfer of learning, knowledge, and skill assessment, during this reporting period, MCHIP conducted post-training follow-up for service providers trained last year in the four regions. During the visit, it was observed that the service providers were confident in performing signal functions and other essential MNH services effectively. Two rounds of BEmONC training were conducted for 29 service providers drawn from the four regions, working in delivery wards and ANC and PNC units. As part of follow-up, daily SMS reminders were sent to the service providers, mainly on signal functions.

Figures 3 and 4 reflect deliveries by skilled birth attendant in MCHIP-supported health facilities.

Figure 3. Delivery by Skilled Attendants, October 2011–March 2013

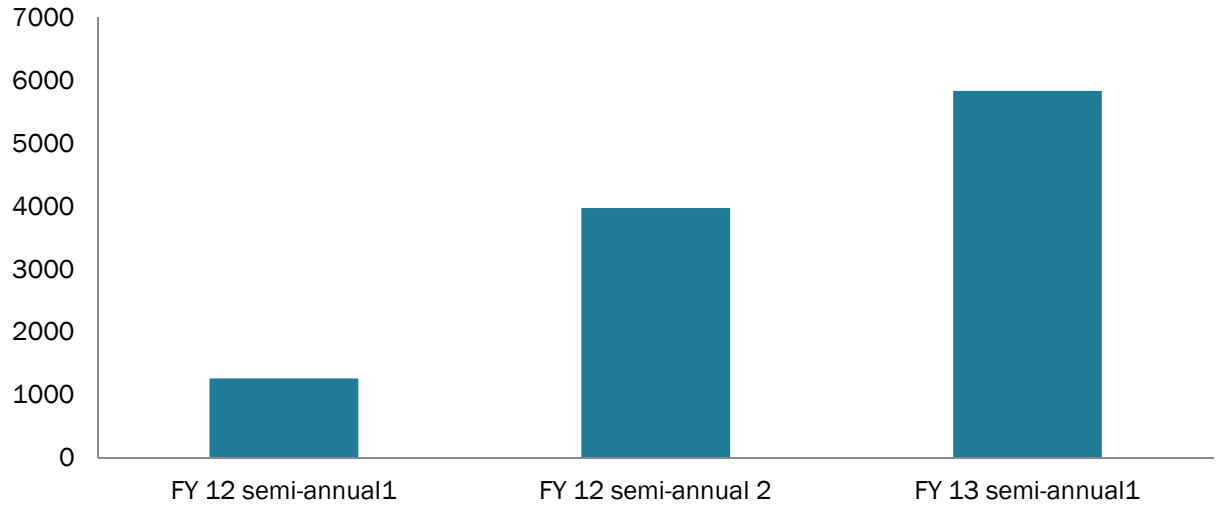
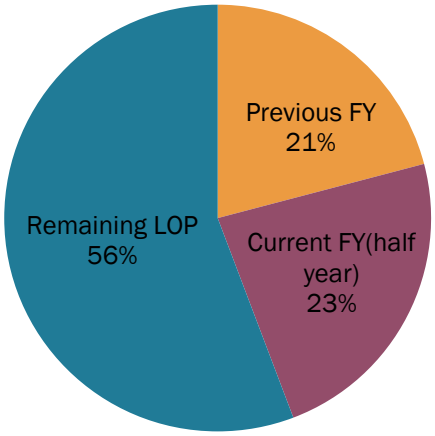


Figure 4: Skilled Birth Attendance in MCHIP-Supported Health Centers, 2012–2013



Helping Babies Breathe (HBB)
In this reporting period, a total 1,118 babies who were asphyxiated at birth, at 26 health facilities, were successfully resuscitated with support from health workers who attended deliveries in MCHIP-supported health facilities. MCHIP is working with health facilities and through the National Child Survival Technical Working Group (NCSTWG) to strengthen the recording and reporting of key indicators on newborn care, including the number of babies asphyxiated at birth and numbers who were successfully resuscitated.

Facility-Based Essential Newborn Care (ENC)
During the Standards-Based Management and Recognition (SBM-R) standards review conducted in the reporting period, the standards were examined to ensure that they captures key ENC standards and verification criteria. The areas addressed by the revised tools now include essential newborn care, resuscitation, management of newborns with sepsis, and thermal care for low birth weight babies.

Facility-Based Kangaroo Mother Care (KMC)
To date, a total of 73 health centers and seven hospitals in the four regions have established ENC services, including KMC services, through MCHIP support. In this reporting period, mothers received KMC counseling during ANC visits and 4,935 babies were provided with KMC at birth.

PMTCT
In this reporting period, the PMTCT services in MCHIP sites have also shown improvements. MCHIP supports 44 health centers in total: 22 woredas in Amhara, four woredas in Oromiya, and four woredas in SNNP regions. Out of these, 39 sites fulfill the PEPFAR Next Generation Indicator definition of PMTCT site (i.e., provision of ARV in the facility).

A total of **11,821** pregnant and laboring mothers were tested for HIV and received their results in the antenatal care/labor and delivery (ANC/L&D) clinics. Among these, **3,170** pregnant and laboring mothers were tested with their partners. Of the **11,821** tested, **26 mothers** tested positive for HIV and eight mothers were already known positives at entry; of the **26** positive mothers, **13** received ARV prophylaxis, nine mothers were referred to ART sites for HAART, and the remaining four are lost to follow-up as they are migrant workers (it is known that the mothers left their permanent homes as they came for temporary work). Efforts are being made to trace these mothers lost to follow-up in coordination with the HEWs and health development army members. In addition, 15 HIV-exposed infants were identified and received ARV prophylaxis.

A total of 1,434 mothers received HIV counseling and testing services in FP and Expanded Program on Immunization/Postnatal Care EPI/PNC as part of integration in all MNCH service outlets.

Postpartum Family Planning (PPFP)
MCHIP continues to support implementation of PPIUCD services in eight existing sites. A follow-up meeting with 24 health care providers trained in PPIUCD insertion from these facilities was conducted to share experiences, achievements, and challenges to PPIUCD service implementation. A practical skills session was also held during the meeting to reinforce provider knowledge and skills. With the recent expansion of PPIUCD services to 26 new site health facilities, health care providers are now providing PPFP counseling services during ANC counseling and when clients are in the labor room. In this reporting period, a total 2,537 pregnant women received PPFP counseling, and 177 newly delivered mothers had an IUCD inserted in the immediate postpartum period (see Table). Post-training follow-up and supportive supervision were conducted for health care providers trained on PPFP counseling and PPIUCD insertion. As a result of the frequent technical support provided through follow-up visits, most facilities have seen an increase in the number of PPIUCD clients.

PP-IUCD performance (October 2012–March 2013)

FACILITIES IMPLEMENTING PPFP	NO. OF FACILITIES PROVIDING PPIUCD	NO. OF PPIUCD INSERTIONS (OCT. 2012–MARCH 2013)	NO. OF PPFP COUNSELED IN ANC	NO. OF MOTHERS RETURNED FOR 1ST FOLLOW-UP VISIT (4–6 WEEKS AFTER INSERTION)	REPORTED SPONTANEOUS EXPULSION
26	18	177	2,537	95	4

Support of the Deployment of Integrated Emergency Surgical Officers (IESO)
In collaboration with the working group established to support the IESO deployment (under the HR Directorate), MCHIP developed a supportive supervision tool to assess site-level performance of the new IESO graduates (the tool developed is based on MCHIP's own supportive supervision tool). MCHIP facilitated a session during the national consultative meeting on how to assess the performance of deployed IESOs.

Pre-Service Midwifery Education
At the beginning of this fiscal year, the MCHIP support for pre-service education in midwifery was handed over to the USAID-funded Strengthening Human Resources for Health (S-HRH) project. MCHIP supported a smooth transition to the new project. The transition included supporting 10 Health Science Colleges (HSCs) to conduct a benchmarking visit to Arbaminch HSC on 19–20 November 2012. The objective of the visit was to share experiences on successes and challenges in improving midwifery education and strengthen networking among colleges and instructors; inform all 10 HSCs that technical support has been handed over to the S-HRH project; and share with the S-HRH project staff accomplishments, challenges, and next steps. MCHIP technical staff who were supporting this activity have been transferred to the new S-HRH project, which will assist with a smooth handover and knowledge management.

Intermediate Result 3: Caretakers' knowledge and behaviors on key MNCH and FP household and care-seeking practices improved.

Community Kangaroo Mother Care (CKMC)
As part of evaluating the feasibility of implementation of Kangaroo Mother Care at the community level in Ethiopia, one key accomplishment during this reporting period is the finalization of the baseline assessment technical report. The manuscript from the baseline assessment and midline qualitative assessment was also drafted and shared with the co-investigators for review and submission to an international peer-reviewed journal; the journal Tropical Medicine & International Health was identified as the journal for submission.

In CKMC sites in Tigray, MCHIP facilitated experience-sharing meetings among pregnant mothers, communities, and mothers who were practicing or had benefited from KMC. In Amhara region, MCHIP conducted training on CKMC for 19 HEWs from three woredas (Kombolcha, Tehuledere, and Yilemanadensa).

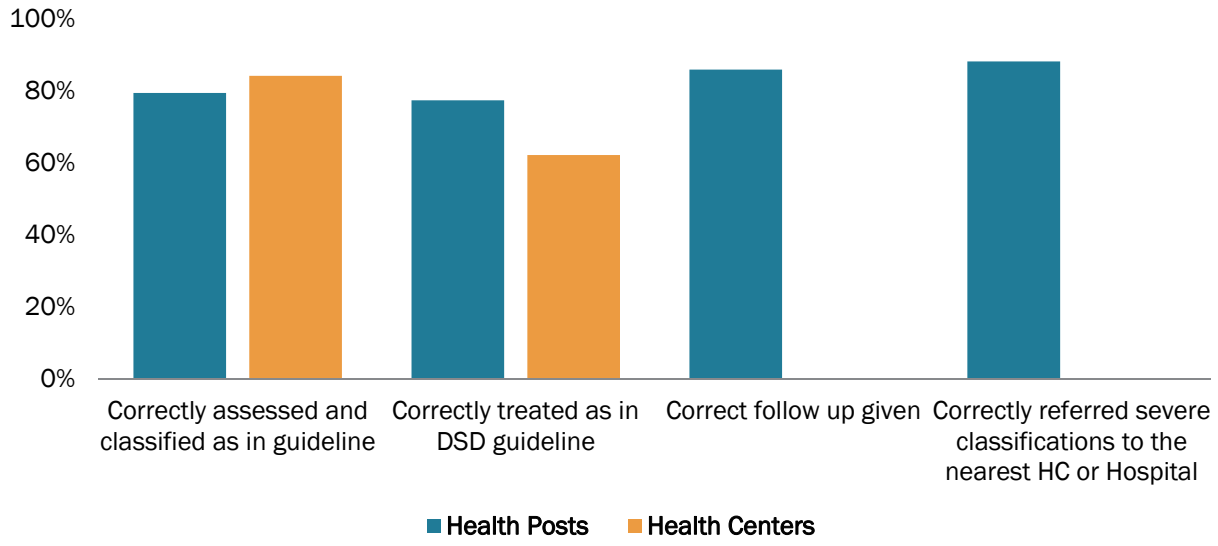
Integrated Community Case Management (ICCM) in Oromia
To improve the technical skill and knowledge of HEWs, the performance review and clinical mentoring meeting (PRCMM) is one of the strategies to address the challenges and successes in ICCM implementation. HEWs who received ICCM training and have provided ICCM services in the health post for at least three months were eligible to participate in the PRCMM. HEWs' supervisors, primary health care unit heads, woreda Health Extension Program focal persons, and woreda health office heads also participated in the PRCMM.

MCHIP, in collaboration with Oromia RHB, conducted 22 rounds of PRCMM for 11 woredas of West Shoa and South West Shoa zones (Ilu Galan, Bako, Danno, Nono, Ejere, Toke Kutaye, Bacho, Tole, Woliso Mida Kenyi and Meta Robi). In these meetings, ICCM facilitators reviewed registers of the catchment health posts for completeness, consistency, and caseload. From a total of 319 health posts of the above woredas, 282 health posts (88%) participated in a review meeting, and the total number of under-five cases managed/registered was 6,560; of the total cases managed, only 4% (241) were young infants (infants less than two months old).

Facilitators also reviewed the registers of each health post for **quality** (completeness, consistency, and referral of severe cases for advanced care), and from a total of 1,705

classifications reviewed, 1,351 (79%) agreed with the assessments and classifications of the cases. From cases correctly assessed and classified, 1,043 (77%) were treated correctly according to the dose-schedule-duration principle. Also, 894 (86%) of the total classifications reviewed correctly agreed with the stated follow-up date, and 88% of the 374 cases with severe classification that needed referral to the nearest health center or hospital were referred.

Figure 5. Classification of Cases Assessed versus Classified in MCHIP-Supported Health Posts, October 2012–March 2013



Intermediate Result 4: Core Funded – Support the GOE's leadership in urban health to improve access to and demand for health services in urban areas.

MCHIP has been working since October 2010 with USAID/Ethiopia's bilaterally funded Urban Health Extension Program (USAID/UHEP) to establish linkages between Ethiopia's urban health leaders/champions and those in other countries. During this period, a qualitative assessment was finalized in order to understand MNCH service utilization barriers in the city of Hawassa and the results were disseminated. A MNCH services directory was also developed and disseminated to urban health extension professionals in an effort to increase awareness of MNCH services and enable urban health extension professionals to refer pregnant women to health facilities nearby.

Selected Priorities for FY 13

Overarching Activities across All Intermediate Results

- Conduct MCHIP's regional review meeting in Tigray region to review performance to date and share the MCHIP Year 3 workplan in order to seek consensus with regional government counterparts. This has been postponed at least three times due to competing activities of the Tigray RHB.

Intermediate Result 1, IR1: MNCH and PMTCT services improved by enhancing and strengthening the enabling environment for MNH care.

Communication and advocacy

- Support the EMA to conduct International Day of the Midwife events and a one-day knowledge update for EMA members.

Intermediate Result 2, IR2: Availability, accessibility and quality of key MNH and PMTCT services improved.

PQI and improving MNCH service delivery

- Provide supervisory skills training for zonal and woreda officers to conduct quality supervision through courses and post-training follow-up, and conduct supportive supervision for all MCHIP sites trained in BEmONC, PMTCT, ENC, and postpartum FP. Supervision will be linked to PQI follow-up.
- Disseminate the revised comprehensive MNCH/PMTCT SBM-R standards to the FMOH, and MCHIP implementing sites.
- Conduct a one-day external verification through facility visits in SNNP region, and provide technical assistance to woreda health offices in Phase 1 sites to select outstanding facilities to be benchmarked against other sites for recognition.
- Support Amhara RHB to conduct PMTCT training for 50 health care providers.
- Establish ENC services in 29 health centers in South West Shoa zone in Oromia through training of midwives and nurses and equipping health centers with basic equipment and supplies essential to newborn care.

PMTCT

- Provide technical support to the FMOH in the provision of training of trainers (TOT) for national trainers on Option B+ Treatment Approach.

Intermediate Result 3: Caretakers' knowledge and behaviors on key MNH/postpartum FP/PMTCT household and care-seeking behavior.

Community KMC

- Conduct a coverage survey on community MNH and CKMC uptake using the Lot Quality Assurance Sampling method.
- Finalize revision of the KMC manual using feedback from the HEWs as necessary.

ICCM

Oromia/Afar

- Provide ICCM and Integrated Management of Newborn and Child Illnesses (IMNCI) training for new/additional HEWs and health center staff, and provide ICCM supervisory skills training for PHCU supervisors (Oromia).
- Conduct ICCM training of trainers and provide ICCM basic trainings for HEWs, frontline health workers, and nurses (Afar).
- Provide ICCM supervisory skill training for PHCU supervisors (Afar and Oromia).
- Provide IMNCI training for new HCs in Afar.
- Conduct a training of trainers course for ICCM, followed by training on ICCM for HEWs and nurses working at hospitals.

Rural Health Center Makes Mothers' Needs a Priority

Morsito, Ethiopia—Every day, coffee alerts Ethiopians to a multitude of events—from weddings to funerals, from births and deaths. Coffee marks the occasion when a child does well in school or when a neighbor gets a good price for his crops in the market. Each day, coffee—brewed in clay pots over hot charcoals—fills countless small cups to the brim with a swirling, life-affirming substance that is consumed by millions of Ethiopians.

The coffee hut at the Morsito Health Center is part of efforts to improve services. The hut offers a place for pregnant women to meet and learn from health care workers about preparing for birth and it provides a place for families to wait and to celebrate the birth with a traditional coffee ceremony.

Because this drink is so popular, the Morsito Health Center—located nearly 26 kilometers from Hosanna—determined that the scent of coffee would attract expectant mothers and their families to the center. To this end, in mid-2012 the center began construction of a coffee hut, a place for family members to wait while their wives, sisters, and mothers give birth. And, when the baby is finally born, the coffee will be ready for the celebration.

"Coffee is a part of our lives even when we are sad. It's the first and last thing we do," says Yeshiharag Agafari, the center's midwife. The coffee hut is part of the center's transformation to a place that provide more family-friendly services.

Yeshiharag has worked at Morsito for the last four years and says the service has not always been like this. Since working with the MCHIP team and using the program's SBM-R process (Figure 1) to identify gaps and develop an action plan, members of Morsito's health center staff have worked together in a number of ways to improve services and their client's experience.

Most of these improvements began with the use of the center's existing resources. Yeshiharag and her team first rearranged the maternity ward to provide more efficient services to expectant mothers.

"Now when a mother comes for prenatal checkups, she'll see the entire process with her own eyes. I show her the delivery room so she can imagine exactly where she will be the day she gives birth," the midwife explains. "We discuss all this in the prenatal room, which allows us to guarantee privacy and confidentiality."

Privacy and ethical concerns are an integral part of the center's transformation. The new maternity ward stresses respecting the mother's choice (e.g., allowing family members in the delivery room if the woman wants them there) and the provision of services by the same midwife through all phases of the mother's pregnancy—from prenatal to delivery to postnatal.

"A mother can now tell me every problem, knowing that it's only me who will know. A mother doesn't like having to explain her situation to more than one midwife or nurse," Yeshiharag says.

Yeshiharag and her colleagues are also spreading the message about the improvements throughout the community. Two days a week, they walk to surrounding villages to tell mothers about the quality of services in the health center.

"When they meet us in their villages, there is less fear. They see us as equals and not as professionals speaking a language they don't understand," she explains. "Through visits, we create a sense of intimacy and they even start to call us by our first names."

Mother-FriendlyService

When a mother has a successful delivery and is happy with the services received, she is more likely to go back to her village and tell her neighbors. One of the services every mother takes home with her is a UNICEF-donated mama kit that is distributed by MCHIP and includes a baby hat and blanket and soap to wash the baby. After just three months of improvements, the number of deliveries has already doubled to 20 per month. In the future, Yeshiharag and her team expect to deliver an average of 30 babies every month.

"The SBM-R tool really encouraged us and taught us how to use multiple sources to get results. Even the people in the village have wondered why we are so motivated. We learned to use what we already have,"

she says showing a delivery screen (crafted from extra, unused materials found in the center's store) that gives mothers more privacy in the delivery room.

Ayelech Ermako lives near Morsito Health Center, but she delivered her first child at home. After hearing about the center's antenatal checkups from a neighbor, Ayelech began going when she was three months pregnant with her second child. She never had a checkup while pregnant with her first child.

Information Is Action

When midwife Yeshiharag saw Ayelech in the prenatal room to go over her case, she gave her a tour of the delivery room and postnatal care room and told her that all maternal and child health services at the center are free of charge.

"I didn't know that the service was for free," Ayelech says, surprised. "I thought it was as much as 300 birr to deliver my baby here."

Yeshiharag dispels the myth and shows mothers the mama kit that includes a baby hat, blanket, and soap. "It's not like old times. Now we have an ambulance that can take you to Hosanna if you have big complications," Yeshiharag says. "And if your family comes, they can wait for you in our coffee hut and celebrate the birth of your baby."

Midwife Yeshiharag Agafari has worked in the Morsito Health Center since 2008, and received MCHIP's SBM-R training to improve the maternity ward.

Country Summary: Ghana

Period: FY 2013, Quarters 1 and 2

Selected Health and Demographic Data for Ghana	
GDP per capita (USD; 2011)*	1,570
Total population (2010)†*	24,392,000
Maternal mortality ratio (2010)** (deaths/100,000 live births)	350
Skilled birth attendant coverage (2011)‡*	68%
Antenatal care, 4+ visits (2011)‡*	87%
Neonatal mortality rate (deaths/1,000 live births) (2011)***	30
Infant mortality rate (deaths/1,000 live births) (2011)***	52
Under-five mortality rate (deaths/1,000 live births) (2011)***	78
Treatment for acute respiratory infection**	60%
Oral rehydration therapy for treatment of diarrhea and continued feeding (2011)‡*	44%
Diphtheria-pertussis-tetanus vaccine coverage (3 doses) (2011)**	91%
Modern contraceptive prevalence rate (2012)****	17%
Total fertility rate (2012)***	4.2
Total health expenditure per capita (USD)**	85

Sources: *World Bank **WHO ***UNICEF **** Population Reference Bureau, UNAIDS † United Nations Population Division, ‡ Multiple Indicator Cluster Survey.

Major Activities

Pre-service education strengthening at all 38 schools by:

- Developing *Reference Manual for Preceptorship in Midwifery Education* and *Reference Manual for Simulation Laboratories in Midwifery Education Programmes*
- Providing technical updates to 82 tutors in TB, HIV, malaria, and family planning
- Training 42 preceptors and 4 tutors in selected BEmONC interventions
- Providing needed equipment and supplies including job aids, books, and models
- Conducting ongoing supervision and mentoring of tutors via site visits and an mMentoring pilot program with SMS reminders, quizzes, and structured calls

Program Dates	October 1, 2009–September 30, 2013					
PY 5 Budget	$1,530,000: MCH: $200,000, FP/RH:$250,000, HIV: $480,000,Malaria: $400,000, Nutrition: $200,000					
Total Mission Funding to Date	$4,642,300					
Geographic Focus	*National: 38 schools in all 10 regions of the country*					
Geographic Coverage	**No. (%) of provinces**	10 (100%)	**No. of districts**	35	**No. of facilities**	N/A
MCHIP In-Country Contact	Chantelle Allen: chantelle.allen@jhpiego.org					
HQ Managers and Technical Advisors	Nancy Ali, nancy.ali@jhpiego.org; Heather Harrison, heather.harrison@jhpiego.org Catherine Carr, catherine.carr@jhpiego.org; Patricia Gomez, patricia.gomez@jhpiego.org					

FY 2013, Quarters 1 and 2: Achievement Highlights

Objective1: Improve midwifery students' knowledge, skills, and attitudes in targeted basic emergency obstetric and newborn care (BEmONC) interventions.

- Forty-six participants—four midwifery tutors and 42 midwifery preceptors—attended a two-week training in selected topics in basic emergency obstetric and newborn care (BEmONC). On average, knowledge increased by an average of 15% while competency and skills increased by as much as 40% in certain areas.

Objective 2: In targeted midwifery schools, equip and improve management of skills laboratories to strengthen student competencies in selected maternal and newborn health interventions.

- Furniture, equipment, and other teaching materials were procured for six skills labs.
- MCHIP finalized the Ghana skills lab manual and it is currently being edited for final publication. It has been extensively reviewed by the Human Resources for Health (HRHD) Unit of the Ministry of Health and the foreword has been written by the Deputy Minister of Health.

Objective 3: Strengthen preceptors' clinical skills and teaching competencies at clinical sites linked to targeted schools.

- MCHIP conducted Training Skills workshops for 58 preceptors from clinical training sites for six midwifery training schools: Ashanti-Mampong, Goaso, Jirapa, Pramso, Hohoe and Twifo Praso Midwifery Training Schools.
- MCHIP has finalized the preceptor reference manual and it will be printed and distributed during the next quarter. It has been extensively reviewed by the Human Resources for Health (HRHD) Unit of the Ministry of Health and the foreword has been written by the Deputy Minister of Health.

Objective 4: Increase competency of tutors and their students at nine Community Health Nursing Schools, one Public Health Nursing School, one Medical Assistant School, and 21 Midwifery Schools in current best practices for HIV/AIDS, tuberculosis, malaria, family planning, newborn resuscitation, and addressing stigma and discrimination.

- Eighty-two tutors from 38 schools encompassing midwifery, community health nursing, public health nursing, medical assistants, and universities were provided technical updates in TB, HIV/AIDS, malaria, and family planning over the course of five days in two training sessions. The assessment results showed an average knowledge increase for all participants of 33%.

Objective 5: Develop, implement, and evaluate the use of m-Coaching (mobile coaching) to reinforce midwifery tutors' new competencies during program interventions.

- Phase 1 (implementation) and Phase 2 (assessment) of the mMentoring program was completed. In mMentoring, the mentors sent SMS reminders, quizzes, and structured calls to the tutors, covering technical areas of newborn resuscitation and manual removal of placenta, for a period of three months. Results are being analyzed.

Objective 6: Improve midwifery and community health nursing tutors' knowledge and skills to teach new nutrition interventions.

- In collaboration with FANTA, MCHIP conducted a stakeholders' consultative meeting in January 2013 to identify key competencies in nutrition needed by midwives and community health nurses. Thirty-one stakeholders representing Ghana Health Service (GHS) Nutrition, the MOH, Nurses and Midwives Council (NMC), FANTA, and Jhpiego were represented. The team identified four basic competency areas: 1) nutrition assessment, 2) nutrition counseling and education, 3) case management of nutrition disorders, and 4) community nutrition.

Objective 7: Enhance training materials by supporting the Nurses and Midwives Council to conduct regular Midwifery Curriculum Reviews and by supporting the Ministry of Health to design an integrated eLearning Program.

- MCHIP and UNFPA co-facilitated with the MOH a very successful workshop to develop a scope of work and action plan to operationalize eLearning in midwifery pre-service education.
- MCHIP met with the Nurses and Midwives Council to discuss the proposed curriculum review process.

Priorities for Quarters 3 and 4

- Launch and disseminate the Simulation Laboratory Reference Manual and the Preceptorship Reference Manual.
- Finish renovating and setting up of skills labs in six targeted midwifery schools.
- Analyze and report on results from the mMentoring program.
- Train tutors in new nutritional areas and assess competency in collaboration with FANTA and GHS.
- Establish linkages between pre-service institutions and PLWA/MARPS groups.
- Support the Nurses and Midwives Council to facilitate midwifery curriculum review and provide technical support to the midwifery curriculum review process.

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

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, Evelyn 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 shares her story with MCHIP's Martha Appiagyei during a follow-up supportive supervision visit.

Country Summary: Guinea

Period: FY 2013, Quarters 1 and 2

Selected Health and Demographic Data for Guinea	
GDP per capita (USD)	407.50
Total population	10,068,724
Maternal mortality ratio (deaths/100,000 live births)	680
Skilled birth attendant coverage	38.1
Antenatal care, 4+ visits	48.8
Neonatal mortality rate (deaths/1,000 live births)	39.3
Infant mortality rate (deaths/1,000 live births)	91.4
Under-five mortality (deaths/1,000 live births)	130 [17]*
Treatment for acute respiratory infection	42
Oral rehydration therapy for treatment of diarrhea	56.7
Diphtheria-pertussis-tetanus vaccine coverage (3 doses)	57
Modern contraceptive prevalence rate	5.7
Total fertility rate	5.7
Total health expenditure per capita (DHS)	18.77

Sources: World Bank, Guinea 2005 Demographic and Health Survey, WHO, UNICEF.
*UNICEF <5 mortality ranking (1=highest mortality rate)

Major Activities

- **Family planning** with a focus on long-acting and permanent methods and postpartum counseling and method adoption
- **Emergency obstetric and newborn care**
- **Quality improvement** through Standards-Based Management and Recognition approach
- **Child health**: integrated management of newborn and childhood illness, community case management
- **Community outreach and community-based service delivery** (family planning and maternal and child health)
- **Pre-service education** of doctors and midwives
- Infection prevention
- mHealth - use of a mobile phone network to facilitate referral and coordination

Program Dates	October 1, 2010–March 31, 2013					
2012–2013 Budget	$3,984,107					
Mission Funding to Date	October 2010-September 2011: $800,000 +$2,000,000 October 2011-September 2012: $2,021,879 October 2012-September 2013: $2,297,000 Total: $7,118,879					
Geographic Focus	National (policy, national guidelines, HMIS), five communes of Conakry, 15 prefectures in the three Eastern regions of Faranah, Nzérékoré, and Kankan, covering a population of 6.4 million, 229 facilities and 1,700 villages					
Geographic Coverage	No. (%) of provinces	4 (50%)	No. of districts	20	No. of facilities	229
MCHIP In-Country Contact	Prof. Yolande Hyjazi: yolande.hyjazi@jhiego.org					
HQ Managers and Technical Advisors	Nancy Ali, nancy.ali@jhpiego.org ; Rachel Waxman, Rachel.waxman@jhpiego.org; Tsigué Pleah, Tsigue.pleah@jhpiego.org; Blami Dao, Blami.dao@jhpiego.org; Serge Raharison, sraharison@mchip.net ; Winifride Mwebesa, wmwebesa@savechildren.org					

FY 2013, Quarters 1 and 2: Achievement Highlights

Objective 1: Increase access to high-quality family planning services.

- In the first half of this year, the MCHIP team completed the Training Skills workshop with 11 providers and regional Trainer Qualification through co-training activities for six providers on long-acting methods (implants and interval IUD). This brings the total number of local LAPM trainers to 18. This new cohort of trainers specifically increases training capacity in the MCHIP intervention regions, and means that when trainers are need, they do not always have to come from the capital, Conakry. An additional five trainers will complete their Trainer Qualification in the coming quarter.
- Twenty-six providers completed training on IUD and implants in this reporting period, bringing the total number of providers trained by MCHIP on the different long-acting and permanent methods to 232 (76 on interval IUD, 42 on PPIUD, 89 on Jadelle® implants, and 25 on tubal ligation). In addition, 149 providers (91% women) have been trained on counseling for postpartum and postabortion family planning (PPFP/PAC-FP). To strengthen integration of services and the reach of counseling services, the training included service providers who work in labor and delivery, antenatal care, and immunization services.
- Post-training follow-up, supervision visits to the trainees' worksite, were completed for 65 providers in 49 facilities trained on LAPM and PPFP counseling in this reporting period. The flip chart for FP counseling was updated to better standardize the counseling given by providers and present a comprehensive method mix so that women can understand their options. Messages on lactational amenorrhea, implants, female condom, and the Standard Days Method® beads were developed and integrated with the flip chart.
- There are now 95 facilities providing LAPM: all 95 offer interval IUD, 18 offer PPIUD services, 60 offer implants, and eight offer tubal ligation in the MCHIP project areas. Seventy-three facilities offer improved PPFP and PAC-FP counseling. Instrument kits are provided to each of the new site as the providers complete the training. Job aids and communication materials for PPFP/PAC-FP also are distributed.

	NEW FP USERS	CONTINUING FP USERS
Oct.–Dec. 2011	52,238	41,936
Jan.–Mar. 2012	43,235	39,702
Apr.–June 2012	35,222	29,785
July–Sept. 2012	45,586	42,254
Oct.–Dec. 2012	43,491	43,317
Jan.–Mar. 2013	47,943	43,601

- During Quarters 1 and 2:
  - FP services were provided to 91,561 new users of FP methods (including 30,437 at the community level (33%).
  - FP services were provided to 86,918 regular users of FP (including 36,764 at the community level (42%).
  - The table to the right shows steady progression in FP uptake and continued use, with some dips due to stock-outs.
  - 99% of women who presented for postabortion care received family planning counseling; 86% agreed to adopt an FP method.

- Among the facilities offering LAPM, 3,235 new users adopted a long-acting method, which represents 10.5% of all methods chosen (3,235/30,885). The following table provides an indication of the evolution of LAPM uptake and its contribution to overall method use across project facilities. The spike in the second quarter is likely due to the high volume of uptake during training activities.

QUARTER	OCT.–DEC. 2011	JAN.–MAR. 2012	APR.–JUNE 2012	JUL.–SEP. 2012	OCT.–DEC. 2012	JAN.–MAR. 2013
Proportion of LAPM among new users in all MCHIP-supported facilities (n= 232)	3.5%	6.7%	6.7%	5.9%	5.9%	4.7%
Proportion of LAPM among all new users in facilities offering any LAPM service (n= 95 by latest quarter)	10.1%	17.1%	12.4%	14.2%	11.9%	9.2%

- This results in 53,598 couple-years of protection in this reporting period. At the clinic level, the CYP is 40,765, of which 35.5% is due to LAPM (14,491/40,765). Total CYP for the project zone has increased by 60% compared to the previous reporting period (33, 463 to 53,598).

Objective 2: Increase access to and improve quality of emergency obstetric and newborn care (EmONC) services.

- In order to improve emergency obstetric care (EmONC) in 20 hospitals, MCHIP in collaboration with the MOH organized a competency-based training of 22 providers from five health structures (two regional and three prefectural hospitals) in comprehensive EmONC. This brings the number of providers trained in CEmONC to 42 working in teams in 10 facilities. Ten more teams of providers will be trained and facilities equipped this year. A key innovation in this activity is the integration of EmONC training and postpartum family planning, specifically training on long-acting methods such as IUD and tubal ligation that can be offered to women at the time of delivery.
- To develop local capacity to conduct EmONC training, 16 potential EmONC trainers were identified for an upcoming Training Skills workshop.
- In preparation for the next round of EmONC training, an evaluation of knowledge and skills of providers trained in basic EmONC was completed at the targeted facilities in order to identify what elements need to be reinforced during the training sessions.
- In preparation for implementing a mobile mentoring system for EmONC providers using cell phones, the MCHIP team developed the SMS messages and voice scripts that will be used to provide support to providers. SMS messages and questions will be sent using a computer software package, while two EmONC trainers and senior clinicians will serve as the mentors for voice calls.
- The MCHIP team in collaboration with the MOH and experts in MNH completed the development and distribution of a job aid on the use of magnesium sulfate for the management of eclampsia and pre-eclampsia for the EmONC sites (dilution of medication and treatment algorithm). The revision and validation of performance standards for cesarean section and for anesthesia and resuscitation to be integrated with SBM-R activities was also completed.
- MCHIP received approval from the MOH ethics review committee for a study of the use of misoprostol at home deliveries for the prevention of PPH. The protocol is now being finalized with Jhpiego's Institutional Review Board (Johns Hopkins University Bloomberg School of Public Health).

- A new initiative within MCHIP's MNH activities is the integration of elimination of maternal-to-child transmission of HIV (eMTCT) into 10 facilities that have VCT services and are implementing SBM-R. MCHIP organized a workshop for 30 representatives of the MOH and health partners to update the norms and protocols and training curriculum for eMTCT. The Guinea MOH has adopted Option B+. Having just participated in a regional meeting on eMTCT led by Jhpiego in February, the MCHIP MNH Advisor was able to support the norms and protocols review using new information from this meeting.

Objective 3: Improve access to high-quality Integrated Management of Newborn and Childhood Illness (IMNCI) services for children under five years of age.

- MCHIP provides ongoing support to the IMNCI Pilot Committee. The development of a monitoring dashboard for community IMNCI facilitates review of progress in implementation by each partner: trainings held, supplies ordered, supplies available. MCHIP has also supported the quantification of products for Integrated Community Case Management (iCCM) in collaboration with other partners such as UNICEF and PSI.
- The training on iCCM was launched in this reporting period, with the training of 18 EPI agents and 89 CHWs on the protocols and skills for management of childhood illness in the community. This was the second phase in setting up the pilot of updated IMNCI and iCCM protocols including the use of a shortened training course at 18 sites. Twenty-three supervisors from the prefectures of Beyla, Mandiana, Dabola, Ratoma, and Matoto and their regional supervisors were previously trained on the updated protocols and training materials, and 18 providers were trained on clinical IMNCI.
- Since the CHW training in January 2013, 286 children received community care in Beyla prefecture; 178 received treatment and 108 were referred. Of these referrals, 81% were for fever because of the absence of rapid diagnostic tests for confirmation of malaria at home. MCHIP continues to advocate with the National Malaria Control Program, Global Fund, PMI, and other stakeholders for the provision of RDTs and other essential supplies for iCCM (pilot sites are in Global Fund-supported zones).
- With assistance from the SBM-R Advisor on the MCHIP Guinea team and the Child Health Advisor from MCHIP headquarters, performance standards of IMNCI were developed for infants and children between the ages of two months and five years.
- MCHIP also supported the strengthening of M&E for child survival. Data collection tools were reviewed and developed in collaboration with MCHIP's M&E advisors, including a report outline for providers working in health centers and a register for community health agents. In addition, indicators for IMNCI were integrated with the HMIS for monitoring of health centers.

Objective 4: Strengthen communications for improved community outreach, health information, and increased access to a package of community-based health services (NEW for 2013).

- As part of developing capacity of local NGOs to support community-based health information and services in each region, 38 animators from the four NGOs trained by MCHIP provided training to 111 CHWs in Quarters 1 and 2 on communications messages for FP, PPFP, PAC, MNCH, and IMNCI, bringing the total to 297 CHWs and 216 members of community associations in Conakry trained and supported by the local NGOs. Activities led by the local NGOs have allowed the project to reach approximately 60% of MCHIP intervention zones to date. Following an initial round of activities led by each NGO, MCHIP conducted a performance review of the NGOs and facilitated a meeting to reinforce skills and develop workplans and budgets for this year.

- A further 146 CHWs were trained on communications messages by Save the Children animators in Mandiana prefecture. Fifty facility providers and 146 community actors (TBAs, nutritionists) were also trained. This brings the total number of CHWs updated on RMNCH messages and supported by Save the Children animators/community liaisons to 292, along with 62 providers who have benefited from multiple updates as new tools and learning have become available.
- NGO animators, SC, and the Community Health Advisor made post-training site visits to 627 CHWs.
- Educational sessions led by animators from one of the NGOs reached 2,456 people in two prefectures in the first quarter. In Conakry, the NGO trained by MCHIP organized meetings in each commune to bring together community associations and health facility staff. Association members have been holding regular events to disseminate health messages to 1,325 people.
- Six radio stations continue to air messages on FP, PPFP, PAC, MNH, and IMNCI developed by MCHIP.
- In an effort to explore innovative ways of reaching women with information about FP, five hair salons were selected in Conakry for the communications initiative, one in each commune, and 10 salon staff were trained as animators on FP and MNH messages.
- Following the distribution of 1,480 bicycles to support the community outreach of CHWs in 2012, follow-up was conducted in collaboration with the Community Health Supervisors from Prefectural Health Offices. More than 80% of the bicycles were observed to be in use by the two CHWs in each village as intended.

Objective 5: Strengthen MCH and FP components of medical and midwifery pre-service education by building the competency-based training capacity of faculty and preceptors.

- Continuing with the integration of the SBM-R approach at the National Midwifery School in Kindia, MCHIP held the Module 1 workshop with 24 participants to introduce this quality improvement process and the performance standards for pre-service education (developed during 2012). The baseline assessment was also conducted in this quarter, which identified adherence to standards of 10.6%. This lays the ground work for improving performance over the next several months.
- Two months later, a progress review of the action plans developed during the workshop found varying progress: 50% of activities had been completed by the school directorate; 83% by teachers and preceptors; and 12.5% by the central level. Students were attending off-site practicals at the time of review and thus their progress could not assessed.

Objective 6: Contribute to improving malaria outcomes and strengthening the quality of services at the facility and community levels.

- Following the launch of PMI in Guinea in November 2011, MCHIP supported malaria activities for 13 months, completing activities in December 2012. MCHIP worked closely with the multi-sectoral bilateral, Faisons Ensemble, to implement malaria activities.
- During this reporting period, MCHIP organized the final training session for 20 providers, 18 from public facilities and two from private facilities in the PMI intervention districts. This final session completed the training of 200 providers on the updated malaria prevention and case management guidelines.

- Of the 180 providers and 101 CHWs from four prefectures (Dinguraye, Boké, Forekariah, and Conakry) trained in the previous reporting period, 92% of providers and 93% of CHWs were reached for follow-up visits by MCHIP staff in conjunction with the 34 regional and prefectural supervisors and trainers oriented on updated malaria protocols. For the CHWs, the post-training follow-up included: installation of the CHWs in their communities through public meetings and advocacy to reassure their respective communities of the skills they have learned; emphasis on the importance on communities seeking their services in order to treat fever in a timely manner; and the need to refer complicated malaria and pregnant women to health facilities for care. CHWs received a kit of educational materials (flip charts), treatment algorithms, an activity register and bag to support their work.
- MCHIP supported the NMCP in the overall coordination of malaria programming, including organizing and hosting coordination meetings with USAID/PMI stakeholders; assisting with distribution of malaria supplies to PMI prefectures; and collaborating with SIAPS to conduct the first End User Verification Survey. Following the end of malaria funding, MCHIP continues to participate in coordination meetings, including preparations for the net distribution campaign.

Cross-Cutting

Quality Improvement: Standards-Based Management and Recognition

- SBM-R is in process in 43 facilities in the MCHIP intervention area. Performance standards are being implemented for FP, EmONC, and infection prevention. Thirty-two facilities have completed all modules of SBM-R and are regularly monitoring performance. Supportive supervision to review evolution of performance is ongoing. Five new facilities have initiated SBM-R so far this year, with another five to be added. Seven facilities in all have achieved recognition, and three ceremonies were held. A further four facilities had their performance validated in the previous reporting period and are awaiting the recognition ceremony (scheduled for April).
- As facilities have implemented SBM-R, they have successfully leveraged additional resources from other donors (UNFPA, EU, NGOs) and local government and community associations to address identified needs for renovation, equipment, emergency transport, etc. Four facilities raised more than $174,000 for construction of incinerators, walkways, latrines, and showers, and purchase of metal trashcans, a generator, and other materials.
- Closer assessment of the evolution of performance among 16 facilities that have been implementing SBM-R for at least a full year has identified positive trends in achievements in overall performance against the checklists of standards as well as in service provision data. Median performance of FP standards has improved from 31% at baseline evaluation to 88% at the most recent assessment, while EmONC performance has improved from 24% to 80%, and infection prevention performance improved from 27% to 82%. Use of the partograph to monitor labor has improved from 23% to 41%, among more than 17,000 deliveries. Active management of third stage labor (AMTSL) has improved from 61% to 89% of deliveries. The same facilities have seen a reduction in postpartum hemorrhage from 2% to 1.5%, with specific facilities seeing reductions as much as 6.3% to 2%.
- To expand the scope of SBM-R, additional performance standards have been developed for cesarean section and anesthesia for comprehensive EmONC facilities, as well as performance standards for IMNCI to be implemented in the pilot facilities.

- MOH officials are pleased with the quality improvement results produced by SBM-R. In addition to the formation of the National SBM-R Committee, SBM-R was included in the National "Road Map" for reduction of maternal, newborn, and child mortality revised in 2012. The SBM-R Committee has successfully leveraged donations of equipment, supplies, and medications from UNICEF and other donors for distribution to the facilities during the recognition ceremonies. The MOH requested MCHIP technical assistance in developing a Quality Assurance and Patient Safety Policy using SBM-R as a key reference.

Monitoring and Evaluation

- At the request of the MOH, MCHIP has supported the revision of indicators and monitoring tools of the National HMIS for several programmatic areas, including FP, MNH, IMNCI, malaria, and community-based health care.
- The MCHIP M&E team provided supportive supervision in collaboration with prefectural community health supervisors to 57 sites including conducting Lot Quality Assurance Sampling (LQAS) in 24 facilities, and reviewing records to validate project data. The team also reviewed with providers the correct use of data recording and management tools. The team noted that data management for PAC and maternal health was better than for FP services, particularly in Kankan. Data on coordination of CHWs (Community Health Agents) and collection of their activity data were particularly weak due to a lack of supervision visits or the regular monthly meetings that are to be held at health centers. Recommendations for improvement were provided to facility managers and prefectural supervisors.
- With the goal of improving information management, a series of orientation sessions was held with providers, including: 18 providers oriented on data management for IMNCI; four animators for the NGO CAM in Conakry oriented on data collection tools; and eight data managers from Faranah and Nzérékoré oriented on how to make use of the MCHIP database.

mHealth

- MCHIP introduced the use of mobile phones (call only) within the network of facilities, as well as the regional and prefectural health offices, to facilitate: 1) referral of patients; 2) stock management, including medications, FP commodities, vaccines, and management tools; 3) clinical consultation; 4) activity coordination; and 5) epidemiological surveillance. MCHIP also prepared and introduced a data-collection form for monthly reporting on phone use. Use of the 264 phones in the network has increased progressively, while the distribution of types of calls has remained fairly consistent. Among all referral calls in Quarters 1 and 2, 61% were for danger signs among children (fever, malaria, and pneumonia); 30% of referrals were for danger signs during pregnancy and delivery and sick newborns; and 9% for FP referrals.

264 PHONES	2012 Q2	2012 Q3	2012 Q4	2013 Q1	2013 Q2
# of calls	**5,752**	**10,060**	**18,319**	**24,034**	**29,938**
Referrals	34%	36%	33%	31%	30%
Stock management	27%	24%	31%	30%	30%
Coordination	17%	20%	18%	19%	18%
Consultation with colleague	12%	11%	10%	8%	9%
Epi surveillance	7%	7%	6%	10%	10%

- MCHIP has also been working on developing a system for mMentoring using text messages and voice calls to reinforce knowledge and skills acquired during training. mMentoring will be introduced in conjunction with EmONC training. Quiz questions and reminders will be sent out by text message, while regular voice calls will be provided by clinical mentors. Providers will also have the opportunity to contact their mentor to ask questions or seek advice about managing a case.

Overall achievement: Building strong partnerships to achieve improved health outcomes for women and children.

- MCHIP has developed strong partnerships with many organizations to achieve project goals. Among USAID partners, MCHIP is collaborating closely with Faisons Ensemble, EngenderHealth, PSI, and the Deliver Project to ensure synergy of activities and to contribute MCHIP technical assistance to other projects. MCHIP is working closely with PSI and UNICEF to coordinate the commodities necessary for community case management of childhood illness by CHWs.
- At the regional level, MCHIP developed committees to insure the coordination of health activities and management of stocks, including contraceptives stocks, in order to address frequent stock-outs. This committee includes all partners involved in MNH, FP, and RH in the field.
- Positive results from MCHIP have generated interest from other organizations in carrying out similar work in other geographical areas. We are currently developing a follow-up collaboration with UNFPA for SBM-R, long-acting FP, and pre-service midwifery education. UNICEF has approached MCHIP to help improve training and performance in focused antenatal care, and other elements of essential obstetric care in Nzérékoré.
- The French Agency for Development (AFD) confirmed their intention to involve MCHIP partners and AGBEF (IPPF affiliate) in the implementation of a new AFD/EU funded project with MOH to support health systems strengthening, specifically the FP and RH components.
- **Program learning:** MCHIP staff presented program results related with SBM-R, mHealth, PPFP/PPIUCD, and PAC in international meetings.

Priorities for Quarters 3 and 4

- **Family Planning:** Regional trainers will complete the remaining IUD and implant courses and their qualification as trainers. A training session on tubal ligation is planned. Ongoing supportive supervision will be conducted.
- **Maternal and Newborn Health and EmONC:** Training and Qualification of EmONC trainers will be completed in April and remaining training sessions will complete the expansion to 10 new facilities. The trainings on VCT and eMTCT for staff at 10 target sites will be held with close follow-up of service implementation.
- **Child Health:** MCHIP will continue to support the IMNCI Pilot Committee, as well as ongoing supportive supervision of IMNCI and iCCM providers. Performance standards for IMNCI will be introduced in the pilot sites.
- **Community Health:** MCHIP will provide ongoing support to NGOs and CHWs. Training of CHWs in communes of Conakry will be completed. An orientation of providers in the facilities linked to selected hair salons will be held.

- **Pre-service Education:** SBM-R Module 2, Effective Teaching Skills, and Clinical Training Skills courses will be conducted for Kindia Midwifery School. A skills lab development course will also be held along with provision of materials for the skills lab.
- **SBM-R:** MCHIP will provide ongoing support and supervision to facilities requesting it. Among the newer sites, remaining modules and assessments will be completed, including launching SBM-R in five more facilities. Validation visits will be organized as requested. Recognition ceremonies for four facilities will be held since their performance has already been validated.
- **Infection Prevention:** National IP trainers who were trained in late 2012 will conduct courses for 80 providers from the SBM-R sites.
- **mHealth:** mMentoring will be launched in conjunction with EmONC trainings. MCHIP will continue to monitor and support the mobile phone network among project facilities.

Guinean Woman's Life Saved by Quick Actions of Health Care Providers

by: Alisha Horowitz

When Dr. Mamadou Oury Barry first saw Hawa Condé, the 23-year-old patient was crying out, "I'm going to die." The young mother had reason to fear. She had given birth 24 hours earlier at her home in the village of Tiro, and though the labor and delivery of her baby boy had gone smoothly, the placenta had not been delivered.

"She told me that she felt dizzy and that her body was tingling. She kept moaning and crying out," said Dr. Barry, 45, Head of the Maternity Department at the Regional Hospital of Faranah, describing Hawa's state when he first examined her. "Her condition was serious, her life was in danger."

Hawa understood well the importance of expelling the placenta—after all, it was her third delivery. Accompanied by a relative, Hawa had walked to the local health center in Tiro, where she was told to go immediately to Faranah for treatment. It took some time to arrange for a car for the 20-minute drive. Once Hawa arrived at the hospital, the staff took swift action. Midwives brought Hawa into the delivery room and gave her an injection of oxytocin to help the uterus contract to deliver the placenta, but they were unable to deliver it. They then called in Dr. Barry to help.

Thanks to training that Dr. Barry and other staff had received in emergency obstetric and newborn care (EmONC) through a Jhpiego-supported effort to improve services at the hospital, he was able to take immediate action on this day in July 2012. This training took place at the request of the Ministry of Health and through the U.S. Agency for International Development's (USAID's) flagship Maternal and Child Health Integrated Program (MCHIP).

Thanks to MCHIP training, Dr. Barry, with midwives at the Regional Hospital of Faranah, helped save the life of a new mother. Here he views the maternity department's partograph chart.

In Hawa's case, Dr. Barry quickly assessed her condition. He found that she had very low blood pressure, an accelerated pulse, rapid breathing, a very pale complexion, and a hanging umbilical cord. After closely following the prescribed EmONC steps, including appropriate infection prevention measures, the doctor and two midwives worked together to manually remove the placenta and then properly disposed of it.

"We felt relieved because we were able to stabilize her. If she had stayed at home, she could have died within hours . . . ," said Dr. Barry, a father of four children whose wife is a nurse at a local health center.

Hawa Condé, in the maternity ward, after Dr. Barry helped prevent her from bleeding to death.

The hospital in Faranah is among 38 health facilities in Guinea that have benefited from other efforts led by Jhpiego and partners to strengthen health care delivery in four regions of Guinea using a Jhpiego-pioneered quality improvement approach. Jhpiego introduced Standards-Based Management and Recognition (SBM-R®) in 2009 at six health facilities. This practical, systems-strengthening approach provides health workers and facilities with tools and methods to improve performance and quality of services. The focus was on building the capacity of health care providers in family planning and infection prevention, as well as fortifying their skills in EmONC.

Before SBM-R was introduced at the regional hospital in 2010, the facility faced challenges related to poor infection prevention practices; incorrect disposal of medical waste; lack of a water source on site (staff fetched water from the river); lack of training for new providers on management of obstetric emergencies; and occasional stock-outs of contraceptive methods. Through SBM-R, the hospital staff have addressed many challenges and achieved successful results in key performance target areas. The most notable increase was in family planning, which went from 61 percent of performance standards achieved at the

initial assessment to 91 percent achieved in April 2012. The results for EmONC were also impressive—increasing from 52 percent to 80 percent for the same time period.

The hospital now has an on-site water pump, improved infection prevention practices, increased numbers of clients using delivery and family planning services, and expanded staff training opportunities. During a visit to the hospital, the Minister of Health, Dr. Naman Keita, congratulated the staff on the facility's cleanliness.

For Dr. Barry, SBM-R has led to direct improvements in patient care. "SBM-R has greatly helped the facility, especially in the management of complications and the hygiene of the structure and equipment," he said. "Now we have drugs for emergencies. Before, that was lacking and there were frequent stock-outs."

Dr. Barry puts his skills into action daily—whether ushering in students for training, helping a young man with filling a prescription, or stabilizing a patient's condition. He said the regular supervision that is part of SBM-R has been particularly motivating. "We have seen an increase in the number of obstetric emergencies we receive, which have increased by nearly 50 percent in three years. We have been able to reduce the number of deaths from abortion, pre-eclampsia, and postpartum infections."

Hawa may not be aware of the work to strengthen health care services for women and their families, but she is grateful for the care she received. Sitting up in bed later that day, the exhausted mother calmly held her newborn son and tried to nurse him while he squirmed.

"When we came to the hospital . . . I was worried because the placenta hadn't come. They gave me an injection . . . ," she said. "When the placenta came out, I felt relieved."

Dr. Mamadou Oury Barry with his patient, Hawa Condé, and her new baby.

Country Summary: India

Period: FY 2013, Quarters 1 and 2

Major Activities

- Supported the initiative of the **Indian Nursing Council** (INC) and the **Government of India**'s (GoI) to strengthen and expand the foundation of **pre-service education** at the national level, while upgrading ANMTC clinical training capacity in Jharkhand and Uttarakhand
- Addressed the unmet need for postpartum family planning (**PPFP**) services by supporting integration in routine **MNCH** services and revitalizing immediate postpartum intrauterine contraceptive device (**PPIUCD**) insertions
- Supported the MOHFW, USAID bilateral health programs, and the new National **Newborn Care and Resuscitation** Initiative (NSSK) in their efforts to strengthen and expand access to essential newborn care (ENC), and teach basic resuscitation techniques
- Developed a scalable model for ENC at the facility level for sub-district health facilities
- 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
- Worked across the fields and with **government** and **NGO** partners to develop, demonstrate, and leverage resources for scaling up ever-more-effective combinations or packages of **MNCH/FP** care

Selected Health and Demographic Data for India	
GDP per capita (USD)	691.49
Total population	1,224,614,000
Maternal mortality ratio (deaths/100,000 live births)	200
Skilled birth attendant coverage	76.2
Antenatal care, 4+ visits	53%
Neonatal mortality rate (deaths/1,000 live births)	31
Infant mortality rate (deaths/1,000 live births)	44
Under-five mortality (deaths per 1,000 live births)	55
Treatment for acute respiratory infection	38.1
Oral rehydration therapy for treatment of diarrhea	53.6
Diphtheria- pertussis-tetanus vaccine coverage (3 doses)	71.5
Total health expenditure per capita (USD)	3.9

Sources: WHO India Health Profile 2009, Government of India.

Program Dates	October 1, 2012–September 30, 2013					
PY 5 Budget	$4,832,340					
Total Mission Funding to Date	$16,776,000					
Geographic Focus	India: Uttar Pradesh, Jharkhand, Uttarakhand, Bihar					
Geographic Coverage	No. (%) of provinces	8 (9%)	No. of districts	62	No. of facilities	169
MCHIP In-Country Contact	Dr. Karan Singh Sagar: karan@mchip.in					
HQ Managers and Technical Advisors	Joseph de Graft-Johnson: jjohnson@savechildren.org; Pat Taylor: pat_taylor@jsi.com; Anne Pfitzer: anne.pfitzer@jhpiego,org; Jeffrey Smith: jeffrey.smith@jhpiego.org; Anne Blauvelt: anne.blauvelt@jhpiego.org; Sara Chace: sara.chace@jhpiego.org					

FY 2013, Quarters 1 and 2: Achievements Highlights

Goal 1: To increase knowledge and skills of ANM graduates from ANMTCs by improving the quality of pre-service education for the Nursing and Midwifery cadre across India.

- **National Nodal Centre Initiative:** MCHIP continued support for the National Nodal Centre (NNC), NRS Kolkata, and back-stopped key activities during six weeks of training for the 27 Auxiliary Nurse Midwife/General Nurse Midwife (ANM/GNM) faculty from Jharkhand, Bihar, Rajasthan, Uttar Pradesh, and Uttarakhand. These trainings used a package that included information on components of effective teaching skills, skilled birth attendance, integrated management of neonatal and childhood illness, family planning, prevention of STIs including HIV, and performance standards for the ANM training centers.
- **Development of State Nodal Centres:** Due to MCHIP's technical support, the college of nursing in Dehradun, Uttarakhand, has been inaugurated as the State Nodal Centre (SNC) for Uttarakhand. Significant progress has been made in the proposed State Nodal Centre at the College of Nursing Ranchi, Jharkhand, through continued technical assistance (TA) in procuring equipment, conducting effective teaching skills (ETS) workshops for all faculty, and facilitating a stakeholder meeting under the chairmanship of the Principal Secretary of Health in Jharkhand.
- **Strengthening of ANM Training Centers in Jharkhand:** MCHIP continued providing TA to the Government of Jharkhand (GoJ) to strengthen three Auxiliary Nurse Midwife Training Centres (ANMTCs) in the three MCHIP focus districts. To accomplish this objective, MCHIP donated models and equipment to strengthen skills labs and organized a clinical skill standardization workshop at the ANMTC in Chaibasa. The team continued to conduct supportive supervision visits to facilitate improvement in classroom teaching, clinical instruction and practice, and training infrastructure organization.
- **Upgrading of School of Nursing Agra to College of Nursing:** The team continued efforts to support the upgrading of the School of Nursing in Agra district into a College of Nursing through developing infrastructure and increasing faculty members and capacity. MCHIP conducted regular, follow-up visits with the new Principal at the School of Nursing, Agra. As a result, the school's teaching infrastructure has been reorganized, the library was improved, an Internet facility initiated, and interviews conducted for additional faculty.
- **Operational Guidelines for Strengthening Pre-Service Education:** MCHIP provided TA to the Ministry of Health and Family Welfare (MOHFW), Government of India (GoI), to develop the operational guidelines for strengthening pre-service nursing and midwifery education. As a follow-up, 38 officers from 10 high-focus states were oriented to the operational guidelines, the detailed steps for establishing SNCs, and how to strengthen ANM and GNM schools during a two-day workshop.

Goal 2: To increase access to quality FP services, including PPFP/ PPIUCD, through advocacy, use of alternative training approaches, focused quality improvement interventions, and increased integration of PPFP with relevant MNCH services.

- **National Review Meeting on Family Planning:** MCHIP co-supported the National Review Meeting on Family Planning with a focus on strengthening postpartum intrauterine contraceptive device (PPIUCD) services in India. **More than 200 participants from 27 states and seven union territories participated.**

- **Learning Resource Package for Reproductive, Maternal, Neonatal, and Child Health (RMNCH) Counselors:** MCHIP provided TA to the Family Planning Division, MOFHW, to develop the facilitator's guide, RMNCH handbook and RMNCH counselor flipbook. **The Learning Resource Package (LRP) was used during the training of the first batch of 27 RMNCH counselors in Uttar Pradesh (UP).** Feedback from this training was shared with the MOHFW and served as a tool for further refinement of the LRP.
- **PPFP/PPIUCD E-Learning Course:** MCHIP supported MOHFW in developing three e-learning course packages for PPIUCD services to reduce the time providers spend outside of their facilities to receive training and improve learning. The final version of the course has been submitted to the MOHFW, and the course is expected to be hosted on the National Institute of Health and Family Welfare (NIHFW) website in May 2013.
- **Scaling-Up Support to the MOHFW, Family Planning Division:** MCHIP continued to support the Family Planning Division and advocate for the scale-up of PPIUCD services in six high-focus states. Some highlights include:
  - **Uttar Pradesh:** Established two new training sites at DWH Kanpur and Medical College of Meerut; heads of 31 facilities participated in PPFP/PPIUCD experience-sharing workshops and 64 providers trained through clinical trainings in PPIUCD services.
  - **Jharkhand:** Conducted need-based orientation for providers at three poor-performing facilities; with the GoJ, developed and disseminated a core set of performance standards to 21 district hospitals, and supported implementation of family planning service delivery standards at 12 health facilities in three focus districts.
  - **Uttarakhand:** Helped introduce PPIUCD services in an additional 12 facilities, trained 17 staff nurses and 19 doctors in PPIUCD clinical training, and conducted six supportive supervision visits.

Goal 3: To contribute to the Government of India's (GoI) effort to achieve full immunization coverage by 12 months of age for at least 80% of India's children.

- Participated in the **"Consultation of Supportive Supervision to Strengthen Capacity of Frontline Workers and Health Providers"** organized by the MOHFW, GoI, and UNICEF, and facilitated a session on the Regular Appraisal of Program Implementation at District (RAPID) process and its achievements.
- **SPEIO Review Meetings:** Supported the GoI in organizing two State EPI Officer (SEPIO) review meetings in the context of Intensification of Routine Immunization activities.
- **Support for the Development of Training Materials:** MCHIP is involved in developing a four-day course on training of the SEPIOs (development of curriculum/agenda). MCHIP also participated in meetings to finalize course material on "Cold Chain and Vaccine Management" where the MCHIP team reviewed four chapters, and reviewed two chapters to finalize the NIPI-UNOPS E-Learning course on immunization for health managers.
- **Technical Support:** Provided technical support to other states in India; the state representative from UP was invited to Tanzania to support and scale up high-impact interventions from MCHIP India, such as the micro-planning tool and RAPID.
- **Routine Immunization Program Implementation Plan (PIP):** MCHIP provided TA to the development of a Routine Immunization (RI) Program Implementation Plan (PIP) in Jharkhand and Uttar Pradesh, and could leverage more than Rs. 77 million (approximately 1,423,830 USD) for scale-up of MCHIP high-impact interventions.

- **State- and District-Level Support:** Participated in and supported the strengthening of RI at state and district levels by giving inputs in district review meetings and field reviews. The team also facilitated sessions during the PIP training of 45 District Program Management Units (DPMUs) in preparation of District Health Action Plans (DHAPs) for RI in the focus states.
- **Conducted Mid-Term Coverage Evaluation Survey (CES) in UP to Understand the Impact, and Also Conducted One Round of RAPID in All Focus Districts.**
- **Assessment of Maternal and Neonatal Tetanus Elimination (MCTs) in Uttar Pradesh:** Participated in the assessment of MCTs organized by the MOHFW and Immunization Technical Support Unit-Public Health Foundation of India to assess MCT progress and prepare a roadmap for improvements.
- **National Effective Vaccine Management:** MCHIP is involved in specialized evaluations such as the "National Effective Vaccine Management" and Maternal and Neonatal Tetanus Elimination (MNTE) validation.
- Supported the development and rollout of an Open Vial Policy in the country.

Goal 4: To strengthen and expand access to ENC and teach basic resuscitation technique under the National Newborn Care and Resuscitation Initiative (NSSK), with the MOHFW and state health departments.

- **Reproductive Maternal Neonatal Child Health +Adolescent (RMNCH+A) Counselor State Training:** The MCHIP family planning team in UP facilitated the first RMNCH+A counselors' training, which included participants from across the country. The state NBC team led sessions on diarrhea and pneumonia management.
- **Nationwide Assessment of Availability and Quality of Essential Newborn Care and Resuscitation (ENC/R):** MCHIP completed a systematic analysis of care being provided at the delivery point and facilities with neonatal stabilization units in the states of Rajasthan, Orissa, Tamil Nadu, Assam, West Bengal, and Gujarat. The objective of the analysis was to assess the availability of 24 x7 services at these delivery points and the quality of care being provided to the newborns at the time of birth and in the postnatal wards.
- **Support to Government of Haryana:** MCHIP supported the GoI in implementing the ENC/R model through a state-level workshop, a real-time assessment for facility readiness, and demonstration of the elements of a scalable program model for improving facility-based essential newborn care.
- **Neonatal Verbal Autopsy (VA) Expert Review Workshop:** A VA workshop was held with experts from UNICEF, INCLEN, the National Neonatal Forum, national Collaborative Centers, and the Department Head from Aligarh Muslim University and Gwalior Medical College, to validate and discuss the Verbal Autopsy tools and process and the results of the VA exercise. As a result, the Verbal Autopsy tool was accepted, 67 verbal autopsy data were validated, and the logic framework for Neonatal Verbal Autopsy software (NeVas) was finalized. With this tool, **28 new cases of VA were investigated**.
- **CSC2A Summit:** National and state NBC teams attended the "Child Survival Call to Action" summit in Chennai. MCHIP displayed key findings from the intervention districts of UP and Jharkhand.
- **National Child Health Review Meeting:** Representatives from 30 states and union territories participated in the meeting, where USAID-MCHIP shared its lessons for scaling up essential newborn care at the facility level.

- **Workshop on Supportive Supervision in ENC/R:** MCHIP organized a one-day, state-level workshop to share and scale up supportive supervision of essential newborn care. Supportive supervision is an effective tool for improving the performance of services by health providers.
- **Inputs in Program Implementation Plan (PIP) 2013–2014:** MCHIP actively supported the Government of Jharkhand and the Government of UP (GoUP) in the preparation of the Newborn Health Component of Child Health PIP 2013–2013. Accepted recommendations in Jharkhand include newborn kits, Vitamin K, three batches of NSSK State Training of Trainers (TOT) for 54 new master trainers, and three batches of refresher training for 69 existing master trainers. In UP, some examples are supportive supervisions of ENC/R in 42 priority districts, Vitamin K, and the inclusion of ASHA facilitators for every 20 ASHAs.
- **Collaboration with the MOHFW and State Governments of Jharkhand and Uttar Pradesh:** In UP and Jharkhand, MCHIP supported training of a total of 348 health personnel in NSSK, provision of essential newborn care to 6551 newborns at 10 demonstration sites, resuscitation of 244 newborns with birth asphyxia, and institutionalization of skin-to-skin care for newborns.

Priorities for Quarters 3 and 4

Pre-Service Nursing and Midwifery Education

- Continue to provide TA for the training of faculty from ANMTCs from existing and new states (Rajasthan, Madhya Pradesh, and Odisha) at the NNC Kolkata, and continue post-training follow-up to existing states.
- Continue to strengthen the college of nursing in Jharkhand and facilitate its functioning as an SNC.
- Continue advocacy and support for the upgrading of the school of nursing in Agra.
- Facilitate the INC certification of the SNC at Dehradun, Uttarakhand.

Repositioning Family Planning

- Provide technical assistance to the GoJ and GoUP to improve the decentralized training capacity for PPFP/PPIUCD services by establishing four new divisional-level training sites in Jharkhand and five new divisional-level training sites in Uttar Pradesh.
- Facilitate the organization of PPFP/PPIUCD experience-sharing and dissemination meetings in Jharkhand.
- Advocate for hiring of remaining RMNH counselors and provide TA for subsequent training in Jharkhand and Uttar Pradesh, using the learning resource package.

VPD Support

- Continue to support the GoI and partners in policy decisions and development of various guidelines.
- Support the development of course content for the proposed SEPIO induction workshop.
- Align with the RMNCH+A activities proposed by the GoI and continue to support the MCHIP-specific activities in focus states and districts.
- Provide States of Jharkhand and Uttar Pradesh with technical support in all RI-related activities.

Essential Newborn Care and Resuscitation

- Compile and analyze available data on verbal autopsy, newborn follow-up, and delivery records for the national workshop.
- Complete the ENC/R video and program learning documents.
- Provide continued support to GoI and state governments to scale up ENC/R as an integral intervention package for reduction of neonatal mortality.
- Provide TA to state governments for implementing the **RMNCH+A** strategy as per GoI proposal.
- Provide support at state levels for supportive supervision and mentoring visits, and provide regular feedback on key newborn health activities to the district- and state-level officers.

MCHIP Prepares State Trainers to Help Strengthen Family Planning Services in India's Most Populous State

Kanpur, India – With the recently held training of trainers (TOT) at the District Women's Hospital (DWH), Kanpur, the U.S. Agency for International Development's flagship Maternal and Child Health Integrated Program (MCHIP) helped prepare the third postpartum intrauterine contraceptive device (PPIUCD) training site in Uttar Pradesh (UP). PPIUCD, a safe and reversible family planning option, is high on the agenda of the Government of India's Ministry of Health and Family Welfare (MoHFW) as a viable pregnancy-spacing option to be provided to women right after childbirth. UP, the most populous state in India, with nearly 200,000 people and the second highest fertility rate (3.5), urgently requires innovative family planning solutions and is a high-focus state for the Indian Government. Every year in UP, out of every 1,000 children born, 57 die before their first birthday, and of every 100,000 mothers who give birth, 359 of them die from childbirth-related complications.

Because it recognizes PPIUCD as an intervention to reduce maternal and infant mortality and save women from unintended pregnancies, the Government of Uttar Pradesh, with technical assistance from MCHIP, plans to scale up the provision of PPIUCD services to all 71 districts.

To facilitate this scale-up and train more service providers, four PPIUCD training sites will be established by March 2013. At present, the capacities of proficient PPIUCD service providers are being developed to prepare them to function as PPIUCD trainers. They in turn will conduct three-day PPIUCD clinical training courses for providers from their own and neighboring districts. This mechanism is critical to ensure sustainability and self-sufficiency of the state in taking the PPIUCD scale-up activities forward.

The latest in these series of trainings was held on January 10–11, 2013, at Kanpur's DWH. "The training was one of a kind and perfect," said one of the participants.

The training focused on building the participants' capacity as effective trainers and prepared them to become competent PPIUCD trainers. A Postpartum Training Package developed by the MoHFW, with technical assistance from MCHIP, was shared with the participants. "The training was very concise and appropriate for the skill development of doctors," said Dr. Ruchi Jain, one of the participants. "We have benefited not just in providing PPIUCD trainings, but our capacities have been developed as trainers."

MCHIP's first training site in UP was at King George's Medical University in 2009. Since then, 20 facilities have come to provide PPIUCD services in the state, 94 doctors have been trained in service provision and more than 4,000 women have accepted PPIUCD insertions. To take services to scale, the state will develop five more training sites by 2014, which will then cater to the training needs of the entire state.

Dr. Anjula Gupta, another participant from the TOT at DWH, Kanpur, understands the importance of her role. She said, "The people who come to our facilities are generally from the poorer sections of society. They are often burdened with the pressures of making two ends meet, but still have big families with several children. These are the people who most need a family planning option. Counseling them and providing them with a family planning method while they are still at the facility will definitely increase their acceptance. Though many a times, cultural barriers make acceptance levels low, we know PPIUCD is a very effective and hassle-free method. This makes it very suitable for these people. As a state trainer, I will keep trying to develop competent providers who will provide quality PPIUCD services and help more women adopt a family planning method for their own health and for a better future of their families."

Country Summary: Kenya

Period: FY 2013, Quarters 1 and 2

Selected Health and Demographic Data for Kenya	
GDP per capita (USD)	875
Total population	38,610,097
Maternal mortality ratio (deaths/100,000 live births)	488
Skilled birth attendant coverage	43.8
Antenatal care, 4+ visits	47.1
Neonatal mortality rate (deaths/1,000 live births)	31
Infant mortality rate (deaths/1,000 live births)	52
Under-five mortality (deaths per 1,000 live births)	74
Treatment for acute respiratory infection	55.9
Oral rehydration therapy for treatment of diarrhea	72
Diphtheria-pertussis-tetanus vaccine coverage (3 doses)	86
Modern contraceptive prevalence rate	53.6
Total fertility rate	4.6
Total health expenditure per capita (USD)	

Sources: 2009 Kenya Demographic and Health Survey, World Bank; 2009 Kenya Population Census.

Major Activities

- Maternal, newborn, and child health
- Maternal, infant, and young child nutrition Immunization
- Child health and survival
- Cervical cancer prevention and control
- Prevention of mother-to-child transmission of HIV
- Malaria in pregnancy
- Community Prevention with Positives
- Injection safety and infection prevention

MCH FP clinic at Bondo District Hospital, Bondo District, Siaya County, Kenya

Program Dates	October 2012–March 2013					
PY 5 Budget	$6,475,800 Field; $1,245,808 Core = $8,067,491 Total					
Total Mission Funding to Date	$6,475,800					
Geographic Focus	National level with MOPHS and MOMS, Provincial level and with APHIAplus programs and 3 districts (Bondo, East Pokot, and Igembe)					
Geographic Coverage	No. (%) of provinces	3 (37%)	No. of districts	14	No. (%) of facilities	121
MCHIP In-Country Contact	Dr. Muthoni Magu-Kariuki: mkariuki@mchip.or.ke					
HQ Managers and Technical Advisors	Pat Taylor: ptaylor@jsi.org , Gabrielle Hecker: gabrielle.hecker@jhpiego.org					

FY 2013, Quarters 1 and 2: Achievement Highlights

Sub-Objective 1: Strengthen the technical and managerial capacity and the ability of the Department of Family Health (DFH) to monitor the implementation of national MNCH policy.

- USAID MCHIP supported the 54th National Nurses Association of Kenya Annual Scientific Conference 2012, held from the 10–12 October 2012. The theme was **"Re-thinking MDGS in the constitution dispensation."**
- MCHIP supported the Nutrition Inter-agency Coordinating Committee, during which the Nutrition M&E framework was endorsed and the MIYCN guidelines were approved for printing and dissemination.
- The Igembe North and South districts' baseline assessment data were disseminated to the District Health Management Teams (DHMTs) and workplans were synchronized to close the gaps identified.
- To implement the community strategy in Igembe district, MCHIP conducted an orientation for 12 Community Health Extension Workers (CHEWs) and 400 Community Health Workers (CHWs) in three community units on Community-Based Health Information Strategy tools and household mapping.

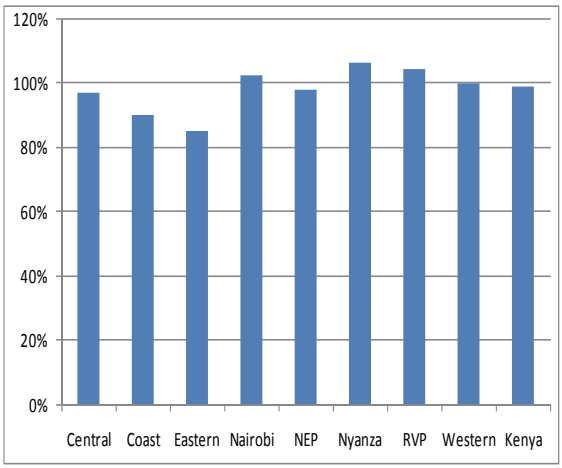
Sub-Objective 2: Support the Division of Nutrition (DON) to improve maternal, infant, and young child nutrition (MIYCN) nationally and in high-priority counties and districts.

- MCHIP held consultative meetings with the Division of Nutrition and the APHIAplus nutrition focal persons to finalize MCHIP's Year 5 workplan and to discuss areas of linkages and collaboration on the MIYCN guidelines and the Baby Friendly Community Initiative (BFCI) package.
- The Ministry of Public Health and Sanitation, with support from partners including MCHIP, hosted the first National Symposium on Scaling-Up Nutrition in Kenya, with the theme: **"Nutrition is Key: Take up your role, Act now."**
- MCHIP led the review and finalization of the MIYCN policy and strategy and the development of behavior change communication (BCC) strategy and key messages for iron and folic acid.
- MCHIP participated in the launch of mandatory food fortification in Kenya, and also provided technical assistance to the Division of Nutrition in the drafting of the breast milk substitutes regulations, which will be used to regulate the breast milk substitutes (Regulations and Control) Act, recently passed in parliaments and signed into law by the President of Kenya.
- MCHIP provided technical support to USAID Kenya Horticulture Competitive Projects in the review and harmonization of their nutrition materials.
- Igembe North district baseline results noted that nutrition indicators were low in Igembe North: 19% exclusive breastfeeding rate; 31% stunting rates; and only 9% of facilities assessing children for height/length for age, among other assessments. During this period, 27 facility in-charges and Igembe North DHMT members were oriented on CHANIS tools, the mother-child booklet, and IMAM guidelines.
- MCHIP carried out a supportive supervision visit with the DHMT and the HMT in Bondo district to establish the current status of FP/MIYCN in health facilities and communities.
- Most of the mothers interviewed via client exit interviews had knowledge about most of the infant feeding practices, especially those that relate to BFCI.

- The infant feeding policy statement was available and translated into the local language and displayed in all relevant areas of the health facility—MCH, Maternity, and OPD—in all facilities except one.
- The nutrition BCC materials for ORT corners developed in collaboration with the MCHIP Child Health Team, Division of Nutrition, and the Division of Child and Adolescent Health were reviewed and finalized. The tools will be pre-tested in the next quarter and finalized for use in Igembe district and disseminated in Igembe North to the facility in-charges; they are now awaiting final printing.

Sub-Objective 3: Support the Division of Vaccine and Immunization (DVI) to increase immunization coverage in lower-performing districts and successfully introduce Rotavirus vaccine nationwide by 2013.

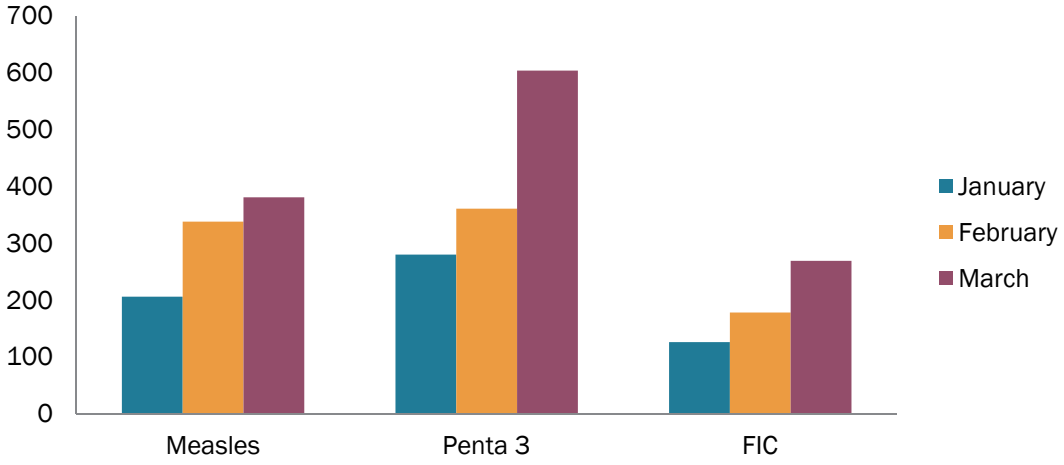
Figure 1. Proportion of Children 12–23 Months Reported to Have Completed Their Routine Infant Immunization Schedule, by Province, National Immunization Coverage Survey, 2012



In November 2012, MCHIP, working with other partners, supported the Ministry of Public Health and Sanitation (MOPHS) to conduct the measles campaign, which was a follow-up to the 2009 campaign. The purpose of the campaign was to provide a second opportunity to susceptible children who had not received the routine dose at nine months or to those who received the dose but did not seroconvert (measles vaccine sero-conversion rate is 85% when given at nine months). MCHIP provided both financial and technical support to the Division of Vaccines and Immunization in the planning and execution of the campaign.

Based on administrative population figures, the national coverage was 99%. However, there were regional variations in coverage as shown in the graph below.

Figure 2. Monthly Performance (Absolute Numbers), Igembe North District, 2013



Sub-Objective 4: Support the Division of Child and Adolescent Health (DCAH) to address the primary causes of child death in Kenya—diarrhea and pneumonia.

Integrated Community Case Management

MCHIP provided support during the technical preparation of the integrated community case management (iCCM) draft implementation guidelines and documents. With technical support from MCHIP/Washington, technical reviews of the iCCM implementation framework and plan of action were done.

- The MCHIP Child Health Team facilitated meetings with key stakeholders in iCCM implementation during the development of the iCCM operational research proposal. **Important outcomes from these meetings include:**
  - The Head DCHS gave approval for MCHIP to pretest/pilot the iCCM strategy in Bondo district, and designated this as the region for its implementation/testing;
  - The head of malaria research and surveillance gave MCHIP assurance that the Division of Malaria Control (DOMC) will facilitate malaria supplies and commodities to ensure that the implementation research was successful, and
  - A presentation of the concept for the draft iCCM proposal and protocol was made to USAID.

Zinc Use in Diarrhea Disease Management at Community Level:

MCHIP supported the compilation of the Zinc evidence document and resources for presentation to the Pharmacy Poisons Board (PPB) by the DCAH. This marked an important milestone in community case management for diarrhea disease in Kenya. **S**ubsequent to the PPB's review of the Zinc evidence document and its approval, **t**he Government of Kenya made it a policy for Zinc to be used as an over-the-counter drug and by CHWs in the management of diarrhea in children under five in Kenya, through circular number MPHS/ADM/1/17.

8th International Conference on the MCH Handbook:

DCAH successfully facilitated the 8th International conference on the MCH Handbook.

Rapid Results Initiative (RRI 2013):

This activity kicked off officially on the 30 November 2012, and was officially opened by the Permanent Secretary, MOPHS, Mark Bor, OGW. The initiative focused on achieving MDGs 4 and 5. The Child Health component is to increase the proportion of facilities that manage sick children under five with diarrhea qualitatively, and ensuring the scale-up in the use of ORS and Zinc to all these children during their management at these facilities.

MCHIP linkage with APHIAplus Kamili ensured that they facilitated the provincial and district teams during the baseline assessment as well as during orientations meetings, with MCHIP and DCAH/DRH giving technical oversight at those levels.

MCHIP facilitated a technical review meeting attended by DCAH, Division of Community Health Services, which edited and made revisions to the CHW training curriculum.

District Implementation Activities:

- **Igembe North District:** The draft Igembe workplan and budget were completed. The Child Health Team facilitated a dissemination meeting for facility in-charges of all the health facilities in Igembe. A total of 24 facilities' in-charges were oriented on the ORT Corner operational guidelines.

- **Bondo District:** MCHIP produced the first draft of the iCCM protocol for the operations research in Bondo. This information was critical to identifying the areas for sampling during the research, and to laying a foundation for the baseline household survey at the initiation of the iCCM implementation.

Important accomplishments included: completion of the household mapping exercise; sensitization of the DHMTs and CHEWs; definition of hard-to-reach areas in Bondo, based on consultative and consensus criteria between MCHIP and the DHMT; and CHW mentorship during the fieldwork registration exercise.

Sub-Objective 5: Support the Division of Reproductive health (DRH) and DCAH to improve the quality of maternal and newborn health care.

5.1 Support to DRH

The need to equip all health care providers with maternal and newborn health care knowledge, skills, and positive attitudes at all levels of service delivery, and with updated, evidence-based interventions, led to the development of the National Guidelines for Quality Obstetrics and Perinatal Care (National MNH guidelines). To improve the quality of care at the facility level, MCHIP supported the Division of Reproductive Health to review MNH service delivery standards, which were developed in the last quarter. MCHIP continues to provide invaluable technical support to the Division of Reproductive Health. MCHIP team members participated in the Family Planning Technical Working Group meeting. The RRI (MNH) was a rigorous process during which several issues pertaining to reproductive health emerged. The DRH and stakeholders supporting the process held meetings and workshops to tackle the issues. MCHIP continued to provide invaluable technical support to the Division of Reproductive Health. MCHIP developed the orientation package for the RRI process.

Achievements on RRI:

- MCHIP supported the DRH and DCAH to develop MNH service delivery standards, which are based on the SBM-R approach. The process, which commenced in the last quarter of Year 4, was finalized in this quarter. The MNH service delivery standards were reviewed by several stakeholders and will be field-tested in two sites in Quarter 3.
- MCHIP supported the DRH to convene special MNH taskforce meetings to discuss the MNH issues and strategize on how to address the high maternal mortality rates. From the meetings, the stakeholders were to develop a National MNH implementation plan and scale-up plan for the five BEmONC signal functions identified.
- MCHIP participated in the RRI process for the scale-up plan of BEmONC signal functions. MCHIP provided technical support and participated in meetings for two BEmONC signal functions, namely postpartum hemorrhage and newborn resuscitation. From the meetings, stakeholders were to identify and quantify the equipment and commodities required, develop supervision tools for the signal functions, and identify process and input indicators and the components of the training package to be utilized. The BEmONC signal functions meetings will continue in the next quarter.
- In March 2013, some members of MCHIP participated in the MNH technical working group meeting. Discussions during the meeting were on BEmONC signal functions and a scale-up plan for maternal and perinatal death reviews.

5.2. Newborn Care

One of the major contributors to stagnant newborn indicators is the poor coordination of newborn care program activities.

Table 1. Milestones and Activities in Newborn Care

MILESTONES	ACTIVITIES
A baseline survey to establish the level of facility preparedness to provide quality basic emergency obstetric and newborn care in selected health facilities conducted	Identify and map regions.*
	Determine selection criteria for health facilities.*
	Identify list of health facilities based on criteria.
	Develop data collection, supervision tools, and instructional manual (includes pre-test).
	Train national and regional assessors.
	Conduct data collection.
	Clean, enter, and analyze data collected.
	Disseminate the preliminary baseline report at the national and regional levels.
	Review implementation plan (as per the baseline report feedback).
	Disseminate the final baseline report at the national and regional levels.
IEC/BCC materials available (include job aids)	Identify/review the IEC/BCC materials for MNH.*
	Develop IEC/BCC materials.*
	Print the IEC/BCC materials.
	Review EmONC training package to include job aid orientation and attitude change.
Orientation of health workers conducted	Sensitize the regional and health facility managers.
	Conduct regional training of trainers (TOT) orientation.
	Conduct orientation of health workers: mentorship/on-the-job training (include dissemination of IEC/BCC materials and guidelines).
Supportive supervision	Conduct supportive supervision by all levels.
Progress report	Ensure complete and timely submission of reports by each district.
	Submit of reports (1x per fortnight).
	Provide feedback to districts (1x per fortnight).
Mid-term assessment	Ensure report and supervision data analysis.
	Provide feedback of mid-term assessment findings to the districts.
	Review implementation plan (as per the mid-term report feedback).
	Conduct data collection.
	Clean, enter, and analyze data collected.
	Disseminate the preliminary mid-term report at the national and regional levels.
	Disseminate final report of the RRI.

Please note: Activities marked with * have been completed.

Major Achievements

1. Mapping where RRI partners will work has been done according to areas where they are working and in phases. The regions will be grouped as follows:
   - Phase 1, four regions – Nyanza, western, North and South Rift
   - Phase 2, three regions – North Eastern, Coast and Upper Eastern
   - Phase 3, three regions – Lower Eastern, Nairobi, Central

MCHIP and APHIAplus programs propose to support Phase 3 regions in Nairobi, Machakos, Makueni, Nakuru, and Baringo counties. Mapping in some regions is not complete.

2. The selection criteria have been met and partners agreed to focus on the following:
   - Thirty percent of the facilities offering deliveries in each district. Selection of facilities and participants to be done in collaboration with the PHMT and DHMT.
   - High-volume facilities currently offering deliveries (public, FBO and private) as identified by DHMT assessment.
   - Identification of regions with strongest partner support.
   - Geographical considerations to factor distance and population.

3. Of the five working groups that have met and acted on their assigned scope of work, the newborn group met and completed the following RRI scope of work based on newborn resuscitation and warm chain:
   - Review the previous RRI MNH package used and see if it is sufficient in building the skills of the health workers to effectively deal with the newborn resuscitation warm chain.
   - Identify newborn job aids to be used.
   - Identify and quantify all equipment and commodities needed for the scale-up of the signal functions.
   - Identify process and input indicators.
   - Identify an asphyxia- and warm chain-related supervision tool.
   - Develop pre- and post-tests.

Handwashing for Newborns: Formative assessment on handwashing knowledge, attitudes, and practices in Korogocho (Nairobi) and Bondo (Nyanza)
MCHIP finalized a formative assessment on newborn handwashing with soap (HWWS) in typical slum communities in Nairobi-Korogocho and in a rural setting in Bondo, Nyanza province. The single most common killer of newborns is neonatal infections, particularly sepsis, pneumonia, and meningitis.

The formative assessment was designed to obtain information from mothers of infants under four weeks and service providers, including both skilled and traditional birth attendants. The assessment strategy was three-pronged and designed to ascertain group and individual perceptions and habits. These strategies included focus group discussions, key informant interviews, and in-depth discussions.

5.3. PPH Study – Urban Health

The PPH Study received approval from the KEMRI Ethical Review Committee (ERC) to commence implementation of the study interventions 31 October 2012.

The MCHIP team started with a visit to the sites. They were taken around by a DHMT member to the various health facilities that provided antenatal care (ANC) and maternity services, and using the global positioning system (GPS) device, mapped the facilities geocodes. The coordinates were then transferred to a computer, and using a geographical information system (ARC GIS), a map was created. The map indicates where facilities that provide ANC and maternity services are located within the community. Data on PPH cases in the district were also extracted from the DHIS data from February to July 2012.

5.4 MNH Surveillance

MCHIP, together with the DRH, conducted clinical and M&E supportive supervision for the four MNH surveillance facilities to reinforce knowledge acquired during training and to strengthen data collection and use at facility level.

During the supervision visits, the team noted that facilities were using different version of registers and partographs; they also had incomplete and inconsistent filling of registers and other data tools, especially the partographs.

5.5 MIYCN/FP Integration

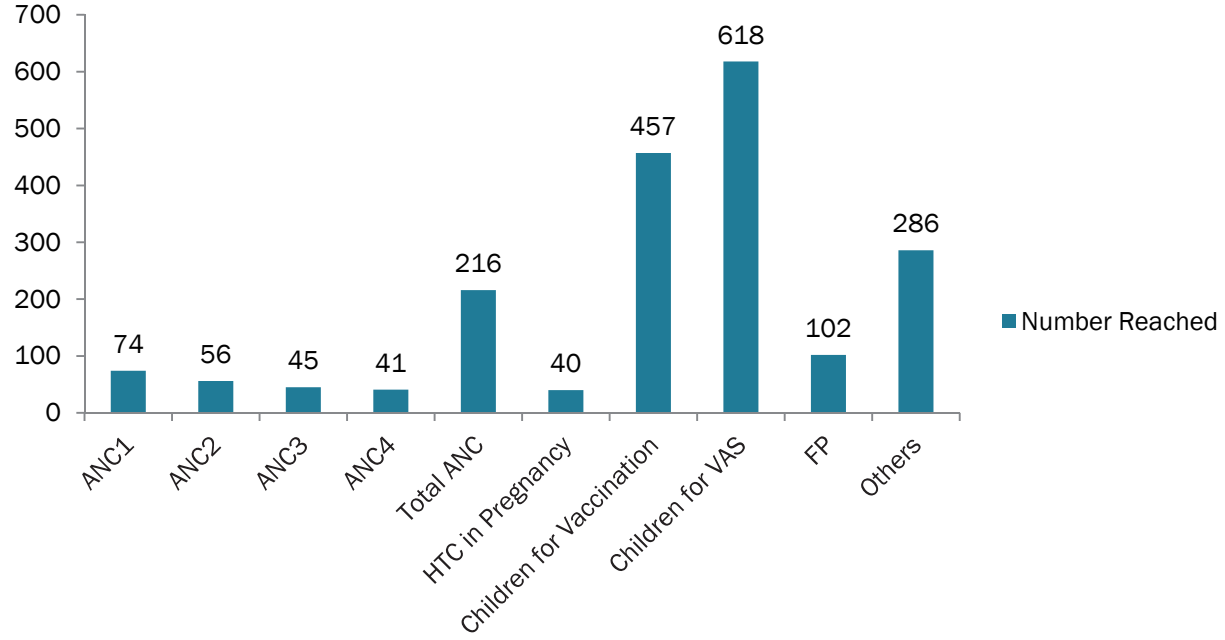
Some of the indicators to be captured from the MIYCN/FP integration process are available in the current MOH registers. As a result, MIYCN/FP supplementary registers and summary forms were developed to be utilized at the health facilities and community levels. The tools were pretested in Bondo District Hospital and Barkowino and Nyawita community units. Thereafter, they were refined as per the comments from the service providers and community health workers.

5.6 Enhance FP and MNH Support to Bondo District

MCHIP continued to support CHWs to promote MNCH services. MCHIP supported 348 and 340 CHWs in October and December, respectively, to conduct home visits and follow-up of women in ANC, PNC, and their infants. CHWs were also supported to do community-based distribution of family planning services and commodities, reaching 3,111 women; 2,948 women; and 2,830 women in the community in October, November, and December respectively.

Further, MCHIP supported the health workers in Bondo to conduct 41 targeted community outreaches in October and November 2012, reaching the following clients with integrated services:

Figure 3. Numbers Reached during October and November 2012 with Integrated Outreaches



Sub-Objective 6: Improve the quality and uptake of PMTCT by integrating along the MNCH continuum of care using an adaptation of the RED approach.

An abstract was prepared and submitted to the Conference on Retroviruses and Opportunistic Infections (CROI), and was selected for poster presentation. The poster was presented during the 2013 CROI held in Atlanta, Georgia, in March of 2013.

Review of Igembe North DHIS data indicates that efforts toward increasing demand for services and training of health workers to respond to the increased demand are yielding results. There is an increase in the number of mothers starting at ANC clinics—46.9% in 2013 compared to 36.3% in 2012. The data show that 16.41% are completing four focused antenatal care visits in 2013, compared to12.6% during the same period in 2012. Furthermore, 96.3% of women attending ANC clinics are being counseled for HIV (compared to 73.8% in 2012), with 102% accepting to take the test (compared to 95% in 2012). Of those testing positive for HIV, 100% were provided with ARVs (as opposed to 68% during the same period in 2012). Partner involvement at ANC has also had a slight change, with 2.5% of the ANC partners getting counseled for HIV, compared to 0.2% in the first quarter of 2012. In this quarter, 644 women delivered with a skilled attendant (27.5% of estimated deliveries), while 465 women delivered with a skilled attendant in 2012 (22% of estimated deliveries).

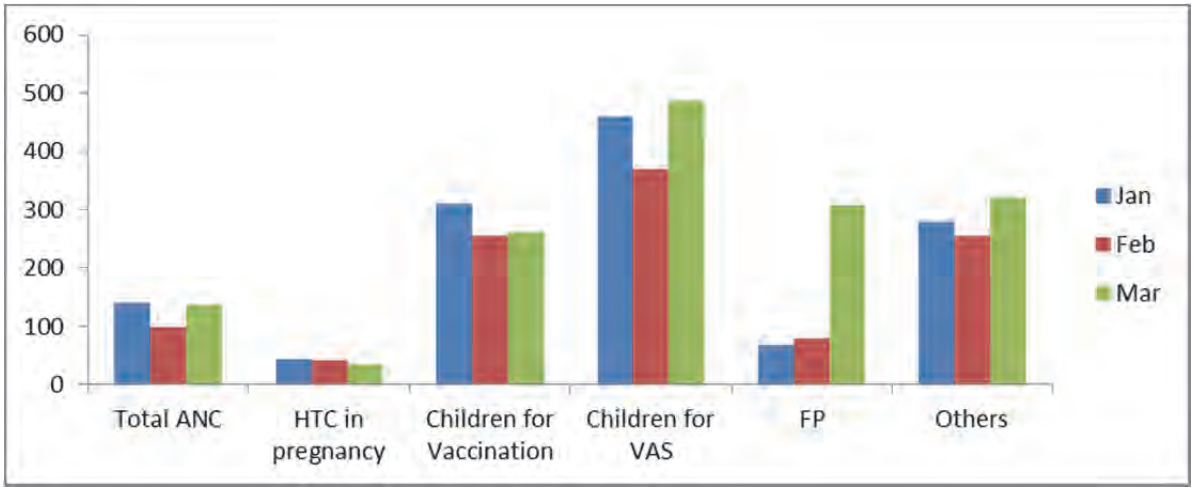
In Bondo district, MCHIP utilized the already established community units to drive demand for family planning services and commodities in the community as part of PMTCT's prong two. These data contribute to the linked facility data at the end of every month.

Table 2. Method Use, Quarter 1, New Clients and Revisits

METHOD	2013 1ST QUARTER NEW CLIENTS	2013 1ST QUARTER REVISITS
Pills – Microlut	125	212
Pills – Microgynon	183	487
FP injections	677	1,752
IUCD insertion	31	9
Implants insertion	346	60
Client receiving condoms	1,028	422
Natural family planning	2	0
All others FP	74	55

In addition, MCHIP supported integrated outreaches to hard-to-reach areas, where services including FP were provided.

Figure 4. Numbers of Clients Reached during Integrated Outreaches



Sub-Objective 7: Support the Division of Malaria Control (DOMC) and Division of Reproductive Health (DRH) to plan, coordinate, monitor, and implement malaria in pregnancy interventions in three targeted provinces (Nyanza, Western, and Coast).
Community malaria in pregnancy (cMIP) data on pregnant women collected from Siaya County (Bondo district), Bungoma County (six districts), and Homa Bay County (five districts) on use of ITNs and IPTp uptake indicated that a total of 1,388 (47%) pregnant women were referred for ANC out 2,947 registered for follow-up.

During a Routine Data Quality Assurance (RDQA), cMIP data collected by the CHEWs and CHWs were verified. the data on the three core MIP indicators—pregnant women using LLINs, pregnant women taking sulfadoxine-pyrimethamine (SP) for intermittent preventive treatment during pregnancy (IPTp), and pregnant women registered for follow-up—were reviewed and cross-verified in the five key community MOH data tools, i.e., MOH513, MOH514, standardized community.

In collaboration with APHIAplus Nairobi and Coast, over 1,800 MIP IEC training materials were distributed to service provides in 11 districts in Coast province. The MIP team will continue to work with the APHIAplus Nairobi and Coast team.

MCHIP in partnership with APHIAplus Kamili, APHIAplus Western, disseminated the MIP IEC materials to health workers during capacity development and supportive supervision activities.

MCHIP updated over 2,000 nurses/midwives drawn from all over Kenya on the following MIP best practices: 1) facility-based orientation on provision of SP for IPTp as per defined guidelines during the 12th FIGO World Congress; and 2) registration and follow-up of pregnant women at community level by CHWs.

The two shared best practices are anticipated to increase early ANC attendance and provision of quality IPTp services resulting in improved maternal and neonatal health outcomes.

Following the registration, follow-up, dissemination of the key MIP messages, and supportive supervision of the same at all levels of service provision in Homa Bay and Bungoma Counties, there has been a marked increase in number of pregnant mothers attending ANC and accessing multiple IPTp doses. DHIS 2 data in the table below from CU linked facilities in Homa Bay and Bungoma Counties show and increase in new ANC attendance and IPTp doses after orientation of the CHWs and mobilization of pregnant mothers by the CHWs at household level.

Sub-Objective 8: Support the National AIDS and STI Control Program (NASCOP) to roll out Community Prevention with Positives (CPwP) interventions in Kenya.
MCHIP in the last quarter provided NASCOP and the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) with technical assistance to refine further the M&E tools. These refinements were made together with other stakeholders through two national technical working group meetings (M&E and materials development) and by giving technical assistance to NASCOP and implementing partners to roll out tools and in support group formations.

Sub-Objective 9: Support districts in Eastern and Rift Valley provinces in promoting infection prevention and control, including injection safety and medical waste management in the community.

The following activities were completed this quarter:

- Completed facility mapping of 25 health facilities (Government of Kenya, private, and faith-based) in Igembe North;

- Conducted a five-day training on focused antenatal care and data management for 30 health care providers, resulting in 17 more health facilities offering ANC services up—from three facilities previously;
- Conducted a five-day Infection Prevention and Control (IPC) TOT training for 25 core trainers; and
- Printed 100 copies of IPC National Guidelines, 50 copies of the IPC National Policy, and 100 copies each of job aids for handwashing, waste segregation, and instrument processing;
- Provided support to 25 core trainers to orient 80 health workers on onsite, whole-site IPC practices;
- Disseminated 100 copies of National IPC guidelines, 50 copies of the National IPC policy, and 100 copies each of job aids each for handwashing, waste segregation, and instrument processing during whole-site training; and
- Established five Infection Prevention and Control Committees in five major health facilities in Igembe North, resulting in the purchase of wastebaskets and liners and use of improvised buckets for handwashing.

Sub-Objective 10: Support the MOH to scale up cervical cancer prevention and control (CECAP).
USAID MCHIP worked to provide technical support to the DRH to revise the national CECAP tools. Feedback from the facilities that are already using the tools was taken into consideration to draft more user-friendly tools, taking into account indicators that were already negotiated at HMIS. USAID MCHIP provided technical advice to GAVI on the piloting of the human papillomavirus (HPV) vaccine. USAID MCHIP worked to provide technical support to the DRH to revise the national CECAP tools.

Forty-seven regional CECAP stakeholders reviewed the national CECAP tools during a consensus workshop convened by the DRH. Participants were able to ensure that each of the four tools was user-friendly enough to assist the health worker to capture data effectively, based on the program indicators.

Priorities for Next Quarter:

Sub-Objective 1

- Conduct data quality audits and review of routine DFH DHIS data.
- Disseminate DCAH and DON M&E frameworks.

Sub-Objective 2

- Facilitate a meeting to link with nutrition focal persons for all APHIAplus projects on BFCI and DON activities.
- Facilitate DON to carry out supportive supervision to guide implementation and rollout of the BFCI package and to assess facilities for BFCI certification.
- Orient HWs, CHWs, and APHIAplus nutrition focal persons on the BFCI package, and the use of the community support guideline and MNPs in Igembe North district.
- Facilitate Annual Work Plan (AWP) meetings for the DON.
- Provide technical support in the planning meetings with the DON for the 2013 World Breastfeeding Week activities.

- Provide technical support to the Igembe North district DHMT in the formation of MIYCN community support groups.
- Start work with Ministry of Agriculture to identify complementary food local recipes for improvement and demonstrations through community support groups in Igembe North districts.
- Conduct supportive supervision visits on the MIYCN/FP integration in Bondo district.
- Finalize, print, and disseminate the nutrition ORT BCC materials at the national/county level and in Igembe district and to the APHIAplus partners.

Sub-Objective 3

- Support selected facilities in Igembe North to conduct integrated outreach services.
- Conduct integrated EPI review meetings in Meru County.
- Share the finding of the timeliness study with Nyanza province.
- Conduct a comprehensive EPI training for Tigania East and West.
- Support the DVI to prepare for the measles second dose introduction.
- Support the DVI to prepare a cold chain replacement and expansion plan.
- Participate in an Effective Vaccine Management Assessment (EVMA).

Sub-Objective 4

- In collaboration with UNICEF, MI, PATH, and CHAI, support the DCAH to review end-term RRI results and data.
- Support the DCAH to conduct a review of the 2012/2013 annual workplan (AWP) and to develop its 2013/2014 AWP.
- Facilitate the DCAH to hold quarterly child health ICC.
- Finalize procurement of ORT equipment for 16 health facilities in Igembe North and plan for commissioning by USAID.
- Conduct mentorships and OJT on pneumonia and diarrhea to HCWs in conjunction with DHMT and APHIAplus MNCH focal persons in Igembe North and Bondo sub counties.
- Finalize review of the iCCM implementation framework, M&E plan, and policy brief for presentation to the heads of the DCAH and DFH.
- In collaboration with UNICEF, provide technical support to the DFH during launch of the iCCM implementation framework and M&E plan, and to MOH county health teams.
- Facilitate iCCM TOT trainings for Siaya County (to include Bondo sub County) in collaboration with UNICEF and DCAH.
- Finalize the Bondo iCCM research protocol and present it to the JHU IRB and local IRB for approval.

Sub-Objective 5

Support to DRH

- Field-test MNH service delivery standards.
- Disseminate National MNH documents in Nairobi, and in Nakuru counties.

Newborn Health

- Support training of county mentors in collaboration with APHIAplus for the RRI scale-up plan.
- Support convening of MNH special task forces for development of the newborn implementation plan.

MIYCN/FP Integration

- Facilitate DHMT to conduct MIYCN/FP supportive supervision.

MNH Surveillance

- Finalize MNH surveillance standards.

PPH/FP – Urban Health

- Conduct rapid assessment/baseline, disseminate findings, and update materials as a result.
- Conduct refresher trainings/updates for service providers and community health workers.

Enhance FP Support to Demonstration Districts

- Support Bondo, Igembe North, and Baringo districts during the AWP process.

Sub-Objective 6

- Hold advocacy and planning meetings in Baringo East.
- Scale up community units in Igembe North and Baringo East districts.
- Conduct training of health workers on RED for PMTCT and development of micro-plans, and on SBM-R for PMTCT, in Igembe North and Baringo East districts.
- Facilitate CHWs to conduct home visits and for follow-up of pregnant women in Igembe North and Baringo East districts.
- Support community-based, monthly psychosocial support groups for pregnant women in Igembe North district.
- Support transportation of DBS samples from health facilities to the collection points in Igembe North district.
- Support Bondo, Igembe North, and Baringo districts during the AWP process.

Sub-Objective 7

- Conduct supportive supervision/mentorship for approximately 5,000 service providers in 700 targeted facilities.
- Convene National MIP TWG, sub-committee, and stakeholder meetings.
- Facilitate integration of MIP services into other relevant national and county programs.
- Provide technical assistance to DOMC/DRH/DCHS and implementing partners, e.g., APHIAplus on malaria/MIP programming.
- Provide technical assistance in other relevant malaria-related TWGs.

Sub-Objective 8

- Finalize the CPwP M&E tools.

- Conduct training of national TOTs (MSM and other MARPs [one training]).
- Disseminate the reporting tools to all 47 counties through the DASCOs, HCBC, and CACCs.
- Conduct CACC trainings for Nairobi province on Community PwP.
- Support trained trainers at the provincial levels to roll out PwP trainings at the county levels—using OJT and mentorship approaches.

Sub-Objective 9

- Hold meetings with APHIA Rift and DHMT, East Pokot, for fact finding.
- Hold a one-day planning meeting with East Pokot DHMT members and other stakeholders in the region.
- Hold a one-day meeting to discuss formation/reviving of community units in East Pokot.
- Conduct support supervision training to 30 DHMT and HMT members in Igembe North.
- Conduct SBM-R for 30 DHMT and HMT members in Igembe.
- Conduct phlebotomy training for 30 laboratory technologists and clinicians in Igembe North.
- Conduct support supervision in Igembe North.

Sub-Objective 10

- Finalize CECAP M&E tools.
- Reproduce CECAP M&E tools.
- Begin regional dissemination of CECAP M&E tools.
- Initiate the adaptation of CECAP standards.
- Procure four complete Loop Electrosurgical Excision Procedure (LEEP) units, together with the starter kits.

Zinc Policy Change in Kenya Expands Access, Paves Way for Improved Child Health

Last month, the Kenya Ministry of Medical Services and Ministry of Public Health and Sanitation officially changed the pharmaceutical classification of zinc from prescription medicine to an over-the-counter drug. This policy change paves the way for expanded community access to zinc, which plays a vital role in helping to decrease the duration and frequency of diarrhea episodes.

Children in Kenya. (Photo courtesy of Jhpiego.)

Diarrhea is the single greatest cause of death for children under five, accounting for 38,802 out of a total 189,928 annual child deaths in Kenya. This is mainly due to dehydration and related complications, including malnutrition. Ensuring that treatment includes a combination of zinc and low osmolarity Oral Rehydration Salts (ORS) contributes to improved outcomes of treating diarrhea as well as decreased childhood mortality.

This work in Kenya is part of MCHIP's global efforts to decrease under-five mortality by addressing the three main killers of children: diarrhea, malaria, and pneumonia. In countries with a high prevalence of diarrheal disease, MCHIP works at both community and facility levels to ensure access to a package of diarrheal disease treatment interventions. Zinc is an essential component of this package, which also includes use of Oral Rehydration Therapy (ORT); advice on appropriate feeding during and after illness; and key water, sanitation, and hygiene practices, notably handwashing.

In Kenya, MCHIP works closely with the Department of Family Health, within the Ministry of Public Health and Sanitation, and focuses on an integrated approach to scaling up high-impact maternal, newborn, and infant services, as well as family planning, malaria and HIV interventions. The tireless work of MCHIP and its partners to facilitate the zinc policy change at the national level will have far-reaching effects in Kenya. This reclassification will expand access to an essential medicine, will strengthen the overall package of diarrheal disease treatment interventions, and will help contribute to reduced childhood illness and mortality in Kenya.

Country Summary: Kyrgyzstan

Period: FY 2013, Quarters 1 and 2

Major Activities

- Built capacity for monitoring with Rayon Initiative working group in Sokuluk
- Conducted two of three capacity building seminars
- Transitioned to the final phase of the CISI software pilot
- Worked with partners at the national level on GAVI HSS application and a manual on the Epidemiological Surveillance of AEFI and SAFE Immunization Practice
- Provided technical support to RCI and guidance on the National Communication Strategy

Selected Health and Demographic Data for Kyrgyzstan	
GDP per capita (USD)	1,124.00
Total population	5,515,000
Maternal mortality ratio (deaths/100,000 live births)	49.7
Skilled birth attendant coverage	99
Antenatal care, 4+ visits	81
Neonatal mortality rate (deaths/1,000 live births)	19
Infant mortality rate (deaths/1,000 live births)	27
Under-five mortality (deaths/1,000 live births)	31
Treatment for acute respiratory infection	62.1
Oral rehydration therapy for treatment of diarrhea	22
Diphtheria-pertussis-tetanus vaccine coverage (third dose)	83
Modern contraceptive prevalence rate	48.9
Total fertility rate	2.7
Total health expenditure per capita (USD)	71.00

Sources: World Bank, WHO, UNICEF.
*UNICEF <5 mortality ranking (1 = highest mortality rate)

Photo © 2007 Irina Popova, Courtesy of Photoshare

Program Dates	Workplan approved: FY 2011–2013; No-cost extension approved until June 2014					
PY 5 Budget	$160,579					
Total Mission Funding to Date	$316,962					
Geographic Focus	*National and Sokuluk Rayon*					
Geographic Coverage	No. (%) of provinces	1 (14%)	No. of districts	1	No. of facilities	3
MCHIP In-Country Contact	Azamat Imakeev: as_im@mail.ru					
HQ Managers and Technical Advisors	Pat Taylor: ptaylor@mchip.net; Kelli Cappelier: kcappelier@mchip.net; Kaili Mumme: kmumme@mchip.net					

FY 2013, Quarters 1 and 2: Achievement Highlights

Although polio-free for more than 20 years, Kyrgyzstan has become surrounded by countries with recent polio cases. Kyrgyzstan's porous international borders and increased internal migration from political unrest provide a dangerous combination for spreading the wild polio virus, and thereby the return of polio. In response to the polio epidemic in Central Asia, USAID provided MCHIP with funds to improve routine immunization for preventing future outbreaks of polio, as well as other vaccine-preventable diseases. In February 2011, MCHIP conducted a preliminary needs assessment, and starting in September 2011, an immunization consultant developed a detailed implementation plan, initiated recruitment, and began project start-up activities.

Objective 1: Build capacity for monitoring and improve evidence-based program planning at the local (rayon) levels.

- **Rayon Initiative Working Group (WG) in Sokuluk:** MCHIP continued its capacity building with the Rayon Initiative Group. The group has identified its implementation plan and objectives and has conducted the first of three capacity-building seminars. The first was on "Creation of an Integrated Public Health Approach on Immunization Issues." The seminar was attended by Family Medical Center (FMC) and Family Group Practice (FGP) doctors, an immunologist and epidemiologists. A second seminar is being planned for the next quarter and will focus on identifying problems, risk factors, and risk groups, and also on identifying efficient methods to influence representatives of rayon structures, populations, and risk groups to improve their level of awareness and acceptance of immunization.
- The group identified under-performing FGPs and associated FAPs (health centers) where coverage is either too high or too low, analyzed issues contributing to the poor coverage estimates, and is working with health managers, health workers, and village health committees to develop evidence-based solutions for addressing the problems.

The following are also in progress as part of activities under Objective 1:

- Planning to develop a strategy for how to engage Muslim religious leaders (Imams) to increase awareness and acceptability of vaccination in their communities to reduce the frequency of vaccination refusal for religious reasons.
- Developing a strategy to address vaccine hesitancy among migrant groups.
- Developing tools for improved monitoring and use of data for health workers to improve timely vaccinations within their catchment areas.
- **Computerized Information System for Immunization (CISI):** MCHIP has led and coordinated the pilot of this software program to track immunization coverage in two pilot Family Medical Centers (FMC) and one Oblast (region) level. The pilot of this software program is in its final phase. The MOH requested an external evaluation of the program to determine its readiness for expansion and its financial feasibility. MCHIP is compiling a report of the CISI pilot for the evaluation team. A CISI phase-out plan will be determined based on the GAVI evaluation results.

Objective 2: Improve partner coordination on immunization aimed at an integrated, public health approach for maintaining optimal immunization coverage at rayon and community levels.

- **MCHIP collaboration with partners at the national level:** MCHIP is an active member of the Interagency Coordination Committee (ICC). The most recent meeting, in March, highlighted the GAVI Health System Strengthening (HSS) application and the planning for new vaccine introduction. MCHIP is also a member of the National Immunization Technical Advisory Group (NITAG), which provides recommendations on policy development for the national immunization program. MCHIP experience and lessons learned at the sub-national level are used and disseminated to these technical bodies.
- MCHIP's technical input to a manual that was drafted in response to an increasing number of reported adverse events following immunization (AEFI). A working group was convened by the Republican Center for Immunoprophylaxis (RCI) to update the manual on the Epidemiological Surveillance of AEFI and SAFE Immunization Injection Practice so that it would be in accordance with current WHO guidelines.
- **Provision of technical review and input to the national communication strategy:** MCHIP continued to follow up on a qualitative assessment conducted last year to better understand the reasons for vaccine refusal in areas with a high concentration of migrant populations. UNICEF implemented an assessment addressing the same issue earlier this year and has since created a working group that is compiling recommendations to the RCI on revisions to the national immunization communication strategy. MCHIP is providing technical input to the working group, convened and coordinated by UNICEF, to develop recommendations and provide feedback on the strategy draft.
- **Technical support to RCI:** MCHIP supported the RCI and SES assisting with development of the immunization sub-component to the National Health Sector Reform Strategy "Den Sooluk" for 2012 to 2016, which covers MCH (sub component: immunization), CVD, TB, and HIV. MCHIP also provided input into the draft decree in preparation for the two-week polio sub-national immunization day.

Priorities for Quarters 3 and4

- Continue Sokuluk working group engagement on the following:
  - Develop and implement a plan of action for strengthening routine immunization at the rayon level that will include:
    - A strategy to address vaccine refusal among religious objectors and migrants
    - Increased engagement with Village Health Committees to work on vaccination issues at community level
    - Leveraging of partnerships with local NGOs
    - Improvement in data monitoring and use for improving timeliness of vaccination
    - Increase in linkages of health services with communities
- Prepare for and complete the independent evaluation of the CISI software program by providing a final report of the software pilot and a users' manual:
  - Phase-out of CISI pilot activity

Country Summary: Lesotho

Period: FY 2013, Quarters 1 and 2

Selected Health and Demographic Data for Lesotho	
GDP per capita (USD)	2.2
Total population	2,170,000
Maternal mortality ratio (deaths/100,000 live births)	530
Skilled birth attendant coverage	61.5%
Antenatal care, 4+ visits	70
Neonatal mortality rate (deaths/1,000 live births)	35
Infant mortality rate (deaths/1,000 live births)	65
Under-five mortality (deaths per 1,000 live births)	84
Under-five children with ARI symptoms taken to a health facility	67%
Under-five children with diarrhea receiving ORT	71.2%
Diphtheria-pertussis-tetanus vaccine coverage (3 doses)	83
Modern contraceptive prevalence rate	35%
Total fertility rate	3.2
Total health expenditure per capita (USD)	8.2

Sources: Demographic information and health systems, World Bank; WHO Global Health Observatory Data Repository; UNICEF Lesotho Statistics.

Major Activities

Voluntary Medical Male Circumcision:

- In February, MOH and MCHIP celebrated 10,000 VMMC clients since last year
- 6,527 clients circumcised this year
- Four teams of doctors, nurses, and HTC counselors (53 providers) trained
- 10 sites now providing services

Nursing Pre-Service Education Training and Capacity-Building:

- 22 nursing, 22 nursing assistants, and 39 midwifery students successful in rural clinical placements to improve community health learning
- 15 clinical/nursing educators from partner institutions trained in Teaching Skills
- 20 clinical/nursing educators trained in Student Performance Assessment skills

Ms. P. Monamane, Roma College of Nursing, and Sister Adina, Mohale Clinic, with a letter of thanks to MCHIP from the school to the clinic for supporting students during the clinical placements.

Program Dates	January 1, 2010–September 29, 2014					
PY 5 Budget	VMMC: $5,000,000 + Pipeline $508,000 = Total $5,508,000 Nursing Pre-service Education: $900,000 + Pipeline $1,870,000 = Total $2,770,000					
Total Mission Funding to Date	$9,933,000					
Geographic Focus	Southern Africa					
Geographic Coverage	No. of provinces	0	No. of districts	9	No. of facilities	6
MCHIP In-Country Contact	Country Director: Laura Skolnik laura.skolnik@jhpiego.org +266.5888.8317					
HQ Managers and Technical Advisors	Senior Program Officer: Tracey Shissler tracey.shissler@jhpiego.org 410.537.1823 Senior Technical Advisor: Tigistu Adamu tigi.adamu@jhpiego.org 202.835.3122 Technical Development Officer: Alice Christensen alice.christensen@jhpiego.org 410.537.1948					

FY 2013: Quarters 1 and 2: Achievement Highlights

MCHIP continued to apply the principles of country ownership, sustainability, local capacity-building, and strategic coordination in partnership with Lesotho's Ministry of Health (MOH) and its partners to the following activities:

Voluntary Medical Male Circumcision (VMMC)

The MCHIP VMMC program has continued to build on FY12 achievements and the strong support from the MOH. This is made possible by in-depth technical support to the MOH through the MCHIP Lesotho Technical Director, who works closely with the MOH to coordinate the scale up of services. As a result, the Lesotho VMMC national program has developed standard operating procedures (SOPs) for service provision, tools for data collection, and other guidance documents. Also through MCHIP, the country MC Technical Working Group (TWG) meets quarterly to provide technical support to the MOH.

The MOH's approach to VMMC service delivery and scale-up is to expand integration of services to all hospitals in the country by the end of Year 2 of the national strategic plan (2014). To achieve this expansion, the MOH has requested MCHIP to assist in implementing a nationwide integrated VMMC program. Through MCHIP, 10 sites are operational, providing services on a twice-a-week basis; four (4) of these sites have started services in the reporting period.

Key activities in this reporting period were conducted under the following objectives:

Objective 1: Support and strengthen Lesotho MOH capacity to scale up VMMC services.

- *Provide technical assistance to the MOH:* The MCHIP MC Technical Director continues to work with and mentor the VMMC focal point in the MOH, as well as directly support the development of VMMC-related policy, monitoring, and guideline materials in the MOH.
- *Building human resources:* MCHIP has hired a Trainer/Quality Assurance doctor; three VMMC doctors; nine VMMC nurses; and four counselors to provide VMMC services under direct MCHIP supervision, as well as a communication officer to work on demand-creation activities.
- *Training of VMMC providers:* Two 10-day (two weeks) MC trainings were organized from 13–23 November and from 18 February–1 March, resulting in **53 providers trained**, including seven doctors, 39 nurses and seven counselors. These trainings were organized to initiate VMMC services in the four additional hospitals.
- *Annual stakeholder meeting:* in collaboration with the MOH, UNICEF, WHO, and other partners, MCHIP supported the first annual stakeholder meeting on VMMC in February. This meeting focused on informing partners and other stakeholders on the achievement of 10,000 MCs conducted in Lesotho since the VMMC program's start. USAID, WHO, and other key partners were represented by regional offices, while the DGHS chaired the meeting.

Objective 2: Gradually scale up facility-based VMMC and early infant male circumcision (EIMC) services in selected hospitals and health facilities.

- *Provision of services:* ***6,527 clients*** have been circumcised as part of the standard package.
- Looking at the trend in Table 1, due to the onset of colder temperatures, we can expect a steady increase in the number of MCs conducted per month from now through the end of this program year. Almost 80% of the target will thus be achieved in the second half of the program year. Table 2 below shows the total number of MCs by age group.

Table 1. Progress of Total MCs Conducted per Month

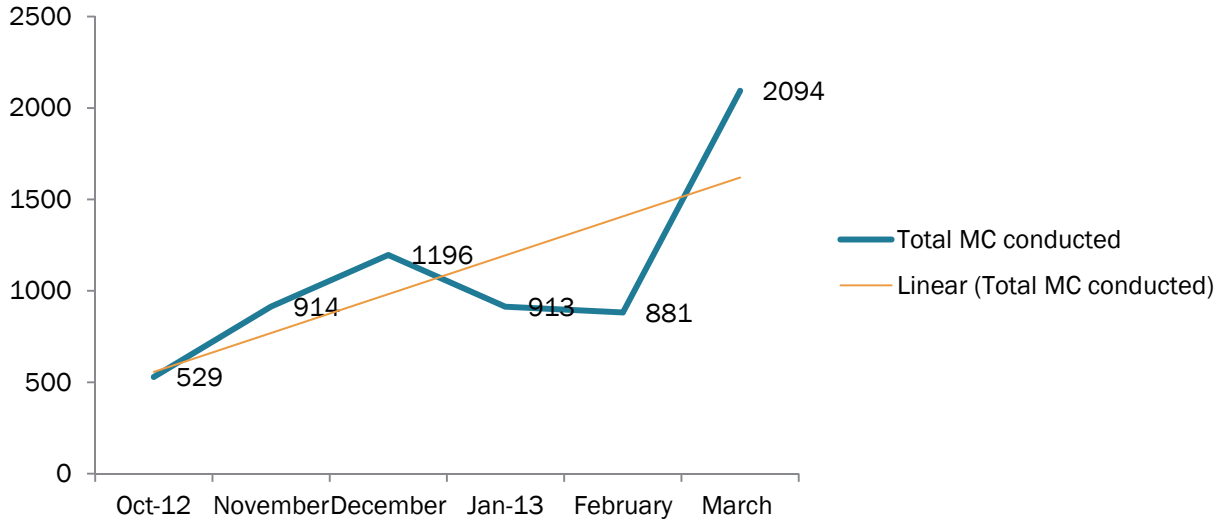
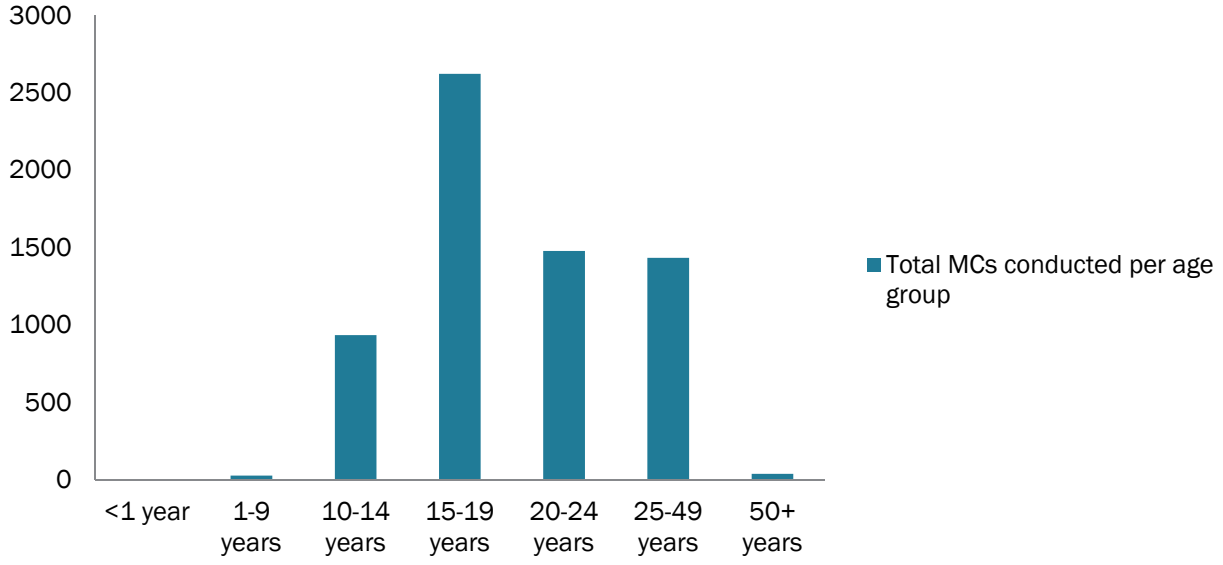


Table 2. Total MCs Conducted per Age Group



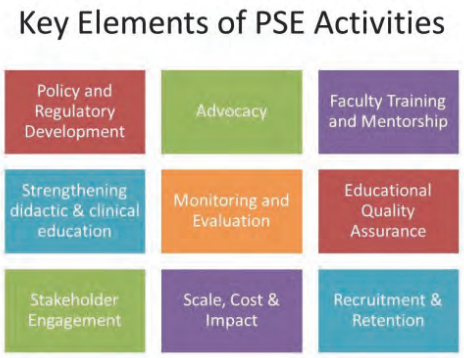
- *Assessment and upgrade of new sites:* **Six potential new sites were assessed during this period, and four sites have been upgraded and are providing VMMC services**. For Maseru, a procurement of a pre-fab clinic is planned. Agreement has been obtained from the MOH, and MCHIP has developed a plan to finalize the bidding process in collaboration with the MOH.
- *Intensified Service Delivery (ISD):* ISDs consist of providing VMMC services on a daily basis at district hospitals over a few weeks instead of twice per week. An ISD was conducted from 26 November–16 December 2012 and 25–30 March 2013 over the Easter break. Turnout over Easter was particularly high, peaking at nearly 50 MMCs per day.
- *Development of a Maseru clinic*: MCHIP negotiated with a private clinic to initiate free VMMC services for the capital city, Maseru. The Carewell Clinic is now partnering with MCHIP to provide VMMC services. MCHIP provides staff and supplies to the clinic while the MOH continues to provide pharmaceuticals.

Objective 3: Increase demand for VMMC services (including EIMC) in Lesotho.

- *IEC material development and dissemination*: MCHIP developed IEC materials in collaboration with the health education unit in the MOH. These IEC materials are distributed at clinics during sessions on VMMC education and are shared with other organizations and associations that have shown interest in VMMC activities.

Pre-Service Education

The pre-service program continues to be successful in strengthening all key element areas outlined in MCHIP's Lesotho PSE Strategic framework



Strengthening didactic and clinical education remains a key area of focus in FY13. MCHIP continues to support activities to strengthen the clinical education of nursing and midwifery students at the Christian Health Association of Lesotho's (CHAL) four Schools of Nursing.

Key activities in this reporting period were conducted under the following objectives:

Objective 1: Strengthen CHAL Schools of Nursing capacity to house and educate nursing and midwifery students.

- *Site assessments and strengthening of clinics for clinical placement*: MCHIP conducted site assessments of potential clinical sites in three of the four CHAL Schools of Nursing (SONs).
  - These site assessments include checklists for planning for student clinical placements, which were developed into action plans by the Schools and facilities.
  - MCHIP in turn, supported CHAL to provide necessary infrastructure requirements for student accommodation as well as transportation costs for students and educators.
  - Support included provision of items for student accommodation during clinical placement, strengthening the schools' ability to place students at the health center clinical sites.
- *Expanding clinical placements*: MCHIP expanded clinical placement rotations to clinics for nursing and midwifery students at three of the four CHAL SONs. The fourth CHAL SON undertook a pilot placement in the last program year and will place students in June 2013.
  - A total of 22 nurses, 22 nurse assistants, and 39 midwives attended clinical placements that ranged from one week to one month. An initial evaluation for these placements has been completed for two of the CHAL schools that placed students; the third evaluation is in progress.
- *CHAL SON dormitory expansion*: Following USAID/W agreement to move forward with this activity, MCHIP issued RFPs for work on the SON dormitories and worked on the USAID contractual package with the selected vendor to be submitted for USAID approvals.
- *Computer and learning materials procurement*: MCHIP has purchased 60 (15 per school) computers (including relevant hardware and software) for all 4 CHAL SONs. These computers are currently being set up and networked and will be used for training in July. MCHIP also procured textbooks, DVDs, and other learning materials for the school libraries, filling key gaps in available resources for educators and students.

Objective 2: Strengthen current didactic and clinical teaching practices.

- *Development of trainers and preceptors*: MCHIP conducted an Effective Teaching Skills (ETS) course 29 October –2 November. A total of 15 preceptors were trained and three candidate trainers were co-trained to become qualified trainers. MCHIP performed supportive supervision of preceptors in March and conducted focus groups with students, which informed MCHIP of preceptors' application of learned skills.
- *Student Performance Assessment (SPA):* 20 educators from six nursing schools were trained to assess student competencies using current, evidence-based methods that are consistent with established educational standards. This training will benefit the educators in the upcoming MCHIP supported activities including logbook development, checklist development, and clinical assessments.
- *Clinical site and school collaboration*: MCHIP has supported regular meetings among schools, clinical sites, educators, and preceptors to develop relationships that foster these clinical placements. A total of eight meetings were supported. Each school has established co-chairs for the meeting and sets their own agendas.

Objective 3: Support the development of an enabling regulatory environment for nursing education through strengthening the Lesotho Nursing Council.

- *Registration support*: MCHIP continues its support for the electronic record-keeping of registered nurses and midwives via the LNC registration database. The LNC has successfully begun to fund the data entry position previously supported by MCHIP.
- *Nursing and Midwifery Act and associated rules and regulations*: MCHIP has supported the LNC in hosting three task force meetings in October, November and December 2012. The task force meetings facilitate the development of draft accreditation, and national educational and practice standards. These drafts have been reviewed and revised by MCHIP staff and an international consultant.
- *Strategic plan:* The strategic plan has been drafted and is awaiting LNC board approval. MCHIP continues to support priority activities in the strategic plan.
- *Build the capacity of the LNC through staffing support*: MCHIP is hiring an Education Officer to sit at the LNC starting in Quarter 3. MCHIP will provide mentorship and support including prioritization of key activities for the Education Officer.

Priorities for Quarters 3 and 4

Voluntary Medical Male Circumcision

- Increased service provision will be prioritized and Intensified Service Deliveries (ISDs) will be held at trained facilities to meet the high demand for services expected.
- Procure the 35,000 VMMC kits needed for VMMC following USAID approval expected in April.
- Preliminary work on the communication strategy will be conducted in April, with further development in Quarters 3 and 4.
- Begin research oriented toward assessing and addressing gender barriers and opportunities in scaling up VMMC/EIMC services.
- Submit the Lesotho Planned Parenthood Association (LPPA) sub award package to USAID for approval, conduct activities in Quarter 4 pending approval.
- Review bids for the Maseru VMMC clinic prefab placement, prepare sub contractual documentation, and submit to USAID for approvals.
- Continue Client Views Study.
- Continue to develop and refine M&E systems and tools.

Pre-Service Education

- Submit the CHAL Schools of Nursing dormitory infrastructure sub contractual packages to USAID for approval in Quarter 3 and once implementation is approved, begin work in Quarter 4.
- Continue to work with the Schools of Nursing and other partners to assess clinical placements for nursing students, with the goal of assisting the students to rotate through designated clinics.
- Finalize the protocol for operational research on clinical site placements and submit it for approvals.
- Continue supportive supervisions visits to the SONs as well as to the educators and clinicians who have participated in training workshops.
- Conduct the last Training Skills course of the year in July and also a Key Skills Refresher Training for preceptors, including BEmONC and FP in August.
- Conduct ICT training for the SONs in the second half of the year to equip nurse educators and preceptors with skills in using multimedia resources.
- MCHIP will be procuring the E-granaries as well as computers, which are required for E-granary installation. (The E-Granary Digital Library provides an off-line collection of millions of educational resources, including books and full-text journals.)
- Disseminate the completed LNC Strategic Plan and national education and accreditation standards within the LNC and finalize for external distribution.
- Conduct various trainings to build capacity of the LNC, including Board orientation, advocacy, policy, the accreditation process for nursing education and practice, scopes of practice, development of standards, and licensure.

Improving Clinical Education Practices in Lesotho: The Role of the Preceptor

by: Alice Christensen and Maleshoane Monethi-Seeiso

One morning Maseabata Thapelo, a young nurse at Maluti hospital, was taking care of a small boy with gastroenteritis. The doctor had ordered the boy to have oral rehydration salts over the next few hours. And, in order for the boy to ingest the vital treatment, he would need to have a nasogastric tube inserted through his nose.

Maseabata was not only taking care of this patient, she was also precepting nursing students who were on a clinical practical from the neighboring Maluti School of Nursing. One student, who had never inserted a nasogastric tube, was nervous and hesitant to perform the tube insertion on the young boy.

“Using the skills I learned in [MCHIP partner] Jhpiego's Training Skills workshop, I was able to take a step-by-step approach with my student," Maseabata says. "First we discussed all of the critical steps needed for the tube insertion. I had her repeat the steps back to me and then prepare all the equipment.

“During the procedure, I used my coaching skills to aid her with the procedure and, once it was complete, gave her positive feedback on what she had done well. I was happy she had done the procedure correctly and she had gained confidence. It made me feel proud to be a preceptor.”

Through MCHIP’s initial pre-service education assessment in Lesotho and work with the Christian Health Association of Lesotho (CHAL) Schools of Nursing, it had become evident that there was a disconnect in the clinical teaching of student nurses and midwives. Nursing schools are dependent on the clinical nurses in the hospital to teach and oversee the student nurses, but these clinical nurses are often unprepared to be preceptors. This hindered the students’ access to adequate clinical training and left them ill-prepared for their post-graduation clinical work.

As a result, Maseabata is one of 151 nurses in Lesotho who have attended MCHIP’s Training Skills workshop to increase their clinical teaching skills. MCHIP has not only provided the initial training skills course, but continued to build the preceptors’ skills through Effective Teaching Skills and Student Performance Assessment workshops. In addition, preceptors are supported and mentored in the months that follow their training to ensure that their new skills are being put to use and implemented appropriately. Ultimately, the pool of preceptors prepared by MCHIP provides CHAL nursing and midwifery students with important resources when the students are in clinical sites.

“The training has helped me communicate with the students. The way I was taught when I was a student is very different than the way I now teach my students," Maseabata says. "I use various teaching methodologies, provide objective feedback, and coach the students through the procedure.”

MCHIP's commitment to developing more nurses into clinical preceptors continues. Eleven Jhpiego-trained preceptors were recently selected to become Qualified Trainers, and will continue to build the pool of preceptors in Lesotho. Maseabata is a prime example of just how important the preceptors are in ensuring competent and confident nursing students.

“In the future, I want all my learners to be competent in all the skills that I have taught them,” she says.

Maseabata Thapelo and Mamponyane Posholi, preceptors at Maluti Hospital, Lesotho. (Photo courtesy of Jhpiego.)

Country Summary: Liberia
Period: FY 2013, Quarters 1 and 2

Selected Health and Demographic Data for Liberia	
GDP per capita (USD)	221.57
Total population	3,954,979
Maternal mortality ratio (deaths/100,000 live births)	994
Skilled birth attendant coverage	46.3
Antenatal care, 4+ visits	66
Neonatal mortality rate (deaths/1,000 live births)	38
Infant mortality rate (deaths/1,000 live births)	72.6
Under-five mortality (deaths/1,000 live births)	103 [24]*
Treatment for acute respiratory infection	62
Oral rehydration therapy for treatment of diarrhea	47
Diphtheria-pertussis-tetanus vaccine coverage (3 doses)	64
Modern contraceptive prevalence rate	11.4
Total fertility rate	5.9
Total health expenditure per capita (USD)	29.36

Sources: World Bank, Liberia 2009 Demographic and Health Survey, UNICEF, WHO
*UNICEF <5 mortality ranking (1 = highest mortality rate).

Major Activities

- Family planning:
  - Developed RAPID Model Dissemination and scale-up plan
  - Drafted "USAID's Liberia Roadmap to Support the MOHSW in Reducing Unintended Pregnancies"
  - Held contraceptive outreach event in Montserrado, Margibi and Grand Bassa districts
- Family planning and Expanded Program of Immunization (EPI) integration:
  - Conducted EPI/FP pilot project endline assessment
  - Held EPI/FP stakeholders meeting with endline assessment results
  - Providing technical assistance to partners scaling up the approach
- Postpartum hemorrhage:
  - Began implementation of prevention of postpartum hemorrhage project by distributing the misoprostol in the program districts
- Newborn health:
  - Developed Kangaroo Mother Care Guidelines and Policy on the Use of Chlorhexidine for Cord Care

Program Dates	October 2012–September 2013					
PY 4 Budget	$ 1,016,288 (field: $856,486 ; FP core: $75,000; Newborn core: $84,802)					
Total Mission Funding to Date	$2,280,000					
Geographic Focus	*Montserrado, Margibi and Grand Bassa Counties*					
Geographic Coverage	No. (%) of provinces	3 (20%)	No. of districts	16	No. of facilities	61
MCHIP In-Country Contact	Comfort Gebeh: comfort.gebeh@jhpiego.org Nyapu Taylor: nyapu.taylor@jhpiego.org Varwo Sirtor-Gbassie: varwo.sirtor-gbassie@jhpiego.org Marion Subah: marion.subah@jhpiego.org					
HQ Managers and Technical Advisors	Emmanuel Otolorin: emmanuel.otolorin@jhpiego.org Alishea Galvin: alishea.galvin@jhpiego.org Holly Blanchard: holly.blanchard@jhpiego.org Chelsea Cooper: chelsea.cooper@jhpiego.org Gbenga Ishola: gbenga.ishola@jhpiego.org					

FY 2013, Quarters 1 and 2: Achievement Highlights

Objective 1: Support the Ministry of Health and Social Welfare (MOHSW) in implementing the national family planning/reproductive health (FP/RH) program and advocating for the family planning agenda.

- **Family Planning Roadmap:** MCHIP hired a consultant to draft the five-year "USAID Liberia Roadmap to Support the MOHSW in Reducing Unintended Pregnancies" and held a stakeholders' meeting on the document.
- **RAPID Model:** RAPID model dissemination and scale-up plan was developed by MCHIP and FHD in collaboration with STTA from Dr. Emmanuel Otolorin. Following the scale-up plan, MOHSW presented the RAPID model at the RHTC meeting and will continue to roll out the presentations at the national and county levels.
- **Maternal Health Champions:** The three Maternal Health Champions (MHCs) traveled to Malawi in February for a workshop that included sessions on advocacy for MNH and change management; updates on PMTCT and MIP; an orientation to the Helping Mothers Survive package on "Bleeding after Birth"; and a session on writing concept notes. They also conducted a three-day training on the use of Helping Mothers Survive (HMS) for 12 participants (nurses and midwives). Participants were also trained on how to prevent and treat PPH.

Objective 2: Increase access to high-quality family planning services.

- **PPFP Training:** MCHIP, in collaboration with the Montserrado County RH Supervisor, conducted a three-day PPFP training for 20 providers from 11 facilities. The participants included 4 CM/RNs and 16 Certified Midwives.

Objective 3: Increase knowledge of and demand for family planning services at the community level.

- **District Contraceptive Awareness Events:** MCHIP, in collaboration with the Montserrado County Health Team, planned and implemented a five-day district contraceptive awareness day in the five districts and provided free FP counseling and modern contraceptive methods as well as reproductive health education discussions. A total of 1,369 clients were served over these five days with various commodities.
- **Expansion of Market Project:** MCHIP conducted supportive supervision and mentoring visits to the four markets providing contraception in Margibi and the four markets in Grand Bassa. During the visits, it was observed that the peer providers are interested in continuing the program. The market peer providers in Grand Bassa had delivered FP services to 251 clients within a month. MCHIP, along with the County RH Supervisor, also conducted a five-day FP training for 15 MOHSW Environmental Health Technicians (EHTs) to expand the market project and to provide FP in 15 markets in Montserrado. The EHTs were trained to provide FP services for continued acceptors and to refer new clients to the facilities with which they are linked in the catchment area.

Objective 4: Expand coverage of family planning services and reach to the community through innovative approaches.

- **EPI/FP Integration:** Conducted the final supportive supervision and monitoring visits with a staff team representing MCHIP, EPI/MOHSW, the County Health Team (CHT) and DHOs at facilities that are currently implementing the EPI/FP project in Lofa and Bong. At the end of Quarter 1, MCHIP conducted the endline assessment for the EPI/FP Integrated Pilot Program in Lofa and Bong Counties with local partners and MOHSW staff from 4–16 December2012. In March 2013, the results from the endline assessment were disseminated during the EPI/FP stakeholders' meeting. This pilot study produced a number of key findings including substantial increases in the number of new contraceptive users in pilot sites (a 90% increase in Lofa County and a 73% increase in Bong County). However, the drop-out rate did not improve at the pilot facilities. These findings were discussed and analyzed at the stakeholders' meeting. In conclusion, most of the partners will scale up the program in their various operational counties but are still awaiting the final approval from the MOHSW.
- **Beauty Salon and Barbershops:** Followed up monthly with the beauty salons and barber shops that participated in the pilot initiative to collect data, track referrals, restock the male and female condom supply, and receive qualitative feedback.
- **Radio Messages:** Drafted PPFP radio spots messages, in collaboration with RBHS, the National Health Promotion Department of the MOHSW, and USAID, with a focus on promoting LAM and transiting to a long-acting reversible method.

Objective 5: Reduce the incidence of postpartum hemorrhage through a prevention of postpartum hemorrhage (PPH) program that includes use of misoprostol at home births.

- **PPH Prevention Program Initiated:** The MOHSW, with support from MCHIP, introduced a service delivery intervention to reduce the incidence of PPH in Grand Bassa and Bong, Liberia. The aim of this project is to generate evidence and inform future policy on the expansion of uterotonic coverage for all women giving birth to prevent PPH, using both facility-based and community-based approaches. While women giving birth in a facility will receive oxytocin, misoprostol is given to women at risk of giving birth outside of a health facility for self-administration. PPH remains the leading cause of maternal mortality in Liberia, accounting for approximately 42% of deaths.
    - In Quarter 1, this program initiated and refresher trainings were conducted on PPH prevention, counseling, and record keeping, for both Trained Traditional Midwives (TTMs) and health facility providers from selected program facilities in Grand Bassa and Bong Counties.
    - In Quarter 2, in collaboration with Family Health Division (FHD)/MOHSW and the CHTs, MCHIP conducted three monthly supervision and data collection exercises. During this period, mentoring and on-the-spot training were conducted for those staff who needed it. In addition, with staff support from the Grand Bassa and Bong CHTs, MCHIP conducted a TTM meeting with 211 TTMs from catchment communities implementing the PPH prevention program.
    - At the end of March, the PPH IRB protocol amendment for Phase 2 of the project was submitted for review and approval by the Liberian Ethics Commission and the Johns Hopkins IRB.

- **PPH Program Printed Materials:** Finalized and printed PPH prevention counseling cards, job aids, and inserts for misoprostol. These counseling cards and jobs aids were distributed to the 160 trained TTMs and health workers, while inserts are being placed in the dispensing bags along with the misoprostol for the eligible pregnant women.

Objective 6: Contribute to improvement of newborn health by working with the MOHSW and implementing partners to assess and develop a plan to address gaps in essential newborn care, including in the management of newborn sepsis.

- **Stakeholders' Meeting:** A stakeholders' meeting was held to discuss the project to obtain buy-in from the MOHSW and other partners during a special Reproductive Technical Committee (RHTC) meeting. The RHTC unanimously agreed to the newborn interventions being addressed in the project. Various working groups were formed to facilitate this, including three subgroups on Chlorhexidine addressing:
  - Policy, regulation, manufacturing,
  - Behavior change communication, and
  - Program implementation including adoption of training materials, the supervisory tool, rollout plan, etc., and a Kangaroo Mother Care Working Group.
- **Chlorhexidine:** The working groups met and the policy document on *Chlorhexidine for Cord Care* and *National Implementation Guideline* adapted from other countries were developed and approved by the MOHSW.
- **Printed Materials:** Supported the MOHSW with the design and printing of counseling cards/booklets for the *Home Based Maternal New Born Health Care Training Manual* adopted from the WHO training manual on community-based care of mothers and newborns for community health workers.

Priorities for Quarters 3 and 4

Family planning:

- Implement the remaining district campaigns and contraceptive outreach campaigns for Grand Bassa and Margibi.
- Conduct monthly meetings with religious leaders and beauty salons and barber shops.
- Complete the validation of the PPFP radio spot messages.
- Conduct monthly supportive supervision with the CHTs.
- Co-facilitate the peer provider training for the market project.

EPI/FP Integration:

- Disseminate the endline reports and stakeholders' meeting report to the stakeholders.
- Provide technical assistance for scale-up of EPI/FP.

PPH Prevention Program:

- Follow up with the TTMs on the mapping of pregnant women in the catchment communities.
- Conduct trainings for postpartum interviews and begin conducting the interviews.
- Continue data analysis and prepare the results report for the stakeholders' meeting.

- Prepare and conduct the PPH stakeholders' meeting for Phase 1 of the PPH program in August.

Newborn Health:

- Step-down training on home-based maternal and newborn health will be conducted for community health workers in the nine clinic catchment areas where the project is being implemented.
- Training of National Trainers on KMC will be conducted. Participants will include doctors and nurses from five hospitals where KMC will be introduced; tutors from some of the schools of nursing/midwifery; Reproductive Health Supervisors from the three counties where the hospitals are located; and National Coordinators for Maternal, Newborn and Child Health from the MOHSW. The training was facilitated by a consultant neonatologist from Ghana.
- Step-down training on KMC will be conducted for all the health workers working in the maternal, newborn and child health section of the hospitals.
- KMC units will be set up in the five hospitals.
- A rapid assessment of consumer preference for Chlorhexidine gel or solution will be conducted in health facilities in preparation for the introduction of Chlorhexidine for cord care.
- Procurement and distribution of Chlorhexidine to the project sites will take place.
- Refresher training will be carried out for health workers on treatment of sick newborns with possible severe bacterial infection.

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

by: Comfort Gebeh, Marion Subah, Nyapu Taylor, and Alishea Galvin

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 and Health Survey (LDHS 2007), the contraceptive unmet need in Liberia is 36%, with a total fertility rate of 5.2. Moreover, the maternal mortality ratio 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 Buchanan city and one in Compound Three District Grand Bassa County.

Marwo Weagai, a Grand Bassa Market family planning provider

Marwo Weagai, a market FP peer provider, 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.

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

By the age of 18, 48% of Liberian girls have begun having children (LDHS 2007), and this percentage could be higher in some counties, especially Grand Bassa. According to the UN 2008 Common Country Survey, the county had 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.”

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, which 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.

Country Summary: Madagascar
Period: FY 2013, Quarters 1 and 2

Selected Health and Demographic Data for Madagascar	
GDP per capita (USD)	437.68
Total population	19,625,030
Maternal mortality ratio (deaths/100,000 live births)	440
Skilled birth attendant coverage	43.9
Antenatal care, 4+ visits	49.3
Neonatal mortality rate (deaths/1,000 live births)	24
Infant mortality rate (deaths/1,000 live births)	47.9
Under-five mortality (deaths/1,000 live births)	62 [48]*
Treatment for acute respiratory infection	42
Oral rehydration therapy for treatment of diarrhea	55.5
Diphtheria-pertussis-tetanus vaccine coverage (3 doses)	78
Modern contraceptive prevalence rate	29.2
Total fertility rate	4.8
Total health expenditure per capita (USD)	17.97

Sources: World Bank, Madagascar 2008–09 Demographic and Health Survey, WHO, UNICEF.
*UNICEF <5 mortality ranking (1 = highest mortality rate)

Major Activities

- Provide technical assistance in maternal, newborn, and child health (**MNCH**) to local faith-based organizations, social franchises, USAID bilateral programs, and others
- Train **Community Health Workers** (CHWs) on community-level MNCH in three demonstration districts
- Certify candidate trainers as master trainers
- Implement the **misoprostol** pilot project in one demonstration district
- Support community efforts to develop emergency referral plans
- Provide technical support to seven private health provider training institutions

Program Dates	October 1, 2009–September 30, 2013					
2012–2013 Budget	$1,721,090					
Mission Funding to Date	October 2008–September 2009: $500,000 October 2009–September 2010: $1,650,000 October 2010–September 2011: $420,750 October 2011–September 2012: $1,550,000 October 2012–September 2013: $1,400,000 Total: $5,520,750					
Geographic Focus	Tolagnaro, Ambatondrazaka and Fenerive Est					
Geographic Coverage	No. (%) of provinces	3 (13%)	No. of districts	3	No. of facilities	127
MCHIP In-Country Contact	Jean Pierre Rakotovao: jeanpierre.rakotovao@jhpiego.org Shannon McAfee: shannon.mcafee@jhpiego.org					
HQ Managers and Technical Advisors	Rachel Favero: rachel.favero@jhpiego.org Patricia Gomez: patricia.gomez@jhpiego.org Blami Dao: blami.dao@jhpiego.org Lyndsey Wilson Williams: lwilsonwilliams@savechildren.org Jeffrey Smith: jeffrey.smith@jhpiego.org Nancy Ali: nancy.ali@jhpiego.org					

FY 2013, Quarters 1 and 2: Achievement Highlights

Objective 1: Provide support and national leadership in MNCH.

- **Training and Supervision in targeted MNH skills and knowledge:** MCHIP has launched its collaboration with faith-based organizations. The COP of MCHIP conducted an informational and lobbying seminar with 137 doctors working with the Catholic Association "ECAR" in best practices in MNH. Trainings of their health professionals on MNCH are planned for the next quarter. In addition, the MCHIP field coordinators have continued to conduct meetings with groups of CDS in the three districts to mobilize efforts to implement emergency referral plans. MOUs were finalized with FBOs including SAF/FJKM, SALFA, ECAR, and the private sector health provider association Santé Sud. MCHIP trained 46 health professionals (30 doctors and 16 midwives) from the aforementioned associations during a five-day MNCH technical training. MCHIP also built the capacity of the pool of consultant trainers in MNCH and held a refresher training for 12 members of MCHIP's consultant trainer pool. MCHIP also conducted training of an additional pool of 15 trainers—13 doctors and two midwives—across four private and faith-based associations (SAF/FJKM, SALFA, ECAR, and Santé Sud).
- **Pre-service training assessment:** MCHIP has successfully lobbied seven private health provider training institutions to adapt their pre-service training by integrating the "enseignement efficace" (improved pedagogy techniques). To ensure that the pre-service programs are delivered in the most effective fashion, MCHIP trained faculty members in the "enseignement efficace." At least two teachers from each institution, for a total of 16 teachers, have received a seven-day training on the improved teaching techniques by MCHIP trainers and will receive supervision during the next quarter. MCHIP has conducted an initial assessment of teaching facilities and tools at each of the institutions, and recommendations are being formulated for rendering the environment more effective. Part of this assessment included a review of available tools and equipment at each institution. Based on this assessment, MCHIP will be equipping certain institutions with mannequins and other essential tools for their training laboratories during the next quarter. This will help faculty and students practice their newly acquired skills. Following the assessments and trainings in improved pedagogic skills conducted this year, the MCHIP technical team revised the curriculum to conform to the standards and norms set forth by the International Confederation of Midwives (ICM). In addition, the MNCH curriculum for private training institutions was revised and updated and has been rolled into the programs at these institutions. At least two teachers from each institution, for a total of 15 teachers, have received training on the revised MNCH curriculum by MCHIP trainers and will receive supervision during the next quarter. During this training, several important outputs were achieved: all participants were trained on the curriculum for midwives for the first through third years, a new midwife profile was developed, and a common vision for pedagogy was reinforced.
- **Information-sharing on key, evidence-based interventions:** The COP shared MCHIP successes with improving quality of care of prevention and management of pre-eclampsia and eclampsia and postpartum hemorrhage at the Conference of the International Federation of Obstetricians and Gynecologists in October, 2012. MCHIP was selected to present its abstract at this internationally renowned conference. MCHIP/Madagascar was also represented by MCHIP/Washington Technical Advisor Eva Bazant at the ISQua Conference in Switzerland in October 2012. Dr. Bazant presented MCHIP/Madagascar's successes in quality of care, with an abstract on "Infection Prevention and Control in Labor and Delivery Wards in Madagascar." On a national level, MCHIP has now operationalized two Technical Advisory Groups that meet on a regular basis: PPH and chlorhexidine. With the encouragement of USAID, the MCHIP COP made a presentation to share a project overview and results with the MOH and health partners during the February monthly MOH meeting. The chlorhexidine Technical Working Group, led by MCHIP, met a number of times to discuss BCC, M&E, Trainings of ACs, and potential additional funding sources. The TWG, through a partnership with PSI and PATH, was able to leverage current activities to procure non-USG funding for the training and supervision of public sector providers in Mahabo on chlorhexidine by Jhpiego.

- **Maternal and newborn health booklets for Health Agents (HAs), CHWs, and women's and health care providers' registers:** In close collaboration with RTI's Santénet2 and JSI's MAHEFA, MCHIP assisted with the recent revisions related to the results of field pre-tests of the maternal and newborn health booklets—used by both women and ACs—to include guidance on community-level recognition and referral of maternal and newborn complications. The health booklets are currently being printed and will be distributed during the next quarter. The registers developed by MCHIP to facilitate data uptake with regard to MNCH variables are currently in use throughout the three MCHIP districts as part of a pre-test approved by the MOH. The registers being pre-tested are improved by including data collection on key interventions that MCHIP targets in trainings, such as AMTSL and the use of magnesium sulfate to treat PE/E.

Objective 2: Integrate health approaches to MNH, based on demonstration activities in three districts (Fenerive Est, Ambatondrazaka, and Tolagnaro).

- **Supervision of ACs on community-level maternal and neonatal health in the three demonstration districts:** MCHIP conducted follow-up supervision visits of 275 CHWs (115 in Fenerive-Est, 80 in Fort-Dauphin, and 80 in Ambatondrazaka) out of the total 448 CHWs previously trained. These visits center on community-level maternal and neonatal health interventions to ensure that the CHWs are using their newly acquired skills correctly. Supervision activities focus on reinforcing capacity of CHWs to respond appropriately to women and newborns with complications. The supervision is done through interactive sessions in which participants are asked to demonstrate skills and share experiences and challenges to practicing their newly acquired skills and knowledge so that possible solutions may be discussed. MCHIP trained 23 new ACs working with ECAR.
- **Compiling and facilitating the adoption of best practices on community-level management of maternal and newborn complications:** In the three demonstration districts, MCHIP Field Coordinators have been assessing the capacity of the existing emergency referral systems at the community level to provide necessary logistical support and immediate transport to the nearest health facility for women and newborns in case of obstetrical and newborn complications. In collaboration with district Health Development Committees or CDS, MCHIP Field Coordinator**s** are working closely with key stakeholders to reinforce and strengthen systems already in place, in particular for setting aside money that women and their families can access when problems arise and for providing emergency transport in the event of problems. With each commune, MCHIP coordinators work with members of the CDS to identify community needs related to the five pillars of the emergency plan development: an entity for decision-making, a transport mechanism, the existence of an available emergency fund, accompaniment, and appropriate referral center information. MCHIP has helped each community to develop a draft plan in a participatory fashion at the commune level. MCHIP has helped 11 communities in Fort Dauphin and six in Fenerive-Est to finalize their plans in a participatory fashion at the commune level. Next quarter, MCHIP coordinators will revisit each commune in the three districts to formalize the plans and assure that they are implemented.

Objective 3: Increase uterotonic coverage to prevent PPH through community agents in the district of Fenerive Est.

- **Constitution and mobilization of a Technical Advisory Group (TAG) of highly motivated key partners:** MCHIP pulled together key partners working in MNCH to constitute a dynamic and committed advisory team with the aim of rolling out the MCHIP PPH project, and potentially expanding enhanced PPH coverage nationwide. The PPH TAG is currently composed of the following partners, with Jhpiego/MCHIP as the lead coordinator: Mahefa/JSI, PSI, UNFPA, MSM, and DMESR of the MinSan. The TAG team participated in these discussions and validated the approach. Marie Stopes Madagascar (MSM) is partnering with MCHIP to procure and supply the misoprostol product to the project.

- **Rollout of trainings and supervision:** As per the USAID guidance and project reorientation, MCHIP did not conduct any trainings or supervision of the health care providers. However, 22 ACs were trained and equipped with appropriate job aids (counseling cards, pregnancy calendars). Nearly all of these ACs received in-depth supervision during this year (15/22). An additional 182 previously trained ACs received in-depth supervision.
- **Commitment to the project:** During this year, 164 ACs and 379 pregnant women have signed informed consent documents indicating their commitment to and understanding of the project. In addition, MCHIP conducted a trimester review meeting with district-level decision-makers across 12 communes and 211 fokontanys wherein they reaffirmed their commitment and support of the project.
- **Distribution of product and supporting tools:** At the end of the first quarter, MSM procured the first allotment of misoprostol and brought it into the country. The misoprostol was repackaged with a simple name Famonjy (Life Saving) as a label on the packaging with MCHIP-developed product inserts (a pictorial brochure with simple Malagasy language). A starter stock of product and IEC materials (a set of four counseling cards, two posters) was distributed to 164 ACs. In total, 511 doses were distributed, with the number of doses per AC being determined based on the number of eligible pregnant women in their community. The doses will be distributed to women who are 32 or more weeks pregnant. Job aids were distributed to ACs (580 counseling cards for ACs and 145 pregnancy calendars for ACs). A total of 237 women who are 32 weeks pregnant or more received the Famonjy misoprostol product from ACs, along with detailed and comprehensive education regarding how to use the product correctly and safely. Of those 237 women, 170 took the product at the time of their delivery. MCHIP also received and packaged the second allotment of misoprostol donated by MSM (14,000 tablets).
- **Supervision of trained ACs:** In January, the field team followed up with intensified supervision for the ACs to reinforce and assure retention of skills. A follow-up supervision was also conducted. The team was able to supervise nearly all ACs (145/149).

Objective 4: Introduce the best practice of chlorhexidine coverage to prevent neonatal infection through community agents in the district of Mahabo/Menabe.

- **Constitution and mobilization of a Technical Advisory Group (TAG) of highly motivated key partners:** This year, MCHIP pulled together key partners working in MNCH to constitute a dynamic and committed advisory TAG team with the aim of not only rolling out the MCHIP chlorhexidine project, but eventually to expand chlorhexidine coverage nationwide. The CHX TAG is currently composed of the following partners, with Jhpiego/MCHIP as the lead coordinator: Mahefa/JSI, PSI, UNFPA, UNICEF, MSM, and DMESR of the MinSan. The TAG team participated in these discussions and validated the approach, which will consist in a strong partnership among MCHIP, Mahefa/JSI, and PSI. While MCHIP will lead the overall project and the elements related to health care professionals, Mahefa/JSI will implement the community agent components and PSI will conduct formative research about the product as well as about behavioral issues that will inform BCC campaign development. The TAG team has met multiple times this year and will be continuing to do so during the next quarter on a monthly or even twice-a-month basis.
- **Completion of formative research:** Results from the formative research that PSI conducted with support from MCHIP and the TWG were disseminated to the entire TWG this year. Based on the results of the research, MCHIP and partners have essential information to inform training of health workers, communication campaigns, and the branding of the chlorhexidine product. The research identified the name and logo of Arofoitra to be widely accepted and appreciated. The research also indicated cord care behaviors, attitudes, and practices, as well as a preference for the product in gel form and a willingness to pay for the product.

Priorities for Quarters 3 and 4

- Continue to distribute Famonjy (misoprostol) to pregnant women via ACs, and support ACs to appropriately counsel and follow up with these pregnant women.
- Increase the coverage of essential MNCH services and counseling through the training of 300 new ACs in the districts of Amparafaravola and Moramanga and 220 health care providers working across the country as members of FBOs and the private sector organization Santé Sud.
- Continue to facilitate community development of emergency referral plans in all project districts.
- Improve the training program for midwives at private training institutes (pre-service) through supervision and training of faculty in four regions: Analamanga, Atsinanana, Vakinankaratra, and Sofia.
- Distribute the newly finalized health booklets in all project districts.
- Expand MCHIP's support to seven new training institutions for midwives and train faculty in these institutions on EmONC, MNH, and improved pedagogy skills.
- Increase the reach of the lifesaving use of misoprostol for PPH prevention through extension of the project to the district of Ambatondrazaka.

Community Health Worker in Madagascar Instructs on Misoprostol Use to Prevent Postpartum Hemorrhage

by: Shannon McAfee, Raoeliarisoa Andriatsarafara, and Jean Pierre Rakotovao

Claudia was nervous about having her first child. The 21-year-old woman from rural Fenerive-Est district, Madagascar, knew that women in her community often died from complications of labor and delivery. Thankfully, she had community health worker (CHW) Tesaka Clairette to put her mind at ease.

Trained by MCHIP in lifesaving maternal, newborn, and child health skills and counseling—and having received further supervision to hone these skills—Tesaka felt comfortable instructing on misoprostol use for postpartum hemorrhage (PPH) prevention. In fact, her district is part of a pilot project to demonstrate how misoprostol can be used successfully at the community level.

In Madagascar, approximately 10 women die every day due to complications from pregnancy and childbirth, and fewer than two in five deliver in a health facility. Giving birth in a facility is more expensive than at home—sometimes more than four times as much—and lack of transport and poor or nonexistent roads are key barriers to health facility access. It is, therefore, critical for women to have access to misoprostol and the knowledge of how to correctly use the drug should a life-threatening emergency arise.

To visit Claudia's home, Tesaka walks about four miles and takes a small boat across swampy waterways. She has made this trek to Claudia's home four times: first, as part of her census of all pregnant and eligible women for the misoprostol project; second, at Claudia's six-month mark to discuss the risks of PPH and to see if Claudia would like to participate in the project; and a third time during Claudia's eighth month of pregnancy to provide her with misoprostol and counseling on how to use it. Tesaka's final visit was a follow-up after Claudia's delivery.

The mother-to-be received a packet of three misoprostol tablets in a locally designed package imprinted with the name *Famonjy*, meaning "to save." Claudia followed Tesaka's instructions to keep the product safe and ready for delivery. When she went into labor at her sister's house, Claudia made the same choice as many women in her country: she opted to go to a traditional birth attendant for the delivery rather than the public sector health center. Thankfully, Claudia brought her packet of *Famonjy* with her, and correctly took the pills immediately after her baby was delivered and before the placenta came out.

Claudia is delighted to have a beautiful and healthy baby girl named Princia, and thanks Tesaka for her guidance and support. She will tell others to use *Famonjy* and will use it again for her second delivery, she said, "because it saved my life!"

Claudia cuddles with her baby during a postpartum visit by CHW Tesaka Clairette.

Country Summary: Malawi
Period: FY 2013, Quarters 1 and 2

Selected Health and Demographic Data for Malawi	
GDP per capita (USD)	309.73
Total population	15,263,417
Maternal mortality ratio (deaths/100,000 live births)	675
Skilled birth attendant coverage	72
Antenatal care, 4+ visits	45.5
Neonatal mortality rate (deaths/1,000 live births)	31
Infant mortality rate (deaths/1,000 live births)	66
Under-five mortality (deaths/1,000 live births)	112 [30]*
Treatment for acute respiratory infection	65.7
Oral rehydration therapy for treatment of diarrhea	70.1
Diphtheria-pertussis-tetanus vaccine coverage (3 doses)	93
Modern contraceptive prevalence rate	42.2
Total fertility rate	5.7
Total health expenditure per capita (USD)	19.07

Sources: World Bank, Malawi Demographic and Health Survey 2010, WHO, UNICEF.
*UNICEF <5 mortality ranking (1=highest mortality rate)

Major Activities

- Rotavirus vaccine introduction in October 2012
- Training of 88 training of trainers (TOTs) for Immunization In Practice (IIP) modules
- Development of a national EPI policy in November 2012
- Helping Babies Breathe (HBB) evaluation
- Initiate HBB training in 13 Malawi pre-service institutions
- Support injection safety activities in three health facilities in Lilongwe
- Support Christian Health Association of Malawi to deliver quality voluntary medical male circumcision services in Thyolo district
- Improve infection prevention practices in Lilongwe district

Program Dates	October 2009–September 2013					
PY 5 Budget	$1,862,253 field; $173,078 core; **Total: $2,035,331**					
Total Mission Funding to Date	$10,535,299					
Geographic Focus	National					
Geographic Coverage	No. (%) of provinces	2 (40%)	No. of districts	2	No. of facilities	8
MCHIP In-Country Contact	Tambudzai Rashidi: tambudzai.rashidi@jhpiego.org Hannah Hausi: hhausi@jsimw.com Abubakari Mwinyi: Abubakari.mwinyi@jhpiego.org					

HQ Managers and Technical Advisors	Patricia Taylor: ptaylor@mchip.net Robert Steinglass: rsteinglass@mchip.net Tigistu Adamu: tadamu@mchip.net Asnakew Tsega: atsega@jsi.com David Burrows: david.burrows@jhpiego.org Jennifer Melgaard: jmelgaard@mchip.net

FY 2013, Quarters 1 and 2: Achievement Highlights

MCHIP work in Malawi is divided into two main phases: 1) from October 2009 to February 2012, and 2) from October 2011 to present. During the first phase, MCHIP continued activities from two earlier USAID projects: the ACCESS Program and Enhanced HIV/AIDS Prevention and Improved Family Health (EHAP-IFH) with broad activities focusing on expansion of quality improvement of MNH services, including integration of PMTCT, community-based MNH, postpartum family planning, voluntary medical male circumcision (VMMC), and community mobilization, in four districts. It also included national distribution of insecticide-treated bed nets and social marketing of high-impact MNCH products. In late FY2011, USAID awarded the Support for Service Delivery Integration-Services (SSDI-Services) Project, which continued and expanded much of the technical support that MCHIP had been providing to the MOH during the first phase.

The second phase began with USAID Malawi's request for MCHIP, using a combination of MCHIP core and Mission field support, to provide technical support for five new activities in FY2012 and FY2013: 1) the introduction of new and underused vaccines (NUVI) and strengthening routine immunization system; 2) an evaluation of the national Helping Babies Breathe (HBB) initiative; 3) introduction of HBB into Malawi's pre-service training institutions; 4) expansion of trainings on injection safety/infection prevention; and 5) support to the Christian Health Association of Malawi to increase availability of quality VMMC services. All of these activities are being conducted side by side with SSDI-Services.

Immunization

The MCHIP immunization workplan contains the following objectives.

Objective 1: Successfully introduce PCV and Rotavirus vaccine nationwide, support MOH/EPI in monitoring and follow-up of PCV and Rotavirus vaccines, and assist with the GAVI Alliance application submission process for the measles second dose.

- ***New vaccine introduction:*** MCHIP provided in-country technical support for Rotavirus vaccine introduction in October 2012. MCHIP supported the MOH to introduce new vaccines by:
  - Zonal-level training of trainers (TOTs) of managers and service providers on Rotavirus vaccine introduction, which resulted in a total of 341 district-level trainers from five health zones trained. These TOTs facilitated the cascaded trainings that took place in all the districts so that the country was able to start administering Rotavirus vaccine in all 28 districts of the country.
  - Provision of technical and financial support for quarterly supportive supervision visits from national to sub-national level.
- ***Training materials and tools*****:** In collaboration with the social mobilization subcommittee, MCHIP assisted in the development of training materials and tools, contributed to the development of the national plan of action for Rotavirus vaccine introduction, and in addition, supported the approval of posters, leaflets, and radio and television messages adapted for new vaccines. MCHIP participated in the development of the Rotavirus vaccine introduction field guide for health workers, which will support providers in delivery of the vaccine.

- ***Reporting tools*:** The MCHIP team assisted in ensuring that all tools (health passport, performance form, and under-one register) have been revised to include Rotavirus vaccine, thereby enabling improved routine data collection and reporting practices.

Objective 2: Improve the capacity of the MOH/EPI to develop skills and improve the performance of its staff in new vaccine introduction and routine immunization.

- MCHIP supported the training of 88 trainers for Immunization In Practice (IIP) modules; these trainers will facilitate district trainings for health workers.
- MCHIP attended the East and Southern Africa (ESA) EPI managers' meeting in Harare in March 2013. This provided a forum for learning and sharing experiences in immunization among representatives from the ESA region. After the ESA EPI managers' meeting, MCHIP participated in a field study in Manicaland province, Zimbabwe, to observe how Reaching Every District (RED) is being implemented in Zimbabwe. The lessons learned from there included the training of health workers in RED with regard to training materials and duration, microplanning in health facilities, use of data, defaulter tracing, community engagement, and supervision of REC implementation. These lessons will be incorporated into RED in Malawi.
- MCHIP attended the March 2013 USAID workshop on Environmental Compliance. The meeting emphasized the development of an Environmental Mitigation and Management Plan (EMMP) and its implementation, monitoring, and reporting on EMMP indicators, and updated USAID program partners on how to use the EMMP as a monitoring tool. Participating in this workshop helped MCHIP to better understand how to incorporate EMMP indicators into MCHIP reporting, which MCHIP aims to do during Quarter 3.

Objective 3: Strengthen the platform for new vaccines introduction by developing national immunization policy, improving routine immunization monitoring and evaluation, data quality, and vaccine and cold chain management at the national, zonal, district, and health facility levels.

- MCHIP supported the development of the national EPI policy. The first draft policy was written in November 2012. MCHIP organized the policy development consultative meeting with stakeholders, which aimed to solicit views from stakeholders on the policy direction. MCHIP provided external technical assistance, working closely with WHO, in development of the draft.
- MCHIP provided technical support to finalize the EPI reference field manual, which was completed in January 2013. The document will be pre-tested next quarter. The finalized EPI field manual will provide guidance to Malawi program partners working on immunization.
- MCHIP assisted in finalizing the EPI comprehensive multi-year plan (cMYP) and the 2013 Plan of Action in collaboration with MCHIP program partners and the MOH. The Plan of Action and cMYP will enable MCHIP to reprioritize activities in line with the national plan and input from additional partners and the MOH.

- The EPI program conducted an Effective Vaccine Management (EVM) assessment in November and December 2012 in 11 sample districts (Nkhatabay, Mzimba South, Dowa, Lilongwe, Mchinji, Ntchisi, Blantyre, Chiradzulu, Mangochi, Nsanje, and Zomba). MCHIP participated in the training of assessors and consolidation of recommendations after the assessment. The EVM assessment found that storage temperatures, maintenance of equipment, and vaccine management were good at all levels; however, storage capacity was inadequate at regional and district levels, distribution of vaccines was a challenge at district level, and stock management was not good at district or health facility levels. The recommendations for the districts included: improve procurement of gas and kerosene and where possible consider replacing these refrigerators with solar powered ones; repair nonfunctioning refrigerators; ensure adequate fire extinguishers and train staff on their usage; conduct refresher trainings in Multi Dose Vial Policy (MDVP) and wastage rate calculations; and consider supplying a two-month stock of vaccines and supplies.
- The EPI comprehensive review was conducted in November and December 2012, in 12 districts (Chitipa, Rumphi, Dedza, Nkhotakota, Ntcheu, Salima, Balaka, Chikwawa, Machinga, Mwanza, Neno, and Phalombe). MCHIP participated in the exercise, along with consultants provided by WHO, and MCHIP provided funding for the data entry and analysis workshop. Finalization of the report and debriefing to the MOH and partners will be done during the next quarter.

Helping Babies Breathe Evaluation: Evaluate the quality, coverage, and impact of the HBB newborn resuscitation intervention at the facility level in Malawi over time.

- MCHIP/HQ continues to provide technical assistance to the HBB Evaluation in Malawi that is being led by SSDI-Services. The first round of data collection finished in September 2012. The first two quarters of this program year focused on data entry, data cleaning, and initial analysis while also preparing for the second round of data collection. The draft analysis from the first round of data collection is being finalized and will be shared with USAID in the next quarter.
- MCHIP/HQ conducted a review of the process to integrate HBB learning materials into the pre-service institutions in Malawi. MCHIP interviewed tutors and students involved in the ENC course from selected training colleges and held discussions with the Nurses and Midwives Council, RHU, and SSDI-Services. The report will be finalized in the next quarter.

Voluntary Medical Male Circumcision

- Forty providers were trained to deliver VMMC services. They form a pool of providers in Thyolo district to deliver VMMC services through routine static or outreach services as well as intense campaign periods. Ten identified providers completed a Clinical Training Skills course to build the pool of quality MC trainers in Malawi to support future trainings as well as provide coaching and mentoring at the service delivery site.
- The Thyolo Campaign conducted 2,833 procedures over the originally scheduled 12 days. The campaign continued for another five days per a request from the Thyolo District Health Office. A total of **3,416 male circumcisions were conducted over the 17-day campaign, 228% of the initial campaign** target of 1,500 circumcisions. There was 100% uptake of HCT and less than a 2% Adverse Event rate. The huge success and high turnout of clients during this campaign are attributed to three unique approaches: 1) engagement of CBOs at campaign sites for demand creation; 2) use of a demand creation team consisting of technical and communication staff to conduct community-wide motivational talks, visit schools, engage tea estate managers, and give public lectures; and 3) strong leadership and support of the DHO, which resulted in district ownership of the campaign and highly motivated and inspired teams of providers.

Figure 1. Cumulative VMMC – Thyolo Campaign

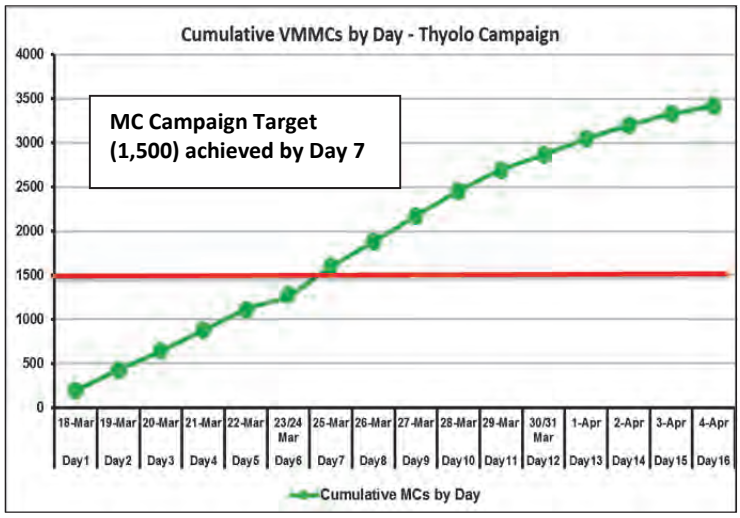
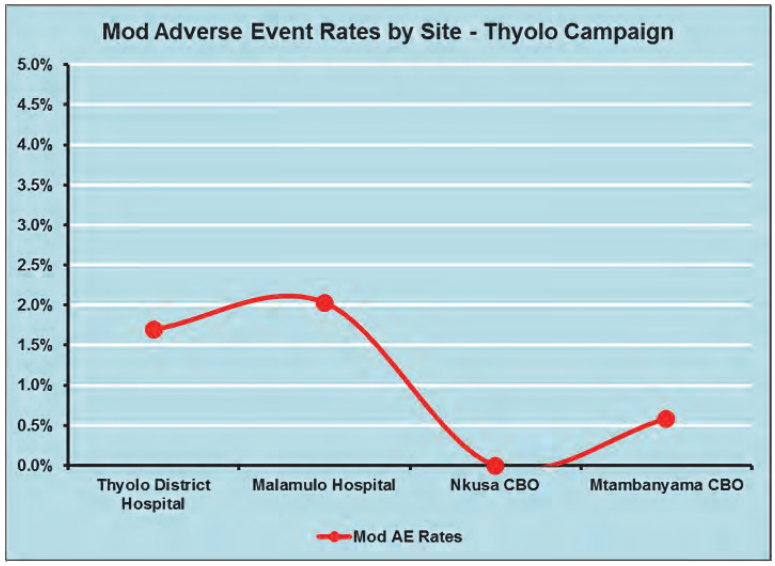


Figure 2. Mod Adverse Event Rates by Site – Thyolo Campaign



- In collaboration with the MOH, developed a VMMC database that will be linked with DHIS2. The database will provide national information on VMMC so the MOH can track progress toward set targets.
- Developed waste management plans for two selected facilities and a generic plan to be disseminated to other VMMC implementing partners.

Injection Safety (Infection Prevention)

- MCHIP trained 40 service providers in infection prevention and performance and quality improvement. This training was followed by distribution of supplies to Lumbadzi Health Center and Mlale and St. Gabriel Hospitals to support infection prevention efforts. SSDI-Services is providing ongoing support to these facilities to foster performance and quality improvement.

Priorities for Quarters 3 and 4

Immunization

- The main immunization priorities for Quarters 3 and 4 include:
  - Conduct Training Needs Assessment (TNA). MCHIP will support the MOH/EPI to assess the training needs of immunization program by conducting a field assessment in training institutions and health facilities.
  - Provide external technical assistance for the conduct of the Rotavirus vaccine Post Introduction Evaluation (PIE) in July 2013. It is recommended that PIE be conducted 6–12 months after the introduction of a vaccine; Malawi introduced rotavirus vaccine in November 2012.
  - Support finalization of the draft EPI policy by supporting zonal and district officers to meet to comment on the draft. MCHIP supported the preparation of the draft EPI policy and also will support its finalization.
  - Conduct Immunization in Practice (IIP) trainings for both TOTs and vaccinators, with a minimum of two health workers per health facility.
- Targeted technical assistance to the MOH will be provided by MCHIP to support:
  - Facilitation by the MOH of Reaching Every Community (REC) training, targeting district and health facility staff. REC is a strategy used to reach the unreached.
  - Development of an immunization M&E framework.
  - Data quality self-assessments (DQSA) in the remaining districts.
  - Regular supportive supervision visits.
  - Mid-level manager (MLM) training of zonal and district managers on immunization.
- HBB:
  - Provide technical support to the second round of data collection, which will be organized and funded by SSDI-Services.
  - Finalize and disseminate report on status of integration of HBB learning materials into pre-service institutions.
- VMMC:
  - Support service delivery through static and outreach sites as well as another mini-campaign to achieve a total of 8,100 circumcisions by the end of September 2013.
  - Orient 40 HTC counselors on the VMMC package to increase the pool of qualified counselors to support VMMC services, particularly for campaign activities.
  - Train four providers who recently joined Thyolo DHO and eight Malamulo college instructors in VMMC. This effort will increase the pool of trained providers in Thyolo district and increase the pool of trainers in Malawi, thereby supporting the long-term training needs of Malawi and helping to develop the human resources necessary to implement a VMMC program at a national scale.
  - Support the MOH to conduct a VMMC gap analysis and develop a National VMMC Strategy to provide framework and guidance to implementing partners and allow Malawi to monitor its progress toward achieving national VMMC targets.

"Like I Have Been Circumcised at Home": Community-Based Outreach Sites for VMMC in Malawi

by: Joel Suzi

When the outreach road show advertising free male circumcision services arrived in the village of Helimani, Malawi, Kizito Liyasi was curious enough to attend an information session. A grocer with a wife and baby boy, Kizito was moved by a man's personal decision to be circumcised as part of a comprehensive strategy to prevent the spread of HIV. Kizito headed home to discuss the free health service with his wife.

Along the way, he met several male friends who tried to dissuade him from undergoing the procedure, arguing that he did not need to be circumcised because he was married. Kizito's wife, Triza, saw it differently, sharing with him the health benefits of circumcision that a local nurse had explained to her. A group education session at the nearby Ntambanyama Community-Based Organization provided further information for the 20-something father. Together, Kizito and his wife decided that voluntary medical male circumcision (VMMC) was right for their family. "I was convinced I needed to do this," he said.

Kizito is among the 3,416 men who were circumcised during a three-week long VMMC campaign in Thyolo District this spring. The campaign was implemented by MCHIP in collaboration with the Christian Health Association of Malawi and Malawi Ministry of Health.

Our Choice Together: Kizito with his wife, Triza, holding their baby at home.

Kizito is older than most of the clients who took advantage of the services at Thyolo District Hospital, Malamulo Mission Hospital, and Nkusa and Ntambanyama Community Based Organization centers. However, as he rightly stated, age should not be a factor in choosing VMMC: "It is not about how old you are, as for me it is about focusing on the high benefits of circumcision. It's never too late for my hygiene and safety," said Kizito, who queued up for services with the younger clients and talked with them during the group education sessions. "It's just the right time. I can protect my wife from cervical cancer. It's more than a choice to me. It's a responsibility."

Kizito during the circumcision procedure.

For Kizito, the convenience of getting the service at the local Ntambanyama CBO—an outreach site near his home and a place that is not a regular health facility—added to his motivation. "It is like the hospital came to my village. I couldn't ask for more with the service available for free. I knew I could easily walk a short distance back home after the procedure. In a way, you can say it is like I have been circumcised at home," explains Kizito.

This "doorstep delivery" setup to deliver circumcision services through community-based temporary sites proved to be a convenient, innovative and intimate approach to provider services. Moreover, the innovative approach helped the campaign to exceed its initial projected target of reaching 2,500 clients, ultimately providing VMMC services to more than 3,000 men in just 17 days.

The campaign's innovative and comprehensive approach to circumcision influenced Kizito's decision, and the group education sessions helped to dispel myths about VMMC while educating Kizito on its benefits. "All my life I had never thought about getting circumcised. What for? It was not part of my culture and religion," he said, adding that stories and hearsay linked circumcision to sexual pleasure and certain cultures and religious sects.

But the conversation with his wife proved most persuasive. To Kizito's surprise, Triza had no reservations. She was happy to encourage him and even shared her knowledge about the benefits of male circumcision:

"During one of my antenatal visits, the nurse at the hospital was teaching us about cervical cancer. She mentioned that male circumcision helps reduce the chance for cervical cancer as well as penile cancer and, most importantly, HIV," she said. "I never told my husband then because I was not sure how he would take it. He might have been angry with me. I was also worried about agreeing to pay around 1,500 kwacha for the service at Malamulo [Hospital] while we are struggling to get other daily necessities in our home. Now that he initiated the issue himself and that the service is being offered freely and near, I encouraged him to go for it for the safety of our family."

Kizito being tested for HIV before undergoing VMMC.

Kizito Liyasi's successful participation in the VMMC campaign in Thyolo is a testament to a married man's interest in choosing VMMC, as well as to family decision-making. And with most villages located far from hospital-based sites, the campaign's delivery of VMMC services at community-based outreach service points in the catchment areas of the static sites made the process more convenient while creating local excitement. This innovative approach also helped to reduce the chances of high client turnover at a single site, which would likely affect the quality output of the providers.

Kizito listening during the group education session.

Country Summary: Mali

Period: FY 2013, Quarters 1 and 2

Selected Health and Demographic Data for Mali	
GDP per capita (USD)	691.49
Total population	13,010,209
Maternal mortality ratio (deaths/100,000 live births)	830
Skilled birth attendant coverage	26.8
Antenatal care, 4+ visits	35.4
Neonatal mortality rate (deaths/1,000 live births)	46
Infant mortality rate (deaths/1,000 live births)	95.8
Under-five mortality (deaths/1,000 live births)	178 [2]*
Treatment for acute respiratory infection	38.1
Oral rehydration therapy for treatment of diarrhea	49.1
Diphtheria-pertussis-tetanus vaccine coverage (3 doses)	74
Modern contraceptive prevalence rate	6.9
Total fertility rate	6.6
Total health expenditure per capita (USD)	38.43

Sources: World Bank, Mali 2006 Demographic and Health Survey, WHO, UNICEF.
*UNICEF <5 mortality ranking (1=highest mortality rate)

Major Activities

- Integrated essential community-based MNCH/FP package:
  - Essential newborn care
  - Postnatal care home visits
  - Integrated community case management
  - Community-based distribution of FP
  - Nutrition
  - WASH
- Postpartum family planning (PPFP)
- AMTSL
- Helping Babies Breathe (newborn resuscitation)
- Urban outreach for FP
- Social marketing of diarrheal disease control, water and sanitation, HIV and FP products

Photo courtesy of Save the Children

Program Dates	MCHIP MNCH/FP: October 1, 2010–September 30, 2013 MCHIP Urban Outreach and Social Marketing: October 1, 2011–September 30, 2013					
2012–2013 Budget	MCHIP MNCH/FP: $6,496,433 MCHIP Urban Outreach and Social Marketing: $5,968,621					
Mission Funding to Date	MNCH/FP Funding: October 2010–September 2011: $1,025,000 October 2011–September 2012: $2,175,000 October 2012–September 2013: $5,036,538 Urban Outreach and Social Marketing Funding: October 2011–September 2012: $2,150,000 October 2012–September 2013: $4,915,393					
Geographic Focus	MCHIP MNCH/FP: National and regions of Kayes and Sikasso MCHIP Urban Outreach and Social Marketing: The cities of Bamako and Koutiala and the regions of Kayes, Ségou, and Sikasso.					
Geographic Coverage	No. (%) of provinces	4 (50%)	No. of districts	16	No. of facilities	255

MCHIP In-Country Contact	MCHIP MNCH/FP: Aida Lo, Chief of Party, alo@savechildren.org MCHIP Urban Outreach and Social Marketing: Dr. Rodio Diallo, PSI Country Director, rdiallo@psimali.org
HQ Managers and Technical Advisors	Anita Gibson, agibson@mchip.net; Rebecca Levine, rlevine@mchip.net; Serge Raharison, sraharison@mchip.net ; Holly Blanchard, hblanchard@mchip.net; Winnie Mwebesa, wmwebesa@mchip.net; Elise Mugabo, emugabo@psi.org

FY 2013, Quarters 1 and 2: Achievement Highlights

MCHIP MNCH/FP Program

Objective 1: Contribute to improved programmatic guidance among SEC implementing partners for increased efficiency and effectiveness.

- **Partnership established with FENASCOM for effective SEC implementation.** Since the coup d'etat in March 2012, and the US Government (USG) restrictions on direct support to Mali's government and its public sector agencies, MCHIP has reoriented its strategic approach and found new and creative ways to achieve program objectives such as establishing and/or increasing engagement with non-government entities. The FENASCOM is the national body overseeing the management of the country's vast network of community health centers (CSCOMs). MCHIP's collaboration with the FENASCOM has improved coordination amongst CSCOMs for SEC (essential community care) implementation and increased commitment and ownership of the SEC strategy by CSCOM staff, crucial to the sustainability of this community-based program.
- **National training curriculum for community volunteers (relais) revised.** MCHIP, in collaboration with UNICEF and other SEC partners, led the review and revision of the national protocol and training curriculum for Mali's relais who conduct health promotion activities and distribute family planning methods at the community level. The revised protocol incorporates new behavior change communication messages particularly around nutrition, and water, sanitation, and hygiene. Next quarter, MCHIP will lead the national-level training of master trainers and begin the rollout of training in the seven districts in which MCHIP is implementing the curriculum.

Objective 2: Improve access to, and quality and efficiency of, the SEC through implementation and M&E support in the two regions of Kayes and Sikasso.

- **Quality of data collection and reporting by community health workers (ASCs) strengthened.** MCHIP worked to improve the accuracy, completeness, and timeliness of data collected and reported by ASCs through focused trainings and skills-building sessions. The trainings were conducted for both the ASCs and their direct supervisors, who review and aggregate the data for submission to the district health team for analysis.

Objective 3: Improve access to, and quality and efficiency of, facility-based integrated services in CSCOMs and rural maternities in the districts of Kita and Diema in Kayes Region.

- **Lower-level skilled matrons at rural maternities trained in MCHIP's integrated package of facility-based care.** In the 2010–2011 program year, MCHIP developed a training and supervision curriculum for an integrated package of MNH/FP services to be delivered at the CSCOM level. In an effort to expand access to key lifesaving services, MCHIP is now training midwifery assistants at rural maternities (managed outside the formal health system) in the provision of these evidence-based interventions. The package includes active management of the third stage of labor (AMTSL), essential newborn care, newborn resuscitation via the Helping Babies Breathe curriculum, and provision of long-acting methods for family planning.

Urban Outreach and Social Marketing Program

Objective 1: Increase the availability of modern family planning and HIV products and services through social marketing.

- **Improved service delivery for long-term methods.** This reporting period was marked by the introduction of mobile teams to promote family planning, with a focus on long-term methods, in the health districts of Sikasso, Kignan, and Yélimané.
- From January to March 2013, 541 interpersonal communication sessions were held in community health centers and ProFam network clinics in the health districts of Bamako, Kayes, Yélimané, Segou, Sikasso, Kigna, and Koutiala. These promotional activities have reached more than 23,000 women of reproductive age, including 9,027 who spontaneously accepted long-term methods (4,409 intrauterine devices and 4,618 Jadelle® implants), bringing the acceptability rate to 38%.

Objective 2: Increase demand and access to specific, socially marketed health commodities and services among key populations, including: ORS/Zinc, Aquatabs, comprehensive FP options, and condoms.

- **Increased demand for ORS/Zinc, Aquatabs, and contraceptives**: In an effort to increase demand for ORS/Zinc and Aquatabs, an extensive proximity campaign was launched in January. The campaign was successful in boosting sales. It also allowed distributors to the general public, and women in particular, to be aware of the new product for the treatment and prevention of diarrhea, and also reinforce messages around Aquatabs use for water treatment in preparation of the upcoming rainy season. This campaign will contribute to the overall objectives of the desired behavior change. Next steps include another campaign in priority areas to improve the penetration of Orasel Zinc, for which we cannot do mass media communication at this point due to public institution restrictions.

Objective 3: Increase the capacity of local partners (ProFam network providers, and community-based organization communications teams) to provide high-quality services, and develop high-quality communication tools targeted to vulnerable groups.

- PSI and its partner ARCAD-SIDA facilitated a workshop to develop appropriate communication materials for people living with HIV (PLHIV). The workshop was based on a situation analysis enriched by existing data in Mali and the West Africa region, including the formative research study discussed in the previous report on sexual and health-seeking behaviors among PLHIV in Bamako, Kayes, Koulikro, and Sikasso. The workshop brought together WHO, UNAIDS, different implementers including local NGOs, PLHIV, and representatives from la Cellule Nationale de Lutte contre le VIH. The workshop recommendations for communication materials and messages include four main points: having simple messages in the local languages on the rights and duties of PLHIV; the importance of treatment adherence; participation in support group activities highlighting the benefit of a healthy lifestyle; and the prevention of opportunistic infections.

Priorities for Quarters 3 and 4

MNCH/FP Program

- Training of 3,318 relais in the newly revised curriculum;
- Provision of supplementary equipment and supplies to relais, ASCs, and CSCOMs such as handwashing kits;
- Construction of 426 latrines at ASC sites in seven districts;
- ASCs and relais in Kayes (Kita and Diema) and Sikasso (Bougouni, Kolondieba, Yanfolila, Selingue, and Yorosso) fully functional and supported through effective routine supervision visits;
- PPIUD trainings in collaboration with the national midwifery association;
- Training of women's and youth groups in MNCH/FP messaging and promotion of SEC services; and
- Conducting of health promotion and education fairs at the village level.

Urban Outreach and Social Marketing Program

- FP activities will intensify during the national FP month; additionally, midwives will be trained in cervical cancer screening.
- HIV activities will focus on the youth radio show to be launched during the month of May, and the MSM DELTA workshop is scheduled to take place in June.
- Communication activities will move forward to increase community promotion of ORS/Zinc and Aquatabs in preparation for the rainy season.

World Malaria Day 2013: Making Lifesaving Treatments Available to Children in Rural Mali

Samata village, Mali, is a rural, agricultural community of about 1,200 people located 35 km (more than 21 miles) from the nearest community-owned health center of Djidian, and 75 km (about 46 miles) from the nearest Reference Health Center of Kita. Before the Community Essential Care program was implemented by MCHIP in collaboration with UNICEF and other partners, the villagers in Samata would walk for four hours to seek care in Djidian when their children were sick. Lack of accessible and high-quality health services took the lives of many children, with malaria being the leading cause of mortality.

Toumani Dagno, who is from another village within the Kita district, took interest in the community health worker position (Agent de Santé Communautaire [ASC]) in Samata. He successfully passed the required exam and was appointed as the ASC by the villagers in September 2011. MCHIP provided Toumani with training to address the community's needs and he was officially installed in Samata to provide treatment to children suffering from diarrhea, malaria, and pneumonia.

Motivated by the number of preventable child deaths in Samata, Toumani understood well the need for high-quality services at the community level and the importance of involving local leaders and actors in mobilizing the community. After completing his training, he did not wait long to begin this process, informing villagers about his assignment, requesting help from the community women and youth groups, and initiating discussions to engage and involve the village authorities. As a result, the village happily welcomed Toumani, and his presence and work were met with relief after much suffering.

Since Toumani's work in Samata began, the villagers have come to better understand how important it is to take care of their own health. This community commitment to health now includes a weekly "day of safety" organized by the women and youth groups with Toumani's help. All households in Samata were also encouraged to build latrines and, as kits for proper handwashing became more available, most families began to regularly wash their hands with soap after using the latrines and before preparing or eating food.

Toumani assisted by one of the village chief's advisors during a health education session.
(Photo courtesy of JSI.)

Most important, with MCHIP's help, children in the village now have access to lifesaving treatment. When Toumani's work began, he treated an average of 10 sick children every month. However, his kindness and dedication and the quality of his services quickly made him popular. Now, even parents from neighboring villages approach him to seek care for their sick children. Toumani uses a rapid test to confirm if a fever is caused by malaria before treating a sick child, and a timer to determine if a coughing child needs antibiotics. One year after his work began, the number of clients he sees has increased more than 10 times: from October 2012 to March 2013, he treated a total of 616 sick children in six months. Among them, 437 tested positive for malaria and were immediately given antimalarials; another 10 were severely ill and referred to the nearby health center of Djidian.

M Sidibé Bourama, the 50-year-old advisor to the village chief, described Toumani's work: "We are very satisfied with the work of the ASC in our village. The number of deaths has decreased in our village. In comparison, last year at the same time we have had 10 deaths of children less than five years old, including two of mine. Today, we can thank God; because of the presence of Toumani, we have not yet registered any child deaths. Also, due to his perseverance, we bought our handwashing material and we wash our hands. He became the friend of women to organize a weekly day of safety in the village. There is less travel to the health center to treat children and this has reduced the burden on families for the transport and care."

Samata is one of 100 MCHIP-supported villages in Kita and Djema districts where many children do not have easy access to regular health facilities. And Toumani Dagno is one of the 100 ASCs who have been trained, equipped, and supported by MCHIP in collaboration with UNICEF to provide lifesaving care and treatment to sick children in these hard-to-reach villages.

M Sidibé concluded: "Putting the cock in the cage is the responsibility of the owner; putting the tail in the cage is the responsibility of the cock itself." In other words, MCHIP has made available to the people of Samata village an ASC to provide care; now it is the villagers' duty to organize themselves to use these services.

Malian Midwife Champions Respectful Care for Pregnant Women and their Families

by: Susan Moffson, MCHIP Senior Program Officer

Haoua Ba participating in an MCHIP Africa Champions training in Bobo Dioulasso, Burkina Faso.

The man brings his pregnant wife into the health center and is confronted by the irritated midwife who raises her voice: "I'm too busy, what do you want? Go outside, this is no place for a man!" Later, the man returns for news about his wife's condition and is promptly told to "go back and sit there."

This role play session about abuse and disrespect in maternity care was part of a training in Burkina Faso sponsored by MCHIP. Through role play, MCHIP trainers demonstrated to doctors and midwives what not to do when attending to their patients, as disrespectful treatment of pregnant women and their families is all too common in health facilities around the world. This is especially true in developing countries, where doctors and midwives often lack basic infrastructure, supplies, manpower, or even awareness about patients' rights to be treated with dignity during birth.

Training participant Haoua Ba had never heard about respectful care until this MCHIP training, even after 22 years as a midwife in Mali. Haoua and about 30 other midwives, pediatricians and obstetricians are known as Africa "Champions" (or advocates) for improving maternal and newborn health by promoting up-to-date knowledge, practices and attitudes in their countries and region. Mali is one of 10 key African countries—along with Benin, Guinea, Kenya, Liberia, Madagascar, Senegal, South Sudan, Uganda and Zambia—where the MCHIP Africa Champions Program is being implemented over two years (2011-2013).

MCHIP maternal and newborn health trainings have always emphasized "women friendly care," for example by introducing skills checklists with which providers are evaluated on their ability to provide respectful care. However, given the prevalence of disrespect and abuse—in Africa in particular—and the lack of knowledge about this issue, Africa Champion trainers developed an entire training module devoted to this topic. In this 1.5 hour session, a facilitator helps training participants understand during group discussion that there is evidence that key components of respectful care, such as involving a woman in her care, will make the birth experience go more smoothly for both the woman and the health care provider.

Haoua described how this training session taught her to respect pregnant women and their families by greeting them politely and continually informing them in a soothing voice about everything she is doing. And since the training last year, Haoua has seen a big difference after putting into practice these new skills.

"When you show respect, it really facilitates things," she said. "If you calmly tell the woman what to do and explain things her, it comforts her. And word gets around so women know who is going to treat them well and they request that midwife when they come into the hospital."

Pregnant woman with companion at the renovated maternity ward in Bobo Dioulasso, Burkina Faso.

It is important that women and their families are welcomed and have a positive birth experience at health centers so that they choose to have subsequent children at a health center. Women and their newborn babies have better odds of survival when women deliver in a facility than at more risky home births.

After participating in three Africa Champions maternal and newborn health trainings on innovative, lifesaving practices, Haoua is uniquely positioned to transfer these lessons learned. She plans to do so with both staff and student interns at the busy Referral Health Center in Bamako, Mali, where she also works as a midwife with 22 other midwives and three gynecologists. In fact, one of her primary goals as a Champion is to help strengthen the health center team by promoting evidence-based care. She described how she and one of the doctors will organize trainings about twice a month on a particular theme and have attendees practice on mannequins under their supervision to ensure they are correctly using their newly acquired skills and knowledge.

Importantly, Haoua has taught her colleagues that a woman should be allowed to have a companion by her side during the birth, which is a central tenant of respectful care. Having a loved one present provides women with essential comfort and support during the birth process, especially when the health center staff are busy or overworked. Evidence supports this practice as one that can help to shorten labor.

As MCHIP Africa Champion trainer and obstetrician Blami Dao explained, “Timing can make a big difference. Maybe in the morning, when there are lots of hospital staff, a provider can take good care of the patient. But at two or three in the morning when there may be 10 or 11 patients and only one provider to attend to them, the mood may be very different.”

Seasoned trainer Blami further explained that “health providers behave better where the woman has a companion, because there is an external observer watching them provide care. If the facility can accommodate it, the woman will receive better care if she is not alone.”

Blami is intimately familiar with the challenges that resource poor countries face when it comes to having basic equipment to enable pregnant women to give birth under decent conditions. Blami and his colleagues took advantage of the 2002 renovation of the hospital in Bobo Dioulasso, Burkina Faso, where he was the head of the maternity ward, and wisely made sure that each birthing room was equipped with both a door to ensure privacy, and a chair for a birth companion. Thanks to concerted efforts of people like Blami, this hospital in Bobo Dioulasso is a model of respectful maternity care relative to many other hospitals throughout Africa.

A pregnant woman who must give birth without the company of a loved one or who must lie on the floor because there are not enough tables, without the privacy of a curtain, is not receiving respectful care.

Renovated maternity ward in Bobo Dioulasso, Burkina Faso, where each room has a chair so that the woman in labor can be accompanied by a family member.

But even in the worst conditions, said Haoua, “if you have the will to do things well, you can help women.”

She is a perfect example of how the USAID-funded Africa Champions program is helping to prevent the untold suffering of women during one of the most vulnerable but extraordinary times in their lives.

Country Summary: Mozambique

Period: FY 2013, Quarters 1 and 2

Selected Health and Demographic Data for Mozambique	
GDP per capita (USD)	427.63
Total population	22.9 million
Maternal mortality ratio (deaths/100,000 live births)	550
Skilled birth attendant coverage	54.3
Antenatal care, 4+ visits	53.1
Neonatal mortality rate (deaths/1,000 live births)	30
Infant mortality rate (deaths/1,000 live births)	64
Under-five mortality (deaths/1,000 live births)	97
Treatment for acute respiratory infection	52.3
Oral rehydration therapy for treatment of diarrhea	61.5
Diphtheria-pertussis-tetanus vaccine coverage (3 doses)	76.2
Modern contraceptive prevalence rate	11
Total fertility rate	5.9
Total health expenditure per capita (USD)	24.72

Sources: World Bank, Instituto Nacional de Estatistica Web site, 2010 projection, Mozambique 2011 Demographic and Health Survey, Mozambique Multiple Indicators Cluster Survey 2008, Population Reference Bureau 2011 World Population Data Sheet, WHO, UNICEF.

Major Activities

- **Model Maternities Initiative** (MMI)/integrated maternal, newborn, and child health (MNCH) package:
  - Antenatal care, **malaria in pregnancy**, **PMTCT**
  - Essential obstetric and newborn care and **BEmONC** skills
  - Helping Babies Breathe and Kangaroo Mother Care
  - Postnatal care/**postpartum family planning**
  - Humanization of care
- Integrated family planning
- **Cervical and breast cancer prevention**
- Development of comprehensive in-service MNCH training packages
- **Quality improvement**
- Malaria case management in adults and children
- Community mobilization in support of MMI and the Cervical Cancer Prevention Program (**CECAP**)

Program Dates	April 12, 2011–March 13, 2015					
2012–2013 Budget	$11,317,093					
Mission Funding to Date	April 2011–September 2012: $8,770,180 October 2012–September 2013: $11,317,093 Total: $20,087,273					
Geographic Focus	National					
Geographic Coverage	No. (%) of provinces	11 (100%)	No. of districts	66	No. of facilities	110
MCHIP In-Country Contact	Eric Ramirez-Ferrero, Chief of Party; Eric.Ramirez-Ferrero@jhpiego.org Kathryn Boryc Smock, Senior Program Manager; Kathryn.Smock@jhpiego.org					

HQ Managers and Technical Advisors	Koki Agarwal, Koki.Agarwal@jhpiego.org; Debora Bossemeyer, Debora.Bossemeyer@jhpiego.org; Connie Lee, Connie.Lee@jhpiego.org; Mary Drake, Mary.Drake@jhpiego.org; Jeff Smith, Jeffrey.Smith@jhpiego.org; Veronica Reis, Veronica.Reis@jhpiego.org; Edgar Necochea, Edgar.Necochea@jhpiego.org

FY 2013, Quarters 1 and 2: Achievement Highlights

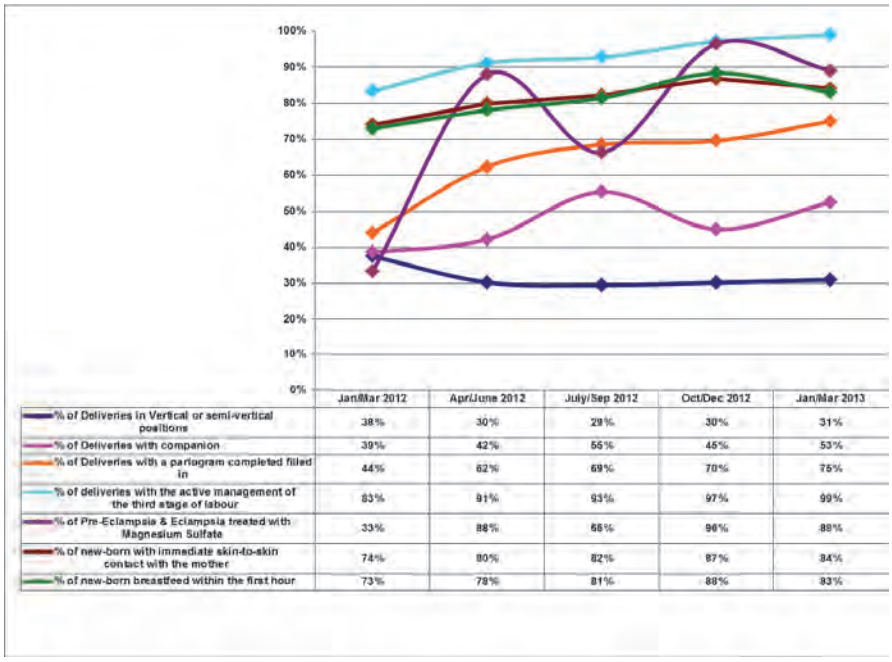
Objective 1: Improved enabling environment.

- MCHIP provided technical assistance to the MOH, in collaboration with AMOG and the Maternal and Neonatal Health working group, to develop a national strategy for the prevention and management of PPH, as well as a rollout plan, which will serve as the basis for implementation of misoprostol initiatives. The draft strategy will be submitted to the MOH for approval in Quarter 3.
- During Quarter 2, a total of 106 Health Committees were created or revitalized, for a total of 186 health committees that are presently functioning with support of the project. Of the 106 committees that were developed during the past quarter, 89 conducted an assessment of the problems affecting their communities using the "problem tree" methodology, and developed action plans based on the magnitude of the problem and the feasibility of proposed solutions.
- Since October 2012, the MCHIP Monitoring and Evaluation (M&E) Team, in collaboration with DPS counterparts, provided onsite technical assistance at 20 health facilities in Nampula, Manica, Sofala, Tete, and Cabo Delgado Provinces. The purpose of this technical assistance is to strengthen each health facility's capacity to use the new MNCH registers and to improve the completeness and quality of data submitted through the national HMIS.
- MCHIP continued to work with the MOH and other partners to revise the national MNCH registers for data collection. The registers are undergoing final revisions to include several key CECAP and malaria-related indicators and will be submitted for final approval to the MOH in Quarter 3.
- MCHIP provided technical and financial support to the MOH to conduct a rapid Data Quality Assessment for the new Maternal and Child Health Registration System. The study sought to determine data completeness, accuracy, and timeliness in reporting during the period January to September 2012 to assess the impact on the provision of health services, to evaluate the health workers' perceptions of the comprehensiveness of information included in the tools, and ultimately to give recommendations for improvement. Some of the findings included: the average data completion rate at roughly 50%; discrepancies among the health facility, district, provincial, and central level data; considerable missing data in the registers; and insufficient numbers of staff trained to complete the registers, and process and analyze data properly.
- MCHIP provided technical assistance to the MOH to complete the report of the first round of the Integrated Services Package Feasibility Study that was conducted in Zambézia and Inhambane Provinces in 2012. The objective of the study was to evaluate the general conditions and level of readiness at selected health facilities for implementing integrated maternal and newborn health services.

Objective 2: Scale up high-impact MNH interventions by assisting expansion of the Model Maternities Initiative (MMI).

- Figure 1 below shows the evolution of selected indicators since January 2012. Ninety of the 94 maternities in the MMI process sent completed data for Quarter 2 (January–March 2013). All indicators show a positive trend, with the exception of the indicator related to the percentage of deliveries in vertical and semi-vertical positions.

Figure 1. Trends of MMI Selected Indicators: January 2012 to March 2013



	Jan/Mar 2012	Apr/June 2012	July/Sep 2012	Oct/Dec 2012	Jan/Mar 2013
% of Deliveries in Vertical or semi-vertical positions	38%	30%	29%	30%	31%
% of Deliveries with companion	39%	42%	55%	45%	53%
% of Deliveries with a partogram completed filled in	44%	62%	69%	70%	75%
% of deliveries with the active management of the third stage of labour	83%	91%	93%	97%	99%
% of Pre-Eclampsia & Eclampsia treated with Magnesium Sulfate	33%	88%	88%	96%	88%
% of new-born with immediate skin-to-skin contact with the mother	74%	80%	82%	87%	84%
% of new-born breastfeed within the first hour	73%	78%	81%	88%	83%

- By the end of March 2013, the MMI expanded from 34 health facilities to 94 facilities. This was enabled by MCHIP support to the MOH to conduct two regional MMI trainings in the Northern and Central regions, resulting in training 65 care workers on essential newborn care, PMTCT, BEmONC, and antenatal care including malaria in pregnancy.
- MCHIP, in collaboration with DPS counterparts in Gaza, Tete, Manica, Sofala, Nampula, Cabo Delgado, and Maputo Province, conducted needs assessments for minor infrastructure improvements to enhance the provision of humanized care at selected health facilities.
- MCHIP supported the MOH to conduct two-day district-level **malaria case management** courses in Chimbunila and Lago Districts in Niassa Province, resulting in training a total of 91 health care workers. MCHIP also supported MIP quality improvement activities by providing technical assistance to health facilities to carry out baseline and internal SBM-R measurements, develop action plans for the MMI including MIP, and provide follow-up to these plans. MCHIP also initiated the elaboration of job aids and updating of the integrated in-service training packages according to the new WHO guidelines on IPTp, in collaboration with the MOH. These job aids will be ready for distribution in Quarter 3.
- MCHIP provided technical assistance to the MOH to develop the package of presentations for trainings in PMTCT and Option B+. MCHIP also provided technical assistance to the MOH, in partnership with UNICEF, to plan and conduct a meeting for the Southern/Central Regions to introduce the Mozambique National Plan for Elimination of PMTCT (2012–2015), discuss the rollout of Option B+, and provide technical assistance to revise the provincial plans, targets, and indicators so they could be aligned with the national plan.
- The Provincial Mentoring Team (which includes DPS counterparts and MCHIP-supported provincial-level MCH nurses) worked with health facility staff to conduct technical assistance and **supportive supervision** and **on-the-job training visits** to 63 MMI facilities during Quarter 1, and 67 during Quarter 2.

- Using the Partnership-Defined Quality (PDQ) methodology, and building on action plans developed by Health Committees, various needs for reinforcing **coordination between maternities and communities** were addressed. To resolve the identified issues at both the community and facility levels, MCHIP created 73 Co-Management Committees, composed of community members and health workers, 58 of which have developed community-facility action plans to address the identified gaps/challenges and are beginning to implement key actions.
- During Quarter 2, 101,426 women and 95,932 men were reached with key messages during group education sessions that promoted MNH practices and behaviors, including the use of waiting houses and community-based emergency transportation. To guarantee consistency in the dissemination of messages, as well as the quality of interventions carried out by community health workers (ACS)/traditional birth attendants, MCHIP conducted supervision visits with Health Committees, 371 ACS, and 213 traditional birth attendants in Nampula, Zambézia, Tete, Manica, Sofala, and Gaza Provinces.

Objective 3: Improve human resources for health, focusing on developing integrated in-service training.

- MCHIP continued its support of strengthening pre-service education in MNCH/RH/FP in partnership with higher education institutions. MCHIP supported ISCISA to develop draft standards on quality and humanization in education, and to provide follow-up and supportive supervision visits for ISCISA graduates trained in MMI and CECAP/FP, placing graduates in three health facilities in Inhambane Province.
- During Quarter 1, MCHIP's PMTCT Technical Advisor facilitated the pre-service training of 28 MCH nursing students in PMTCT/TARV at the Chicumbane Health Training Center, in collaboration with the CDC "Strengthening Safe Hospitals and Clinics in HIV/AIDS Prevention Activities" project. MCHIP also provided technical support and worked in collaboration with other USG-funded partners to review and revise PMTCT materials developed by I-TECH.
- During this reporting period, the Integrated In-Service Training Packages were tested and validated at the provincial level. As a member of the Integrated In-Service Training Packages Working Groups, MCHIP is presently helping to review and incorporate the comments and proposed revisions sent by the provinces. MCHIP also provided technical support to the MOH to review and revise Package 4 to include updates in PMTCT policy and guidelines, including Option B+, and to develop a package of presentations on Option B+. Finally, MCHIP worked with partners to present and review comments on Integrated Package 1 (Community Health); the Package is scheduled to be finalized in Quarter 3.
- MCHIP supported the MOH to conduct training for 190 health care providers from nine provinces in Child Health (Package 5): TATE Component - Triage, Assessment, and Treatment of Emergencies. In addition, MCHIP and the MOH collaborated to conduct regional trainings for 90 providers from the Northern, Central, and Southern regions of Mozambique in the area of Child Health (Package 5: Well-Child/At-Risk Child Component).
- MCHIP and the MOH trained 31 members of partner organizations in the implementation methodology of the Integrated In-Service Training Packages. The purpose of the training was to build synergies in the rollout of the packages and to expand the technical assistance available to address and overcome implementation challenges at the health facility, district, and provincial levels.

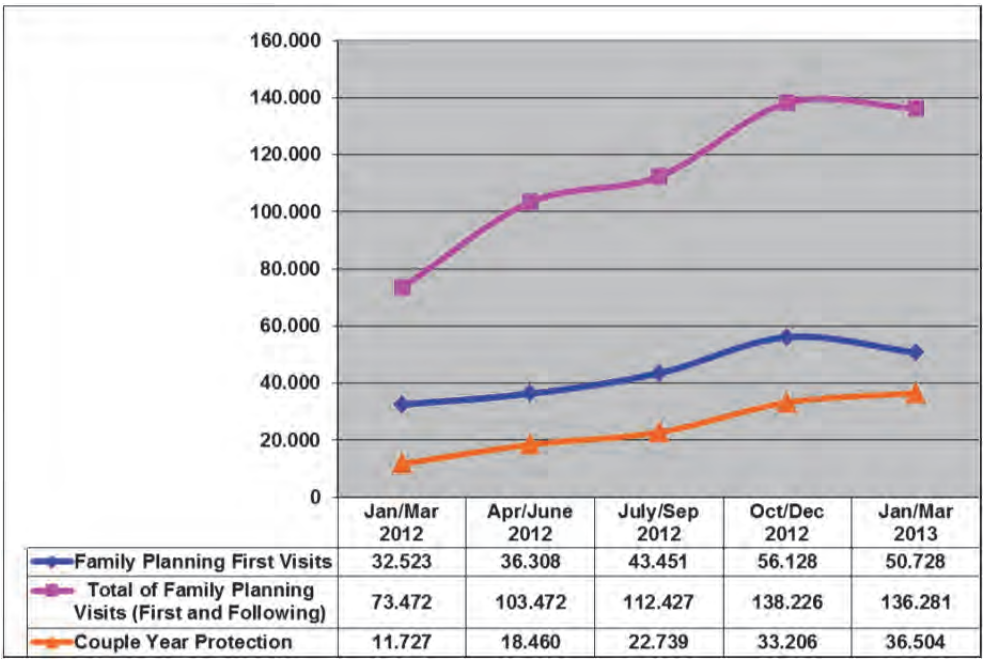
Objectives 4 and 5: Integrate cervical cancer prevention (CECAP) and family planning services.

- By the end of March 2013, MCHIP assisted the MOH to expand the number of health facilities offering integrated CECAP/FP services from 17 to 82. Selected CECAP indicators for Quarter 2 from the 69 sites that sent complete data are presented in the table below:

INDICATOR	JAN–MAR 2013
General information on integrated FP/CECAP services	
No. of women attended at Reproductive Health Outpatient Services (including first and following visits)	108,282
% of women with unknown status tested for HIV	68%
% of women tested HIV+	5.8%
VIA screening of women accessing FP/CECAP services	
No. of VIAs performed	12,916
% of women screened with VIA with a positive result	5.1%
% of VIA+ women who are also HIV+	13.1%
Single visit approach rate (% of VIA+ women treated with cryotherapy the same day)	45%
% of VIA+ women receiving LEEP or colposcopy for treatment of large lesions	29%

- Figure 2 below shows the overall positive trends of three FP indicators from January 2012 to March 2013 in the 96 (out of 124) health facilities providing FP services reporting complete data. In Quarter 2, 49,153 new family planning acceptors were attended to in MMI and CECAP/FP facilities. A small reduction can be observed in first and total (first and following) family planning visits during Quarter 2, although it is important to note that information provided does not include the month of March for several health facilities. Despite incomplete data for March, the couple years of protection (CYP) indicator shows an increase over last quarter, with an estimated 36,230 couples/women protected against pregnancy. This CYP calculation does not include implants or the total number of Depo-Provera doses administered, as the current registers and monthly reports do not collect these data. To address this gap, the FP/RH Outpatient Register Book and Monthly Summary Forms have been revised and updated with support from MCHIP and other partners to include this information.

Figure 2. Trends in Couple Years of Protection and Family Planning Visits from January 2012 to March 2013



	Jan/Mar 2012	Apr/June 2012	July/Sep 2012	Oct/Dec 2012	Jan/Mar 2013
Family Planning First Visits	32.523	36.308	43.451	56.128	50.728
Total of Family Planning Visits (First and Following)	73.472	103.472	112.427	138.226	136.281
Couple Year Protection	11.727	18.460	22.739	33.206	36.504

- MCHIP worked collaboratively with the MOH and other partners to prepare a National Workshop in Advocacy and Lessons Learned in Family Planning. MCHIP also provided technical support to develop several presentations and other materials for the workshop.
- MCHIP also participated actively in the national-level Reproductive Health Commodity Security Task Force. Discussions were held on the forecasting needs for all modern contraceptive methods (Microlut, Microgynon, Depo-Provera, IUD, implants, and female/male condoms) for 2013. The task force also reviewed the requests/requisitions sent by provinces, reached a consensus on quantities to be distributed, and elaborated a distribution plan.
- During Quarter 1, MCHIP, with technical support from Dr. Ricky Lu, Jhpiego Director of Reproductive Health and Family Planning, and Veronica Reis, MNH/SRH Senior Technical Advisor, conducted a review of the CECAP/FP program accomplishments, challenges, and lessons, and provided recommendations to guide the scale-up of the program in Mozambique.
- During Quarter 2, 38 health workers were trained in integrated cervical cancer prevention and family planning services in five provinces (Niassa, Manica, and Cabo Delgado, Maputo Province, and Maputo City) during formal and on-the-job trainings. Of the 38 trained, 31 demonstrated proficiency in CECAP and implant services by the end of the training.
- MCHIP, in partnership with DPS counterparts, provided integrated supportive supervision and technical assistance to 67 CECAP/FP facilities, as well as 63 health facilities in the MMI process, to strengthen the provision of FP services. To address the gap in family planning IEC and counseling materials at health facilities, MCHIP also began developing several job aids (including flowcharts) and IEC materials (posters and pamphlets) that will be finalized, printed/reproduced, and distributed to health facilities during Quarter 3.

- MCHIP supported the development of Quality Standards for Family Planning, VIA and Cryotherapy (Basic Level Services), and Colposcopy and LEEP (Reference Services). MCHIP also provided technical assistance to the Provincial Health Directorates and health facility staff to carry out CECAP SBM-R baseline assessments at seven health facilities in Niassa, Manica, and Cabo Delgado Provinces, where formal training of health workers took place during the reporting period, as well as Gaza and Maputo Province.
- To address demand generation for MNCH/FP/SRH services, MCHIP supported the airing of 83 radio spots in Niassa, Nampula, Manica, Gaza, and Inhambane Provinces, including 25 radio spots promoting family planning (five radio spots/province). The radio spots were aired two to three times per week in three languages (Portuguese and two national languages, depending on the languages most frequently spoken in a given province) during two consecutive months.

Objective 6: Pilot neonatal circumcision.

- In the draft National Male Circumcision Strategy recently developed, the MOH states that neonatal male circumcision is not a priority for the next five years. MCHIP will continue to work with the MOH on advocacy and to further explore the design of a pilot.

Objective 7/8: Leadership in quality improvement.

- In November 2012, MCHIP supported the MOH to hold the National Quality and Humanization of Care (QHC) Meeting, presided by the Minister of Health, Dr. Alexandre Manguele. Approximately 250 participants attended the meeting, including members of QHC 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. During the meeting, participants shared and exchanged progress, experiences, innovations, and major challenges in the area of quality and humanization of care.
- MCHIP disseminated the results of the national QHC meeting to the MOH and key partners, and provided technical support for three provincial QHC committee meetings in Niassa, Maputo Province, and Maputo City, where results from the national meeting were disseminated and workplans were developed for 2013 activities.
- In collaboration with DEPROS, MCHIP trained 129 health workers, including Preventive Medicine Officers and Technicians, MCH Nurses, physicians, entry-level nurses, and Medical Technicians from Cabo Delgado, Maputo Province, Niassa, and Gaza, as well as all health facilities in Vilanculos District, in Community Mobilization and the PDQ methodology. MCHIP also trained 15 staff from partner organizations in community mobilization.
- To increase the visibility of the MOH' s and MCHIP's work in QHC, MCHIP presented Mozambique's experience at the International Alliance of Patients' Organizations international conference on "Healthcare in Africa: the Patient Perspective" on 19 and 20 February in Cape Town. MCHIP also submitted an abstract to ISQua's 30th International Conference on "Setting the Grounds to Improve Quality and Humanize Healthcare: the Case of Mozambique."
- During Quarter 2, MCHIP provided intensified support to the quality improvement process at Model Maternities in four provinces (Cabo Delgado, Manica, Sofala, and Nampula). This was accomplished through onsite technical assistance in training quality improvement teams at the health facility, district, and provincial levels to carry out internal assessments, develop action plans, and monitor the implementation of these action plans.

Priorities for Quarters 3 and 4

- Work with key stakeholders to finalize the draft of the National Strategy and Action Plan for Prevention and Management of PPH, including facility-based and community-based distribution of misoprostol.
- Provide on-site technical assistance to health facilities in data collection and reporting using the new MNCH integrated registers, with a focus on data completeness and quality.
- Support the MOH/DEPROS to conduct the Baseline Community Study on Knowledge, Attitudes, and Practices related to MNCH.
- Plan the next phase of the implementation of Integrated Service Packages for Reproductive, Maternal, Newborn, Child, and Adolescent Health with the MOH.
- Continue providing support for minor infrastructure improvements at selected health facilities to enhance structural aspects related to humanization.
- Support the MOH to further expand the health workforce trained in MMI and integrated CECAP/FP services.
- Collaborate with the MOH and UNICEF to implement one additional regional meeting to disseminate the Mozambique National Plan for Elimination of PMTCT (2012–2015) and to discuss the rollout of Option B+.
- Conduct a three-day training for the MOH and representatives from partner organizations to be members of the external evaluation team for SBM-R.
- Support the MOH to conduct a national TOT in Helping Babies Breathe. Participants will include provincial health staff, members of provincial training institutes, and members of the Health Sciences Institute.
- Support a meeting between the MOH, AMOG, and the Maternal and Neonatal Mortality Committee to review MMR at the institutional level and review/discuss trends in order to identify priority interventions to reduce MMR.
- Provide technical support to the MOH to implement a national advocacy meeting in MNCH to review program accomplishments, challenges, and priorities for the coming year.
- Develop a technology platform for mMentoring, in order to reinforce critical messages/knowledge for evidence-based MNH practices and humanization of care.
- Continue supporting provincial- and district-level meetings with local partners and DPS/SDSMAS to coordinate and monitor community mobilization activities, and support coordination meetings between health facilities and community mobilization agents.
- Support ISCISA to finalize and submit the performance standards on quality and humanization in education for approval during Quarter 3. Support ISCISA to train 40 finalists in the advanced level nursing course in the MMI, CECAP-FP, and SBM-R.
- Support the MOH to complete the draft of Integrated Package 1 (Community Health), and finalize the incorporation of feedback from the testing phase of Integrated In-Service Training Packages 2, 3, 4, 5, and 6, for submission to the Minister of Health for approval.
- Support the MOH to further expand LEEP/colposcopy services to Gaza, Inhambane, Tete, Manica, Nampula, and Niassa referral facilities.
- Provide technical support to the national advocacy meeting (2–22 May) for the Stop Cervical Cancer in Africa National Conference (to be held in July).

- Provide financial and technical support to the MOH to conduct regional trainings on implants and PPIUCD insertion and removal.
- Work with the DPS at the provincial level to strengthen supportive supervision of FP services at MMI and CECAP/FP facilities, with a focus on strengthening balanced family planning counseling.
- Expand radio messaging program to promote demand for family planning and MNH services
- Support a training program in SBM-R for supervisors, administrators, program heads, and partners to review newly developed/revised performance standards.
- Continue providing support to revitalize quality and humanization committees in MMI facilities, as well as to carry out internal measurements, conduct gap analyses, and develop action plans.

Grandmother of Three in Mozambique Saved through Cervical Cancer Prevention Program

In 2002, 61-year-old grandmother Amelia Tamele was diagnosed with HIV. Having worked as a laboratory assistant and in other jobs within Maputo's public health care system, she knew that it was important to begin antiretroviral medications to stay healthy.

And Amelia did stay healthy with treatment until last year, when she began to feel bad. During an examination at Polana Caniço Health Center, Nurse Blanca Catalan found a lesion on her cervix, and did a Pap smear. "The result was not good—it was a high-grade lesion," Amelia said.

Nurse Blanca, a Cervical Cancer Prevention Program Nursing Supervisor working with the MCHIP/Mozambique project, referred Amelia to Mavalane General Hospital for immediate treatment. "Some people told me to wait and pray, but I knew that I needed to be seen right away by the doctor," Amelia said.

Cervical cancer is a major cause of death for women in sub-Saharan Africa: data from the cancer registry at Central Hospital in Mozambique indicates that cervical cancer is the most frequent malignant tumor in adult women. Moreover, 80% of the cases of cervical cancer diagnosed at the largest hospital in Mozambique are already in an advanced stage, when surgical treatment is no longer possible.

Cervical cancer is an even greater risk for women like Amelia, who are living with HIV. Until 2008, there was no national policy, strategy, or program for cervical cancer prevention, screening, and treatment in Mozambique. The National Cervical Cancer Prevention and Control Program was officially launched by the Minister of Health in 2009, and since that time, MCHIP/Mozambique has supported the Ministry to expand the program to 84 health facilities in all 11 provinces of the country.

Amelia went to the referral hospital, where a biopsy was performed that confirmed the diagnosis of a high-grade, precancerous lesion. She quickly underwent surgery for a hysterectomy, and considers herself lucky to have caught her cancer early and to have received the necessary treatment in time.

"After the surgery, I was fine. I don't have any problems," she said, adding that a close friend of hers was not so lucky. The friend passed away recently from cervical cancer, which was already at a very advanced stage when it was diagnosed.

"I wish that she would have gone to the health facilities that I had gone to earlier so that they could have helped her too," Amelia said.

Amelia Tamele is fully healed from her surgery to treat a precancerous cervical lesion.

Country Summary: Namibia
Period: FY 2013, Quarters 1 and 2

Selected Health and Demographic Data for Namibia	
GDP per capita (USD)	$4,700
Total population	2,324,000
Maternal mortality ratio (deaths/100,000 live births)	210
Skilled birth attendant coverage (percentage)	81.4
Antenatal care, 4+ visits (percentage)	70.4
Neonatal mortality rate (deaths/1,000 live births)	18
Infant mortality rate (deaths/1,000 live births)	30
Under-five mortality (deaths/1,000 live births)	42 [63]*
Treatment for acute respiratory infection	-
Oral rehydration therapy for treatment of diarrhea	63
Diphtheria-pertussis-tetanus vaccine coverage (3 doses)	82
Modern contraceptive prevalence rate	55.1
Total fertility rate	3
Total health expenditure per capita (USD)	283

Sources: World Bank, WHO, UNICEF.
*UNICEF <5 mortality ranking (1 = highest mortality rate)

Major Activities

- Revised and resubmitted workplan to USAID
- Commenced start-up activities:
  - Researched office location possibilities, initiated in-country registration process, and began bank account opening process
  - Strengthened partner relations
- Developed Scopes of Work for all full-time and part-time positions and began recruitment for Interim Start-up Manager
- Drafted National Health Information (HIS) strategy

Program Dates	October 2012–June 2014					
PY 5 Budget	$1,600,000 (October–September 2013)					
Total Mission Funding to Date	$800,000					
Geographic Focus	*National; Kunene and Kavango Districts*					
Geographic Coverage	No. (%) of provinces	2 (13%)	No. of districts	1	No. of facilities	0
MCHIP In-Country Contact	TBD					
HQ Managers and Technical Advisors	Patricia Taylor: ptaylor@mchip.net Jennifer Melgaard: jmelgaard@mchip.net					

Namibia is one of The United States President's Emergency Plan for AIDS Relief (PEPFAR) countries, achieving positive results in prevention, treatment, and care since the early 2000s. Based on these successes, PEPFAR recently named Namibia as a "transitioning" country, meaning the Government of Namibia (GRN) will begin to cover costs previously covered under PEPFAR. During this transition, USAID will continue to support health systems strengthening in Namibia.

FY 2013, Quarters 1 and 2: Achievement Highlights

MCHIP's program in Namibia, supported by USAID, focuses on providing the GRN with technical assistance to strengthen human resources management and development by working with the Ministry of Health and Social Service (MOHSS) in a number of other ways to maintain past achievements in HIV/AIDS and TB services. An initial program description was sent to MCHIP in September 2012; in November 2012, an MCHIP team conducted the initial assessment and a first draft workplan was submitted in January 2013 with *provisional* approval granted to begin some activities. A final workplan was sent in May 2013 and is currently pending final approval.

With *provisional* approval of the Namibia workplan, MCHIP has engaged in start-up research activities in Windhoek, including evaluating potential office locations, exploring recruitment needs, identifying local registration requirements, and opening a local bank account. During this start-up phase, MCHIP is working to align technical activities with those of program implementation partners including: the MOHSS, FHI360's C-Change, UNICEF, WHO, IntraHealth, the Centers for Disease Control and Prevention (CDC), and Abt Associates.

The Namibia MCHIP country workplan comprises four very distinct components focusing on scale-up of the newly created Health Extension cadre and the Health Extension Program (HEP); the integration of HIV services with primary health care services; the design and implementation of a pregnancy-prevention program in Kavango Region; and the development and implementation of a national Health Information System (HIS). An assessment is currently being done to explore opportunities of developing and implementing a Voluntary Medical Male Circumcision (VMMC) program under MCHIP as well.

MCHIP/Namibia's Main Objectives

Objective 1: Institutionalize the Health Extension Worker cadre and build capacity at all levels to take the Health Extension Program to scale.

Objective 2: Provide the GRN with evidence-informed strategic approaches and models for integration of HIV/AIDS services in Primary Health Care.

Objective 3: Design and implement a pregnancy-prevention program in Kavango region with stakeholders.

Objective 4: Design and implement a national HIS strategy.

Priorities for Quarters 3 and 4

- Facilitate final approval of the workplan.
- Continue with office start-up activities: in-country registration; hiring of staff; and securing co-location office (share with USAID partner, if possible).

- Finalize the revision of the HEP training materials, develop Standard Operating Procedures and begin expedited expansion of the HEP.
- Support the GRN to establish national guidelines and procedures to implement a coordinated response for HIV integration into primary health care services and identify three health facilities as HIV-PHC integration "learning labs."
- Design and implement a pregnancy-prevention program in Kavango region, working closely with stakeholders.
- Finalize the national HIS strategy in partnership with the MOHSS Technical Working Group.
- As the MOHSS priority for the HIS system, develop essential indicators, hospital-specific indicators, and a master health facility and patient identifier coding system.
- Assess opportunities for a Voluntary Medical Male Circumcision component to be added to the MCHIP workplan.

Saving Mothers' Lives with Calcium: An Innovative Program in Nepal to Prevent Pre-Eclampsia

by: Dipendra Rai and Yeshoda Aryal

Dailekh, Nepal – While attending her prenatal care visits, Sunita learned about a new program offered by the Government of Nepal that gives pregnant women calcium supplements for free. The 25-year-old mother of three knew the value of calcium: it reduces the risk of a potentially fatal pregnancy-related condition. But, at $10, it was too costly.

A pregnant woman receives a free supply of calcium at a health facility participating in Nepal's program to prevent pre-eclampsia/eclampsia, the leading cause of maternal deaths in the country.

Through the new calcium supplementation program, Sunita can now get the calcium that will help reduce her risk of pre-eclampsia, which if left untreated can lead to eclampsia—the leading cause of maternal death in Nepal. Sunita visited the local health clinic in her home district of Dailekh. There, she was examined for symptoms of pre-eclampsia, including high blood pressure and elevated levels of protein in the urine, and counseled on calcium use. Before leaving, she received two bottles of calcium and an informational brochure.

Sunita is one of nearly 5,000 pregnant women in Dailekh who have participated in the calcium supplementation program. This intervention is being implemented by the Family Health Division of the Nepal Ministry of Health and Population (MoHP), with support from the U.S. Agency for International Development's Maternal and Child Health Integrated Program (MCHIP), which is led by Jhpiego.

This innovative calcium intervention could mean 50 percent fewer mothers and babies who need emergency care, which is especially critical in places where women cannot easily reach a hospital. In the remote villages of Nepal, accessing health care can mean a several-hour walk through mountainous terrain.

Because pre-eclampsia/eclampsia can develop rapidly and it can be difficult to predict who might be at risk, the MoHP and MCHIP started the program in Dailekh. Together, they launched the pilot in August 2012, after training 268 health workers and 789 female community health volunteers. Now in Dailekh, a pregnant woman who comes for even one prenatal care checkup receives a supply of calcium tablets for the duration of her pregnancy.

Since participating in the program, Sunita has encouraged other women to receive prenatal care and take calcium. Upon meeting an MCHIP staff member, Sunita said, "I already finished one bottle and started the second bottle, and I am feeling better. I have recovered from the weakness which I was experiencing."

This program is yet another example of a successful collaboration between Jhpiego and the Government of Nepal. Almost a decade ago, Jhpiego worked in partnership with the MoHP to help reduce the number of women dying from postpartum hemorrhage (PPH), which was the leading cause of maternal death at the time. The innovative PPH program trained community health workers to educate pregnant women and their families on the use and benefits of misoprostol, as well as how to properly distribute this lifesaving medication to women who could not reach a health facility to give birth. The program was so successful in preventing PPH at home births that the MoHP has since expanded the intervention from 31 to 75 districts.

Sunita is one of the thousands of women in Dailekh district to benefit from calcium during her most recent pregnancy. (Photo by Dipendra Rai.)

Ultimately, the calcium supplementation program seeks to demonstrate that women are interested in receiving calcium and taking it throughout their pregnancy. Thus far, the free supplementation has proven to be so popular that the number of women who have received calcium has exceeded expectations. Based on these findings, the government will consider providing it for free to all pregnant women in Nepal, as it already does with iron/folic acid tablets.

Country Summary: Pakistan

Period: FY 2013, Quarters 1 and 2

Selected Health and Demographic Data for Pakistan	
Total population	182,000,000
Maternal mortality ratio (deaths/100,000 live births)	260
Skilled birth attendant coverage	45
Infant mortality rate (deaths/1,000 live births)	70
Neonatal mortality rate (deaths/1,000 births)	58
Under-five mortality (deaths/1,000 live births)	87
Modern contraceptive prevalence rate	19
Total fertility rate	3.4

Sources: World Bank, Mali 2006 Demographic and Health Survey, WHO, UNICEF.
*UNICEF <5 mortality ranking (1=highest mortality rate).

Major Activities

- MNCH Services Project:
  - Deliver high-quality FP and MNCH services
  - Improve quality and coverage of those services
  - Strengthen public-private partnerships
- FATA-KP Health Program:
  - Improve availability and access to MNCH services
  - Increase use of high-impact services and practices

Program Dates	MNCH Services Project: February 5, 2013–September 30, 2017 FATA-KP Health Program: September 30, 2013–September 30, 2017
2012–2013 Budget	MNCH Services Project: $46,500,000 FATA-KP Health Program: $33,000,000
Geographic Focus	MNCH Services Project: Sindh District FATA-KP Health Program: Federally Administered Tribal Areas – Khyber Paktunkhwa
MCHIP In-Country Contact	MNCH Services Project: Shahida Azfar (COP) Shahida.Azfar@jhpiego.org FATA-KP Health Program: aftab.ihsan@savethechildren.org
HQ Managers and Technical Advisors	Nabeel Akram, Nabeel.Akram@jhpiego.org; Deirdre Russo, Deirdre.Russo@jhpiego.org; Laura Fitzgerald, Laura.Fitzgerald@jhpiego.org; Jeffery Smith, Jeffrey.Smith@jhpiego.org; Anita Gibson, agibson@mchip.net; Rebecca Levine, rlevine@mchip.net

FY 2013, Quarters 1 and 2: Achievement Highlights

The MNCH Services Project, a component of USAID/Pakistan's Maternal and Child Health Program, is being implemented by MCHIP, a consortium led by Jhpiego with Save the Children and John Snow, Incorporated as associate partners.

The objective of the project is to increase access to maternal, newborn, and child health services for mothers and children in Sindh Province through: 1) building capacity of health workers to deliver high-quality family planning, maternal, newborn, and child health services; 2) improving quality and coverage of those health services; and 3) strengthening of public-private partnerships.

The MNCH Services Project was awarded to Jhpiego on February 5, 2013, and will cover a five-year period from 2013 to 2017.

The Project will undertake some Sindh Province-wide activities, while implementing an integrated package of MNCH services in selected districts within the Province. The selection of the initial districts for Year 1 in Sindh was based on key indicators via an objective, rational selection process. In these districts, the MNCH Services Project will implement an Essential Services Package that spans the household-to-hospital continuum of care by improving the quality of existing public and private MNCH services, supporting newly established Midwife-Led Birthing Centers (MLBCs), and introducing a targeted community mobilization campaign.

The overall strategy of the program is to support synergy, scale, and system development for sustainability, innovation, and regular program activities. The essential package will be implemented through: 1) health service delivery, 2) community mobilization, 3) capacity development, and 4) public-private partnerships.

The overall salient features of the project include:

- Innovation through partnerships and use of technology
- Strengthening of existing capacity and utilization rather than creation of a parallel system
- Support for entrepreneurship and empowerment of health service delivery providers
- Ensuring effective and timely monitoring and evaluation

The overall goal of the project is to help avert 2,550 maternal deaths, 57,725 newborn deaths, and 81,000 child deaths within the project period.

The FATA-KP Health Program approach builds on the successes and lessons learned from the current ICH Project and experience; learning from Save the Children's (SC) public-private partnership initiative in Battagram District; advocacy, community mobilization, and the Partnership-Defined Quality (PDQ) approaches of the Pakistan Initiative for Mothers and Newborns (PAIMAN); family planning (FP) behavior change and service delivery experience under the Family Advancement of Life and Health (FALAH) Project; SC's community case management of pneumonia project in Haripur District; and Jhpiego's work under the Primary Healthcare Revitalization, Integration and Decentralization in Earthquake-affected areas (PRIDE) Project in using performance standards to strengthen MNCH services.

The MCHIP FATA-KP Health Program will support the Department of Health (DOH) in KP and the Directorate of Health (DH) in FATA to achieve the objectives of the DOH Health Strategy and the FATA Sustainable Development Plan, as well as the achievement of USAID/Pakistan's Maternal and Child Health Initiative goals and objectives. The program will contribute to achieving the development objective of USAID/Pakistan's Health Strategy: Improved maternal

and child health outcomes in the target areas, through intermediate results 1 and 3 (i.e., Improved access to integrated family planning, maternal and child health care services and Strengthened health system, respectively). The key technical interventions for MNCH and HTSP services under the proposed MCHIP program are designed with an integrated approach and will be complemented and supplemented by health system strengthening interventions that align well with USAID/Pakistan's Health Strategy. In addition, MCHIP focuses on building capacity of the public sector to improve access, availability, and quality of health care services, as well as strengthening provincial and district health management, which will further contribute to USAID/Pakistan's Stabilization Strategy and its intermediate result of improved government service delivery in the FATA/KP.

Activities Implemented

The MCHIP Associate Award, which began on February 5, 2013, builds on work completed under field funding, which began in early 2012. Under field funding, MCHIP started a dialogue with the Provincial Government of Sindh on various issues. The following activities/deliverables were completed under field funding:

- In the first quarter, secured office space and hired new staff members. Additional staff are currently being interviewed and staffing up remains a critical component to catching up during the second quarter.
- Wrote GBV reports and shared with USAID, drafted SOWs for local sub grantees working in service delivery, and established MLBC Technical Advisory Groups (TAG) in Sindh Province. A report on the GBV situation and a strategic plan were shared with USAID as part of field fund support. MLBC operational and performance standards were discussed among the TAG group and a decision was made to review technical standards by the MNCH program, Midwifery Association of Pakistan (MAP), and National Committee for Maternal and Newborn Health (NCMNH). Documents were reviewed by the concerned organizations; they provided their feedback and planned to present it at the second meeting. TAG TOR and membership were endorsed during the meeting.
- Developed detailed action plans for Postpartum Hemorrhage Prevention and Management in Sindh and collaborated with USAID MCH Program Component #4: Health Commodities (implemented by USAID-funded JSI's DELIVER Project) to successfully advocate for adding misoprostol to the Essential Drug List (EDL) in Punjab. The DELIVER Project will host a similar discussion for Sindh and Balochistan at the beginning of April. Sindh has already included misoprostol in the PC-1 for procurement (currently under review by the Planning Commission).
- Initiated implementation of the MLBC component of the MNCH Services Project via a consultative meeting in September 2012 with key stakeholders from Sindh Province. In close collaboration with key stakeholders, finalized operational standards for MLBCs. Began mapping of all five focus districts, established the MLBC Technical Advisory Group for Sindh Province and held two meetings. To date, the TAG has endorsed guidelines/ specifications for MLBC infrastructure, as well as lists of essential supplies and equipment. In the first year, the Project will continue to utilize the MLBC TAG to ensure systematic and decisive input for the successful implementation of the MLBC concept. Quarterly meetings will ensure that programmatic decisions are taken in a timely fashion.

- Held meetings with DKT to coordinate CMW verification in selected districts. Developed concept papers on MLBC including an equipment and supply list for MLBC and draft budget for establishing one MLBC. Meetings with the organizations for project orientation, such as RSPNs, HANDS, and Integrated Health Services (IHS), were held with the perspective of exploring potential partners as sub grantees for project implementation. In addition, held meetings with Abu Zafar Institute of medical sciences (AZIMS), AKUSONAM, and HANDS, and discussed possible collaboration on supportive supervision mechanisms and trainings. Finally, meetings were organized with UNICEF, DoH (Director General Health, Provincial Project Director Sindh), and PSI/Greenstar to work on the priority MNCH areas for the BCC campaign; areas were identified and sent to PSI, as well as feedback on logo options.
- Held preliminary discussions with Stimulus as a potential "capacity development" for CMWs. Designed partnerships with two key private sector organizations: DKT, a social marketing company, and Aman Foundation, a not-for-profit organization. The nature of these collaborative partnerships and the key activities proposed for each partner are detailed in Section 4.
- Completed Terms of Reference for a business advisory firm, issued an RFP, and received 13 proposals. These proposals are currently under review by the MNCH Services Project Evaluation Review committee. Short-listed companies, as well as analysis criteria and evaluations, will be shared with USAID for review and approval by late April. Details about the business advisory firm, and the number and nature of training, are noted in Section 1.
- Liaised with USAID-supported MCH partners (DELIVER, PSI/Greenstar and MSS) to outline opportunities for collaboration. Preliminary Excel documentation about organizations (who, where, and what) working in Sindh for mapping was completed.
- Completed preliminary compilation of available secondary district wise MNCH situation/ services data (analysis pending).

FATA-KP Health Program, Quarter 2 (January to March 2013) focused on: catching up on delayed interventions; developing a fast-track workplan to achieve targets; conducting separate strategic planning workshops with health authorities of KPK and FATA; incorporating recommendations within the detailed implementation plan in the strategic planning workshops held with the DG Health office, KPK, and Directorate of Health Services, FATA; signing MoUs with government authorities; setting up district-based offices in Malakand Division; hiring consultants and firms for a baseline survey; designing the SBCC strategy; conducting a gender analysis; and hiring of remaining staff for the program. By the end of the quarter, all remaining positions were filled.

In this quarter, the team conducted rigorous follow-up on NOC with an application for FATA submitted to the Directorate of Projects, FATA, on appropriate formats and for Malakand to PDMA. The latter was returned because this program did not fit under the domain of PDMA. The team plans to meet the Commissioner of Malakand Division and acquire a letter of support allowing FKHP staff to work in Malakand Division. This letter is expected to be issued in April 2013.

For rolling out different training activities, trainer's and participant's manuals were adopted and printed in this quarter. The first IMNCI Training of Trainers (TOT) for FATA health staff was conducted in March 2013. The training on gender sensitization for program staff was conducted in Peshawar, and agency-based training on supportive supervision for Lady Health Supervisors of the National Program was also conducted in Mohmand and Bajaur during the reporting quarter.

Priorities for Quarters 3 and 4

The MNCH Services Project

- An EOI for seeking service delivery, community mobilization, and technology sub-awardees will be advertised.
- Meetings with GOS/DOH Health Sindh and District Offices will be held.
- An RFP for service delivery, community mobilization, and a technology firm will be approved by USAID, shared with selected firms, and respective pre-bid meetings will be held.
- Service delivery, community mobilization, technology, and business advisory sub-awardees will be selected and oriented.
- Site strengthening of two Karachi-based midwifery training institutions (i.e., Koohi Goth and HANDS) will be initiated.
- Assessment of Tharparkar DHQ hospital and Countess Deferens CDF training hospital will be completed.
- A six-day clinical update training of Koohi Goth and HANDS midwifery institution tutors and DHQ Tharparkar labor room staff will be held to strengthen these institutions.
- The Essential Services Package will be endorsed through a provincial consultative workshop.
- Performance standards for implementing ESP will be established through a provincial workshop.
- Tracking and identification of CMWs for construction of MLBCs in Year 1 will be completed.
- Skills assessment of all active CMWs and the first batch of pre-active CMWs will be completed.
- A CMW Training Plan for Year 1 will be finalized and implementation will begin.
- Review of all training curricula and materials will be completed—for group training, on-the-job training, and refresher trainings.
- MLBC sites for Year 1 will be finalized and eight MLBCs will be constructed/upgraded during the next quarter.
- On-the-job training for all active 47 CMWs selected by the Project for establishing MLBCs in Year 1 will be initiated.
- Refresher training of one batch (10) of pre-active CMWs selected by the Project for developing Year 1 MLBCs will be completed.
- A service contract with MAP/NCMNH and Aga Khan University for implementation of misoprostol and HBB across the province will be signed.
- Training of Master Trainers on misoprostol and HBB will be completed.
- A community mobilization intervention strategy will be endorsed by the LHW Program.
- Training of LHW trainers on the support group methodology will be completed.
- MOUs with DKT, AMAN, ZAFA, and Pfizer will be signed.
- The third MLBC TAG meeting will be held.
- An oxytocin policy briefer will be submitted for approval by the Government of Sindh.

The FATA-KP Health Project

- Symbolic Project launching ceremony.
- Hiring and awarding of contract to consultants/firms for conducting formative assessment, development of the SBCC strategy, gender analysis, and baseline surveys.
- Selection of partners (NGOs) for provision of outreach services in areas not covered by LHWs.
- Capacity building of health care providers on IMNCI, EMNC, HTSP, supportive supervision, IYCF, ENA, CCM, DHIS, LMIS, and training of health managers on planning and budgeting.
- Continued provision of health services through MHUs and CMHDs in FATA.
- Formation of QITs.

Country Summary: Rwanda

Period: FY 2013, Quarters 1 and 2

Selected Health and Demographic Data for Rwanda	
GDP per capita (USD)	521.71
Total population	10,537,222
Maternal mortality ratio (deaths/100,000 live births)	476
Skilled birth attendant coverage (percentage)	69
Antenatal care, 4+ visits (percentage)	35
Neonatal mortality rate (deaths/1,000 live births)	27
Infant mortality rate (deaths/1,000 live births)	50
Under-five mortality (deaths/1,000 live births)	76
Treatment for acute respiratory infection	28
Oral rehydration therapy for treatment of diarrhea	39.1
Diphtheria-pertussis-tetanus vaccine coverage (3 doses)	97
Modern contraceptive prevalence rate	45
Total fertility rate	4.6
Total health expenditure per capita (USD)	48.18

Sources: World Bank, Rwanda 2010 Demographic and Health Survey, Rwanda 2012 population and housing census, WHO, UNICEF.
*UNICEF <5 mortality ranking (1 = highest mortality rate)

Major Activities

- Continued the malaria prevalence study by analyzing MIP study samples with PCR tests, finalizing data entry and writing of the report
- Supported malaria forum report writing
- Contributed to the Rwanda malaria impact evaluation
- Initiated PPH prevention at community level using misoprostol by conducting a study in four districts
- Supported MoH in participation in KMC international conference
- Handed over the modern medical incinerator to Kayonza district

Photo courtesy of John Healey.

Program Dates	October 1, 2009–September 30, 2013					
2012–2013 Budget	$550,000					
Mission Funding to Date	October 2008–September 2009: $570,800 October 2009–September 2010: $1,831,999 October 2010-September 2011 : $4,905,540 October 2011-September 2012 : $5,333,561 October 2012 – September 2013 : $550,000 Total: $12,641,900					
Geographic Focus	National Level and Rubavu, Nyanza, Gakenke, and Musanze for the PPH study					
Geographic Coverage	No. (%) of provinces	4 (80%)	No. of districts	7	No. of facilities	64
MCHIP In-Country Contact	Jérémie Zoungrana: jeremie.zougrana@jhpiego.org					
HQ Managers and Technical Advisors	Koki Agarwal: kagarwal@mchip.net; Nancy Ali: nancy.ali@jhpiego.org; Rachel Favero: rachel.favero@jhpiego.org					

FY 2013, Quarters 1 and 2: Achievement Highlights

- Continued work on a "Study to Determine the Current Prevalence of Malaria Detectable among Pregnant Mother Registering for ANC in Six Districts in Rwanda" by Johns Hopkins University laboratory analysis of the PCR samples. Data entry was finalized and data analysis conducted.
- Supported the malaria forum report by writing and editing the report.
- Contributed to the Rwanda malaria impact evaluation.
- Initiated PPH prevention at community level using misoprostol by conducting a study in four districts: During this period, the PPH study continued with data collection at the community level and supervision of the community and health center by MCHIP. Data collection was finalized and analysis is ongoing.
- Supported the MoH in participating in the KMC international conference: A team from Rwanda participated in the IX KMC international conference in Ahmedabad, India.
- Handed over of the modern medical incinerator to Kayonza district.

Narrative of Major Accomplishments

- **During this period, MCHIP continued the study to determine the current prevalence of detectable malaria among pregnant mothers registering for ANC in six districts in Rwanda:** The study has been ongoing since November 2011. Data have been collected and microscopies have been done at selected health centers to detect malaria among pregnant women coming for their first antenatal care visit; PCR samples were collected and sent to JHU for results.
- During this period of October to March 2013, data entry was finalized and data analysis was completed. The writing of the report was initiated and the first draft is available to be shared with the Ministry of Health.
- **Supported malaria forum report writing:** During this quarter, in collaboration with the MOPDD team, MCHIP continued its contribution to the writing of the malaria forum report. The report has been edited by Jhpiego's Publications unit and the final draft is available for review.
- Contribution to the Rwanda malaria impact evaluation

The goal of the Roll Back Malaria Partnership (RBM) is to reduce the number of malaria cases and deaths by 50% by the year 2010 and to reduce the global incidence of malaria by 75% by 2015 through the scale-up of four proven interventions: indoor residual spraying (IRS), insecticide-treated nets (ITNs), artemisinin-based combination therapy (ACTs), and intermittent preventive treatment of pregnant women (IPTp). To assess progress toward this goal, in 2010 RBM and partners started evaluations in a number of countries. The impact evaluations will assess whether or not changes have occurred in all-cause under-five mortality. All-cause under-five mortality is used as a primary measure of impact because of the difficulty in directly measuring levels and trends in malaria-specific mortality in sub-Saharan Africa. The evaluation will be guided by the RBM Monitoring and Evaluation Reference Group (MERG) recommendations on using indirect methods and models to measure the change in malaria-specific mortality.

In Rwanda, the purpose of this effort is to support the Ministry of Health to assess progress toward achieving national and international goals and targets that result from the combined efforts of the Government of Rwanda and other partners involved in malaria control in the country for the 2000–2010 timeframe.

MOPDD is leading the Rwanda impact evaluation. The RBM Partnership provides coordination assistance while the President's Malaria Initiative (PMI) provides funding and on-the-ground assistance through its resident advisors and MCHIP. Additional support will be provided by ICF International for data analyses. Other stakeholders will be encouraged to support the effort through participation in meetings and technical reviews. During this period of October 2012 to March 2013, MCHIP made initial contacts with the MOPDD to conduct the Malaria Impact Evaluation (Malaria IE). Key documents to be used in the Malaria IE were reviewed and writing of sections of the evaluation began. MCHIP continued to participate in the IE conference calls scheduled every three weeks and provided updates on the progress of the activity. MCHIP made contributions to a summary report detailing implementation of the activity; the report aimed to obtain an authorization from the Minister of Health to implement the activity. An agreement was reached and the Minister of Health has concurred that the activity can be conducted. MCHIP participated in various meetings with the MOPDD for preparation of a workshop to build capacity for the writing of the Malaria IE report. A workshop was organized at Centre Saint Andre in the Muhanga district from 16–18 January 2013. The agenda and objectives of the workshop were the following:

- Identify and address analytical gaps and move forward with the impact evaluation report,
- Complete analyses of any additional, supplementary databases available to complement the work already done on national household survey databases,
- Work with colleagues who are conducting analyses of Sis-com (government database) and plan and implement analyses specifically tailored for the impact evaluation, including updating risk maps, and
- Discuss/plan/conduct any further analyses of DHS data.

The facilitators of the workshop were from ICF, and participants were from PMI Washington and Rwanda, the MoH, and MCHIP Rwanda. MCHIP was responsible for organizing the workshop.

At the end of the workshop, participants reached a consensus and shared responsibility on how to finalize the IE report.

Post-workshop, the Rwanda team has met twice to write up sections of the report. MCHIP hosted those meetings and participated actively.

- **Initiation of PPH prevention at community level using misoprostol by conducting a study in four districts.** Rwanda has a very high maternal mortality ratio, and postpartum hemorrhage is the main cause of maternal death. A comprehensive approach to the reduction of PPH must address both births in facilities (or as a proxy, births with a skilled attendant) and births at home (without a skilled attendant). To help address high maternal mortality, and in collaboration with MCHIP, the Rwanda Ministry of health has been conducting a study since 2012 on "Increasing Access to Prevention of Postpartum Hemorrhage Interventions for Births in Health Facilities and at Home in Four Districts of Rwanda."

During the period October 2012 to March 2013, the study continued with data collection at the community level and supervision of the community and health center by MCHIP and MoH staff. Prof. Blami Dao conducted a one-week trip from 5–9 November 2012 to provide guidance on the progress of the PPH study. The trip objectives were to:

- Visit selected study sites with country staff to assess the progress of the study,
- Review the quality of data collected since the beginning of the study, and
- Work with the country study team to address any pending issues.

During this period, data collection was completed and data entry initiated.

- **Support to the MoH to participate in KMC international conference:** A team from Rwanda participated in the IX KMC international conference in Ahmedabad, India. MCHIP supported the participation of one MoH staff member and one Jhpiego staff member. Rwanda shared the results of the KMC assessment conducted by MCHIP and Save the Children/SNL.
- **Official handover of the modern medical incinerator to Kayonza district.** The medical incinerator that USAID provided to the MoH and installed in Kayonza district through MCHIP was officially handed over on 25 October in the presence of the USAID health service delivery Team Leader, Jhpiego Vice President, Kayonza Vice Mayor in charge of social affairs, and the MoH individual in charge of hygiene.

Challenges and Opportunities

- USAID and MoH/District support to MCHIP has been helpful in the implementation of activities at all levels.
- Limited funding, due to the new bilateral (awarded to another organization), has been a challenge.
- There has been a lack of precision in the scope of work, which has been changed a number of times.

Country Summary: Senegal

Period: FY 2013, Quarters 1 and 2

Selected Health and Demographic Data for Senegal	
GDP per capita (USD)	1,119.00
Total population	12,770,000
Maternal mortality ratio (deaths/100,000 live births)	410
Skilled birth attendant coverage	52
Antenatal care, 4+ visits	40
Neonatal mortality rate (deaths/1,000 live births)	27
Infant mortality rate (deaths/1,000 live births)	50
Under-five mortality (deaths/1,000 live births)	95
Treatment for acute respiratory infection	49.9
Oral rehydration therapy for treatment of diarrhea	42
Diphtheria-pertussis-tetanus vaccine coverage (3 doses)	83
Modern contraceptive prevalence rate	12
Total fertility rate	4.8
Total health expenditure per capita (USD)	67.00

Sources: World Bank, UNICEF, WHO.
*UNICEF <5 mortality ranking (1 = highest mortality rate)

Major Activities

- Collaborated with partners to plan and implement mass vaccination campaign against meningococcal A meningitis with MenAfriVacTM
- Launched Vaccinology pre-service training certification course with the University of Dakar School of Medicine
- Participated in planning of National Logistics Inventory and Effective Management of Vaccines
- Provided technical assistance to the National Immunization Coverage Survey

Program Dates	Workplan approved June 2012: January 2012–September 2013, no-cost extension request submitted for June 2014.					
PY 5 Budget	$540,542					
Total Mission Funding to Date	$700,000					
Geographic Focus	National and subnational (3 regions: Matam, Kaffrine, and Kolda)					
Geographic Coverage	No. (%) of provinces	3 (21%)	No. (%) of districts	3	No. (%) of facilities	0
MCHIP In-Country Contact	Hassane Yaradou: hyaradou@jsisen.org					
HQ Managers and Technical Advisors	Koki Agarwal: kagarwal@mchip.net; Patricia Taylor: ptaylor@mchip.net; Michel Othepa: mothepa@mchip.net; Kelli Cappelier: kcappelier@mchip.net; Kaili Mumme: kmumme@mchip.net					

FY 2013, Quarters 1 and 2: Achievement Highlights

In the last decade, Senegal experienced a significant increase and then a sharp decline in its routine immunization coverage, resulting in measles and polio outbreaks in 2009 and 2010. In 2010, USAID Senegal requested technical assistance from MCHIP to work with the Ministry of Health (MOH) and its National Immunization Program on a comprehensive external Immunization Program (EPI) review, combined with an immunization coverage survey, in response to the declining immunization coverage. Based on findings from the review, MCHIP assisted the EPI to identify factors that were contributing to declining routine immunization coverage, and then presented the EPI review and coverage survey findings and recommendations to MOH officials and partners during a special Interagency Coordinating Committee (ICC) meeting. These recommendations are the foundation of MCHIP's work in Senegal to strengthen the routine immunization system, increase vaccination coverage, and prepare the country for the introduction of new vaccines.

Objective 1: Reinvigorate the routine immunization system to increase immunization coverage, maximize investments in new and underused vaccines, improve data quality and reduce inequities among hard-to-reach populations.

- **Launched the Inter-University Diploma (IUD) on Vaccinology:** MCHIP is collaborating with the University of Dakar to integrate principles of the WHO Mid-level Managers training course for immunization program managers into medical curriculum, resulting in the Inter-University Diploma on Vaccinology. MCHIP is also working with University professors to design curriculum materials, and assisting in guest lectures. This pre-service training course will lead to better-trained graduates on immunization program management, which will in turn strengthen the routine immunization system by providing better capacity to deliver services.
- **Routine immunization strengthening:** In an effort to improve immunization coverage in poorer performing districts, MCHIP is collaborating with partners IntraHealth and ChildFund to implement the RED approach and other high-impact interventions. The team is selecting three regions where they will implement proven approaches such as micro-planning, monitoring, and use of data for decision making and measure how these interventions impact the immunization program. Focus districts have not yet been selected, but will be prioritized based on coverage, proportion of under-vaccinated children, and overlapping where partners are working at the operational level.
- **Effective Management of Vaccines (EVM):** The Effective Management of Vaccines (EVM) was conducted and followed by the national logistics inventory. The MCHIP Senegal team supported these activities by providing technical input and guidance for the development of forms to collect logistics information and tools, training workshops to plan and train staff for the logistics inventory and implementation of activities. Gaps in cold chain and logistics were identified through the logistics inventory.
- **National Immunization Coverage Survey:** MCHIP provided technical assistance for the coverage survey through the training of supervisors and surveyors implementing the survey.

Objective 2: Successfully introduce nationwide, pneumococcal conjugate vaccine (PCV-13) and MenA conjugate vaccine (MenAfriVac) in 2012.

- **Collaborated with partners to plan and implement mass vaccination campaign against meningococcal A meningitis with MenAfriVac™:** MCHIP collaborated with partners to plan and implement the meningococcal A meningitis mass campaign targeting people between the ages of one and 29 across 35 districts in eight regions where the risk of meningococcal A meningitis spread was the highest. MCHIP technical assistance contributed to the microplanning workshops, training materials and other media campaign articles, and planning of the communications activities, and participated in the official launch. The National Technical Advisor supervised the campaign in the Diourbel region. MCHIP also provided technical support in the training of supervisors for the MenA campaign coverage survey, in addition to participating in its implementation. The survey concluded that the campaign attained satisfactory coverage, reaching 95% of the target population in most health districts (based on immunization cards and recall), with 12 of the 35 districts having coverage from 91–94% and seven districts having coverage below 80% (based on card only).
- **Planning for the introduction of PCV13 and measles-rubella (MR) vaccines**: MCHIP is providing technical assistance to the National Immunization Program to assist in the timely planning and preparation for introduction of the PCV13 vaccine, which is planned for October 2013, and the MR vaccine through mass campaign in November 2013.
- **Revised EPI guidebook to include new vaccines**: The updated EPI guidebook now includes rubella, PCV13, rotavirus, meningococcal A meningitis, and HPV.[1] Once the guidebook is finalized, it will be printed and disseminated.

Priorities for Quarters 3 and 4

- Pilot the Using Measles Activities to Strengthen Immunization and Surveillance (UMASIS) module for the up-coming MR catch-up campaign.
- Develop and implement a collaborative framework that will define IntraHealth and ChildFund activities in identified target districts across three regions.
- Continue PCV13 and MR introduction planning and preparatory activities. Introduction is planned for October and November 2013, respectively.
- Assist with the preparations and compiling of applications to GAVI for rotavirus and measles second dose vaccines

[1] MCHIP does not provide technical assistance for HPV-related activities.

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 PATH. In countries where the vaccine has been introduced, a profound impact has been seen on reported meningitis cases, with no cases reported among those who were vaccinated and with dramatically reduced bacterial carriage—even among those too old to have been vaccinated.[1]

As highlighted in an MCHIP post,[2] the Senegalese Ministry of Health launched a successful 2-week MenAfriVac® campaign on November 12, 2012, in one of the areas most severely affected by meningitis outbreaks, targeting a cohort of 3.9 million people between the ages of 1 and 29 years. The launch and distribution of the vaccine were a success by many standards due to their organization and management. All districts received the required supplies in a timely manner with special attention given to resource mobilization for 8 of the 14 regions that were targeted as having the greatest need. Senegal came up with resourceful vaccine mobilization solutions, using transport such as automobiles, bikes, motorcycles, and even carts pulled by donkeys and horses.

With vaccination campaigns typically targeting infants under the age of 1, reaching 15- to 29-year-olds is a difficult feat. This vaccine is one of the only available vaccines targeting this age group, requiring a well-thought-out and creative strategy. To understand the complexity of vaccinating this group, imagine a taxi stand with hundreds of commuters trying to find the correct vehicle or motorbike and then bargaining for the right price, combined with drivers yelling for passengers while trying to drop them at their destinations and squeezing their vehicles in and out of a jam-packed area. This is a small example of environments where campaign volunteers ventured out to vaccinate the 15- to 29-year-old age group as they are more likely to be at their workplaces than in their homes. The volunteers also visited gathering places such as markets, colleges and universities, and military camps. District teams went to prisons, taxi stands, labor workshops, and out to the fields where people were farming their crops to uncover these hard-to-reach individuals, going 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 activities and will continue to collaborate with the Ministry of Health and partners on monitoring and evaluating post-introduction activities to assess the coverage, quality, and impact of the campaign.[3]

This campaign, and the process leading up to it, required careful preparations, 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 some imaginary finish line.

To learn more about the MVP, visit:
http://www.meningvax.org/index.php

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

[3] Coverage will be calculated after all data has been reported from the 35 districts where the campaign was rolled out.

Country Summary: South Sudan

Period: FY 2013, Quarters 1 and 2

Selected Health and Demographic Data for South Sudan	
GDP per capita (USD)	1,546
Total population	8,200,00
Maternal mortality ratio (deaths/100,000 live births)	2,054
Skilled birth attendant coverage	10
Antenatal care, 4+ visits	17
Neonatal mortality rate (deaths/1,000 live births)	52
Infant mortality rate (deaths/1,000 live births)	102
Under-five mortality (deaths/1,000 live births)	135
Treatment for acute respiratory infection	87.8
Oral rehydration therapy for treatment of diarrhea	63.9
Diphtheria-pertussis-tetanus vaccine coverage (3 doses)	24
Modern contraceptive prevalence rate	5.7
Total fertility rate	6.7
Total health expenditure per capita (USD)	*141

Sources: Southern Sudan Center for Census, Statistics, and Evaluation 2010, World Bank, Southern Sudan Household Health Survey 2006, WHO, 2012 South Sudan HIV/AIDS Epidemiologic Profile
*combined with Sudan

Major Activities

- Build capacity for family planning (FP) and reproductive health (RH)
- Strengthen human resources in the areas of monitoring and evaluation for HIV/AIDS
- Disseminate the national expanded program of immunization (EPI) policies and support a national, multi-partner EPI review
- Support a program for prevention of postpartum hemorrhage (PPH)

Program Dates	August 2011–September 2013					
2011–2012 Budget	$1,764,000					
Total Mission Funding to Date	October 2007–September 2008: $416,000 October 2010–September 2011: $498,000 October 2011–September 2013: $1,764,000 Total: $2,678,000					
Geographic Focus	Support to Ministry of Health (MOH): National Prevention of PPH Program: Mvolo and Mundri East Counties					
Geographic Coverage	**No. (%) of provinces**	1 (10%)	**No. of districts**	2	**No. of facilities**	31
MCHIP In-Country Contact	Dr. Catharine McKaig					
HQ Managers and Technical Advisors	Nancy Ali: nancy.ali@jhpiego.org; Jaime Mungia: jaime.mungia@jhpiego.org; Sheena Currie: scurrie@mchip.net; Vikas Dwivedi: vdwivedi@mchip.net					

FY 2013, Quarters 1 and 2: Achievement Highlights

Objective 1: To build capacity for family planning and reproductive health (FP/RH).

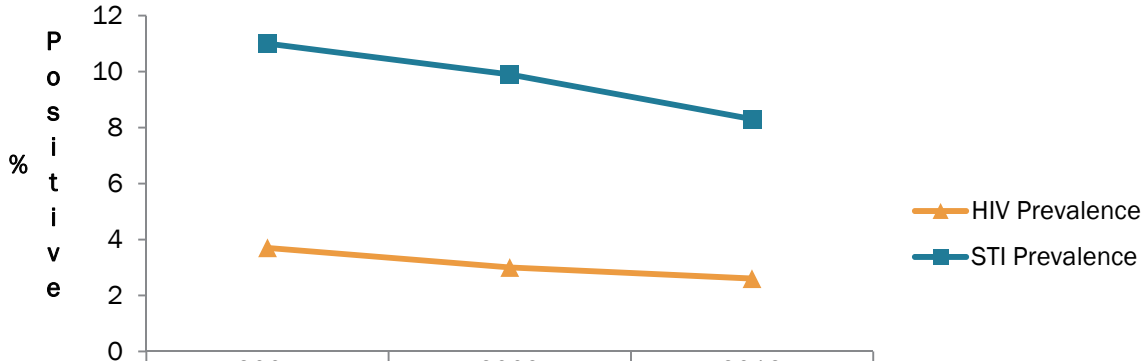
- Convened three FP Technical Working Groups, hosted by Marie Stopes International, MCHIP, and UNFPA.
- Continued to advance the endorsement of the National FP policy, RH policy, and RH strategy by the Minister and Under Secretary, which culminated in the eventual signing of the Foreword and Acknowledgement, respectively. All of the documents are currently in print for dissemination.
- Prepared the background information on RH/FP in South Sudan and population issues for the 6th Coordination Meeting of the East African Reproductive Health Network (EARHN), which was held in Addis Ababa from 5–9 March. The Sr. RH/FP Advisor accompanied the Ag. Director General Directorate of RH to the meeting. Following feedback to the MOH senior management board, it was decided that South Sudan should pursue the necessary steps to officially join the network and possibly host a future meeting. The Sr. RH/FP Advisor has continued to support the documentation needs resulting from the recommendations of the senior management board, including technical collaboration with network member countries.
- Provided technical support to IMA Worldwide and facilitated a training of 13 health workers in basic FP from 11–16 March. Emphasis was put on the use of the draft FP curriculum being reviewed and service providers' value clarification and attitudinal transformation. This is a process of training to help the providers identify their own values and attitudes toward FP and how that impacts their provision of FP services. The training and process help the providers identify socio-cultural barriers to FP and how to transform their attitudes to promote quality services in FP. The participants had previously attended a nine-month training in Kenya on EmONC.

Objective 2: To strengthen human resources.

- As a member of the Transitional Funding Mechanism (TFM) Technical Working Group, the Senior Technical Advisor for HIV/AIDS M&E assisted the MOH in proposal writing for the TFM grant from Global Fund. The TFM proposal seeks transitional funding for an HIV CoS grant that will end on 30 November 2013. The TFM proposal covers the cost of ARV drugs, OIs/HIV care, tests, technical support and clinical mentorship, supply-chain management, and program management for 7,419 HIV patients estimated to be on ART by the end of the TFM grant (30 November 2015), as well as 8,517 patients estimated to be on pre-ART at the beginning of the TFM grant. The M&E Advisor provided the necessary data, reviewed documents, and attended meetings—culminating in the successful submission of the proposal.
- Supported the MOH and SSAC in drafting of National Strategic Plan on HIV and AIDS (NSP) 2012–2016. The plan describes the national response under the stewardship of the Government of South Sudan and stipulates strategic directions and action on how the unique challenges that HIV and AIDS pose to the welfare of the South Sudanese population will be addressed. For instance, one key challenge is in relation to the effect that the epidemic will have on the health workforce, particularly as the epidemic evolves. The M&E Advisor provided the necessary data, reviewed documents, and attended meetings of the Technical Working Group tasked with drafting of the plan.

- Assisted the MOH, with the support of the World Health Organization (WHO), to conduct data quality assessment and cohort analysis at ART sites. The HIV M&E Advisor co-facilitated a portion of the training during which nine staff in the HIV Division were equipped to undertake the exercise. Subsequently, a total of 10 sites have been covered at the end of the reporting period. Data analysis is ongoing and dissemination of the results will be undertaken in the next quarter.
- Assisted the MOH to analyze and disseminate results of the South Sudan 2012 Sentinel Surveillance of HIV and Syphilis Survey and the Phase 1 2012 Mapping Report of Female Sex Workers in South Sudan. The primary objective of the ANC sentinel surveillance survey was to determine the prevalence and correlates of HIV and syphilis among pregnant women attending antenatal care in South Sudan. Results of the survey show:
  - Overall HIV prevalence from the 2012 surveillance survey was 2.6%, 95% CI [2.3-2.8].
  - At the site-specific level, Ezo reported the highest prevalence of HIV infection at 14%, followed by Yambio and Tambura at 8.4% and 6.5%, respectively. Gokmachar and Kwanjok reported the lowest prevalence of HIV infection at 0%, followed by Katigiri at 0.1%.
  - Correlates of HIV infection; marital status and level of education and gravida. Compared to those with one pregnancy, women with two pregnancies were almost twice more likely to have HIV infection (Odds Ratio, OR [95% C.I], p-value: 1.8 [1.2 – 2.6], p<0.001).

Figure 1. Trends in HIV and Syphilis Prevalence among Pregnant Women, 2007, 2009, and 2012



	2007	2009	2012
HIV Prevalence	3.7	3	2.6
STI Prevalence	11	9.9	8.3

Objective 3: Disseminate Expanded Program on Immunization (EPI) policies.

- Activities under this objective were completed in FY12.

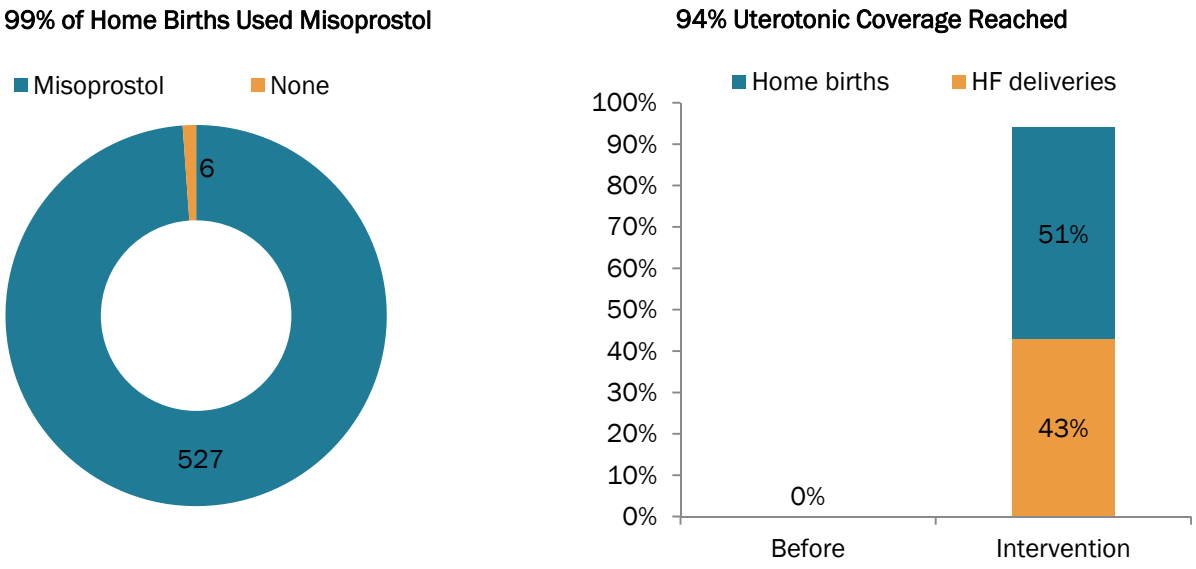
Objective 4: Support a program for prevention of postpartum hemorrhage.

- Trained a total of 60 health care providers in clean and safe birth, including active management of the third stage of labor and immediate newborn care, as well as management of PPH. The first training was conducted in Lui Hospital with participants from MRDA in Mundri East. The second training was conducted in a midwifery training center in Juba for Save the Children staff from Mvolo. The training package was field-tested and is now being finalized.

.

- Trained a total of 260 HHPs in Mvolo and Mundri East Counties. The four-day training consisted of three days of classroom interactive sessions, lecture, role plays, and group work, while the fourth day focused on community-supervised practice on counselling of pregnant women and their families using counseling flip cards. The training imparted participants with knowledge, skills, and attitudes needed to counsel pregnant women, their support persons, families, and other community members about the importance of taking misoprostol tables for prevention of PPH and what actions to take in case of PPH.
- Implemented field work of the program learning phase from September 2012 to March 2013. Mundri East County completed data collection and Mvolo data collection is ongoing
- Hired two consultants as data collectors to interview enrolled study women who have delivered in Mundri East. Data collection commenced at the beginning of February 2013, and a total of 513 clients were interviewed as of the end of the reporting period. Clients were interviewed at facilities as well as in their households if they are unable to travel to their nearest health facility. Data collection will be completed in April 2013.
- Held PPH Technical Advisory Group meetings on 8 November 2012 and 4 March 2013 and organized face-to-face meetings with the two implementing partners to discuss implementation to date, supervision and follow-up or trainees, selection of HHPs, and training plans.

Figure 2. Findings from Mundri East



Priorities for Quarters 3 and 4

- Conduct a national dissemination meeting on 15 May 2013 for results of the prevention of PPH learning phase.
- Complete final products for dissemination: briefer, manuscript, and implementation guide.
- Utilize results to inform gradual scale-up of prevention of PPH activities to all counties in Western and Central Equatoria State under the Integrated Service Delivery Program (ISDP).

MCHIP Helps Prevent Postpartum Hemorrhage in South Sudan through Innovative Community Project

by: Mary Rose Dalaka

Juba, South Sudan – The mother of five children, Linda Kenneth had a history of excessive bleeding after birth. When she learned that she was pregnant again, she planned this time to deliver at the local hospital in Lui in case of an emergency or complications. During the final month of her pregnancy, Linda received a visit from a home health promoter trained by the U.S. Agency for International Development's global Maternal and Child Health Integrated Program (MCHIP). The health promoter helped her draft a birth plan, counseled her on the risk of postpartum hemorrhage, and provided her with the misoprostol to take to prevent heavy bleeding if she couldn't get to the hospital.

Linda was grateful for the misoprostol, recalling the significant bleeding that followed her two previous births. On August 29, she went into labor in the middle of the night. The rainy season had left many roads in poor condition and Linda worried about getting transportation at the late hour. She called a skilled birth attendant who worked at Lui Hospital to help her deliver at home. After Linda gave birth to a healthy baby girl, she swallowed the three misoprostol pills as instructed by the home health promoter.

Linda experienced no heavy bleeding, and once her uterus began to contract, delivered the placenta. Linda's delivery of her baby girl went smoothly and safely. She was the first woman to give birth at home with the help of the innovative program for community distribution of misoprostol in Mundri East, a county in Central Equatoria State in South Sudan. This program is part of a pilot intervention—implemented by MCHIP, Jhpiego, and the Mundri Relief and Development Association in collaboration with the Ministry of Health—to help reduce maternal deaths.

South Sudan is among the first countries in which MCHIP has rolled out the program for the prevention of postpartum hemorrhage and community distribution of misoprostol. South Sudan was primed for this intervention because of its high maternal mortality ratio (2,054 per 100,000 live births), high rate of home births and limited access to health care facilities. This reality made 2012 the right time to introduce this lifesaving intervention into communities in South Sudan.

In addition, qualified health workers account for 10% of the civil service workforce (1.5 physicians and 2 nurses/midwives for every 100,000 citizens in an urban area); life expectancy is 42 years of age; 12.3% of births take place in a health facility; and a skilled birth attendant is present at only 14.7% of births.

"With a non-functioning health system and limited numbers of skilled birth attendants, we are placing the intervention in the hands of those who are present at all births, the women themselves," said Khatidja Jivani Naithani, Jhpiego Program Officer in South Sudan.

The year-long pilot program is designed to help the Ministry of Health carry out its maternal health objectives by building the capacity of health workers to perform this vital service and expand this innovative, community-based initiative throughout the country. For many women like Linda Kenneth, who deliver at home without a skilled birth attendant, their ability to take misoprostol on their own after delivery of the baby will reduce the risk of heavy bleeding and potentially save their lives.

MCHIP advisor Mary Rose Dalaka (right) visits Linda Kenneth (center), who survived the birth of her sixth child (shown here) with help from a skilled birth attendant and home health visitor, Yunis (left), and an MCHIP program that helps prevent postpartum hemorrhage, the leading cause of maternal deaths in the world.

Country Summary: Tajikistan

Period: FY 2013, Quarters 1 and 2

Selected Health and Demographic Data for Tajikistan	
GDP per capita (USD)	935.00
Total population	7,075,000
Maternal mortality ratio (deaths/100,000 live births)	64
Skilled birth attendant coverage	88
Antenatal care, 4+ visits	49
Neonatal mortality rate (deaths/1,000 live births)	25
Infant mortality rate (deaths/1,000 live births)	52
Under-five mortality (deaths/1,000 live births)	63
Treatment for acute respiratory infection	63.9
Oral rehydration therapy for treatment of diarrhea	22
Diphtheria-pertussis-tetanus vaccine coverage (third dose)	96
Modern contraceptive prevalence rate	38
Total fertility rate	3.4
Total health expenditure per capita (USD)	54.00

Sources: World Bank, WHO, UNICEF.
*UNICEF <5 mortality ranking (1=highest mortality rate)

Major Activities

- Participated in multi-agency national EPI review
- Advanced toward program implementation through signing of Memorandum of Understanding with the Ministry of Health
- Conducted needs assessment in two focus catchment areas
- Fostered relationships with key immunization partners

Photo © 2005 Jordan Stolper, Courtesy of Photoshare

Program Dates	Workplan approved: FY 2011–2013; National Technical Coordinator hired January 2012. No-cost extension requested for end date of June 2014.					
PY 5 Budget	$265,942					
Total Mission Funding to Date	$408,013					
Geographic Focus	*National, and Vakhsh and Qabodiyon Districts*					
Geographic Coverage	No. (%) of provinces	1 (13%)	No. of districts	2	No. of facilities	2
MCHIP In-Country Contact	Lola Sattori: lola_sattori@mail.ru					
HQ Managers and Technical Advisors	Pat Taylor: ptaylor@mchip.net; Kelli Cappelier: kcappelier@mchip.net; Kaili Mumme: kmumme@mchip.net					

FY 2013, Quarters 1 and 2: Achievement Highlights

Although certified polio-free in 2002 and consistently reporting immunization coverage above 90%, Tajikistan had 458 laboratory-confirmed cases of paralytic poliomyelitis, or one-half of the global polio cases in 2010. Although UNICEF's Tajikistan Living Standards Survey (TLSS) had given a clear warning in 2007 about the vulnerability of the children for vaccine-preventable diseases, revealing only 50% of infants nationwide with OPV3, denial prevailed over taking corrective action. In response to the polio epidemic in Central Asia, USAID provided MCHIP with funds to improve routine immunization to prevent future outbreaks of polio, as well as other vaccine-preventable diseases. In February 2011, MCHIP conducted a preliminary needs assessment, and starting in September 2011, an immunization consultant developed a detailed implementation plan, initiated recruitment, and began project start-up activities. The National Technical Officer was hired in January 2012, and MCHIP established its office within the USAID Quality Health Care Project office.

Almost immediately following USAID's funding of MCHIP/Tajikistan in 2011, the USAID Memorandum of Understanding (MOU) with the Ministry of Health (MOH), which would have allowed MCHIP to legally operate in-country, expired. As a result of the unresolved and ongoing negotiations between the USAID/Tajikistan Mission and the Tajik government, implementation of MCHIP activities has been severely delayed. During this implementation period, MCHIP moved forward in signing an MOU with the MOH (independent of USAID's negotiations with the Ministry), which has allowed the program to progress with its activity planning and implementation. However, for MCHIP to operate legally in Tajikistan, the implementing organization (in this case, JSI) must be registered with the Ministry of Justice. The recent signing of the MOU was a necessary step to allow JSI to move forward with formal registration, which is expected to be complete in the next reporting period.

Objective 1: Build capacity for monitoring and evaluation at national and local (rayon) levels.

- MCHIP became a member of and participated in the Interagency Coordinating Committee (ICC) meetings. The ICC is led by the MOH Republican Center for Immunioprophylaxis (RCIP).
- MCHIP also became a member of and participated in the Maternal, Child, and Reproductive Health Advisory Council, which is led by the MOH. There are more than 15 active member organizations and it serves as the coordinating mechanism between all implementing maternal and child health projects.

Objective 2: Improve evidence-based program planning and prioritization at the district level for identifying and immunizing targeted groups and areas with inadequate immunization coverage.

- MCHIP conducted a needs assessment in two focus catchment areas (Chughdara and Kizil-Ittifok villages) to identify health facility and immunization system strengths and weaknesses at the district and community levels.
- **MCHIP workplan is under development for the two revised districts:** A revised workplan that includes the two focus rayons (districts) (Vahksh and Qabodiyon) is being developed and will be translated.

Objective 3: Improve partner coordination on immunization aimed at an integrated, public health approach for maintaining optimal immunization coverage at rayon and community levels.

- **MCHIP participated in the national EPI Review:** MCHIP participated in the EPI comprehensive review of the Tajikistan National Immunization Programme (NIP). MCHIP contributed to the EPI final report and recommendations for the MOH, which revealed further evidence on the critical needs for strengthening the routine immunization system.

Priorities for Quarters 3 and 4

- Complete official registration of JSI with the Ministry of Justice to ensure that Tajikistan can continue implementation activities.
- Finalize the updated MCHIP workplan to include an updated activity matrix and budget.
- Conduct a baseline assessment with community members in two MCHIP focus communities.
- Initiate project activity implementation following approval of the updated workplan.

Country Summary: Tanzania

Period: FY 2013, Quarters 1 and 2

Selected Health and Demographic Data for Tanzania	
GDP per capita (USD)	532
Total population	46,218,486
Maternal mortality ratio (deaths/100,000 live births)	450
Skilled birth attendant coverage	49%
Antenatal care, 4+ visits	43%
Neonatal mortality rate (deaths/1,000 live births)	26
Infant mortality rate (deaths/1,000 live births)	50
Under-five mortality (deaths per 1,000 live births)	76
Under-five children with ARI symptoms taken to a health facility	71%
Under-five children with diarrhea receiving ORT	50%
Diphtheria-pertussis-tetanus vaccine coverage (3 doses)	91
Modern contraceptive prevalence rate	34%
Total fertility rate	5.5
Total health expenditure per capita (USD)	37

Sources: World Bank and UNICEF, 2010–2011.

Major Activities

- **Voluntary Medical Male Circumcision (VMMC):**
  - 15 static sites and more than 100 outreach sites in Iringa, Njombe, and Tabora
  - To date, 171,561 adult male circumcisions have been performed
  - Target is 100,000 VMMCs for 2012–2013; over 47,000 VMMCs performed thus far
  - Refresher trainings (178 providers refreshed and 66 new providers trained)
  - Four pilot sites launched in Iringa for early infant male circumcision (EIMC)
- **Payment for Performance (P4P) – implementer Broad Branch Associates (BBA)**
- **Immunization – implementer John Snow, Inc. (JSI)**

Program Dates	September 30, 2008–September 29, 2014					
PY 5 Budget	$19,470,918.00					
Total Mission Funding to Date	VMMC (implemented by Jhpiego) to date: $17,848,042 Partner: $1,622,876					
Geographic Focus	Iringa, Njombe, and Tabora					
Geographic Coverage	No. (%) of provinces	2 (7%)	No. of districts	9	No. of facilities	12
MCHIP In-Country Contact	Hally Mahler, MCHIP/Tanzania HIV Director, hally.mahler@jhpiego.org: Molly O'Bryan, Program Officer II, molly.obryan@jhpiego.org					
HQ Managers and Technical Advisors	Brenda Rakama, brenda.rakama@jhpiego.org, Alice Christensen, alice.christensen@jhpiego.org, Tigistu Adamu, tigi.adamu@jhpiego.org, and Kelly Curran, kelly.curran@jhpiego.org					

FY 2013, Quarters 1 and 2: Achievement Highlights

MCHIP continued to support Iringa, Njombe, and Tabora regions in providing voluntary medical male circumcision (VMMC) services for HIV prevention through robust campaigns, outreach, and static site models.

Summary of achievements:

- Hosted a visit to Iringa by MCHIP Director Koki Agarwal. During her visit, a total of 457 clients received VMMC services through two outreaches within six working days.
- Conducted comprehensive VMMC training for 66 providers from Tabora municipal, Nzega, Urambo, and Igunga districts.
- 101 VMMC providers from Iringa and Njombe regions received emergency resuscitation and refresher training.
- Added two new static sites in Tabora region: Urambo District Hospital and Kaliua Health Centre.
- Conducted an outreach in Njombe DC and Wanging'ombe districts in which 2,397 clients received comprehensive VMMC services in seven health facilities within 12 days.
- Conducted an outreach in Mufindi district in which 2,839 clients received comprehensive VMMC services in four health facilities within 12 days.
- Pre-tested EIMC BCC materials and M&E tools in the four sites that will be piloting EIMC.
- Conducted a two-day workshop to review the annual workplan and strategize on how to best reach program targets.
- Continued to support static services at seven sites in Iringa region, five sites in Njombe region and three sites in Tabora region. A total of 1,404 clients received VMMC through static services.
- Supported NACP to review and refine the national VMMC tools.
- Supported MOHSW/NACP to add a VMMC site monthly summary to the National DHIS2.
- Conducted outreaches in Kilolo and Ludewa districts, serving 3,264 clients in two weeks at 10 sites.
- Conducted outreach in Njombe, serving 2,179 clients in two weeks at five sites.
- Conducted a school holiday campaign in Igunga district of Tabora, serving 6,081 clients within three weeks at nine sites.
- 37 VMMC providers from Tabora municipal, Nzega, and Igunga districts received emergency resuscitation and refresher training.
- 40 VMMC providers from Iringa municipal and Iringa Rural districts received emergency resuscitation and refresher training.
- A two-day VMMC re-orientation meeting was held for regional and district officials at Igunga, Nzega, and Tabora municipal.
- An early infant male circumcision (EIMC) stakeholder's consultation was held in Dar es Salaam.
- Designed and implemented a facility and community assessment in preparation for piloting EIMC in Iringa.
- Held an EIMC Advocacy Meeting for Iringa-based stakeholders.

- Supported VMMC fixed clinics in Iringa, Njombe, and Tabora regions, where a total of 1,395 clients received services.

Voluntary Medical Male Circumcision (VMMC)
The MCHIP VMMC program has continued to build on FY12 achievements and the strong support from the MOHSW. This is made possible by in-depth technical support to the MOHSW through the MCHIP Tanzania HIV Director, who works closely with the MOHSW to coordinate the scale-up of services. As a result, the Tanzania VMMC program has developed standard operating procedures (SOPs) for service provision, tools for data collection, guidance documents, and a learning example for countries in the region implementing VMMC. Also through MCHIP, Jhpiego provides technical support to the National AIDS Control Program (NACP) and Male Circumcision Technical Working Group (MCTWG) at the MOHSW.

Key activities in this reporting period were conducted under the following objectives:

Objective 1: Continue supporting Tabora, Njombe, and Iringa regions to implement VMMC services through outreach and campaign models.

- *HIV Counseling and Testing:* Despite the continued national shortage of HIV testing kits during this period, 92% of clients received HIV counseling and testing; 1% of these clients tested positive. MCHIP supported the program by providing HIV test kits in Quarter 2.

Objective 2: Continue supporting Njombe, Tabora, and Iringa regions to implement VMMC services through static sites and expand services to new static sites.

- *Provision of services:* ***47,000 clients*** have been circumcised in Njombe, Iringa, and Tabora.
- *Assessment:* In Iringa, overall, 42% of the circumcisions performed were for boys age 14 years or younger and 29% for men age 20 years and above. In Njombe, overall 44% of the men circumcised were age 20 years and above. In Tabora, an estimated 37% of circumcisions were performed for men age 20 years and above. There have been increasing efforts to make VMMC appealing to older men (20 years old and above).
- *Reaching out to older men:* Efforts such as collaborating with EngenderHealth (CHAMPION) to increase the service demand for older men, implementing a study to assess older men's preferences, and piloting an adult male-only clinic are ongoing.

Objective 3: Provide a comprehensive package of VMMC training of new VMMC providers and refresher training for active VMMC providers.

- A total of 43 new VMMC providers and 18 new counselors were trained in March. The providers were from both new and existing static sites. Three newly employed Jhpiego Regional Technical Advisers also joined the group of providers to be trained on VMMC delivery. The training was shortened from the usual 10 days to eight days, with three days of classroom theoretical training and five days of practical coaching on real clients at the Nzega District Hospital static site and Natta Dispensary outreach site. The participant evaluation of the training revealed that only 1% of participants felt that the duration of training was too short for them to acquire the knowledge and skills required to gain competency.

Objective 4: Support initiation of early infant male circumcision services in four selected pilot sites in Iringa.

- *Development and dissemination of demand creation materials*: MCHIP developed a series of BCC materials such as flyers, brochures, posters, counseling flip charts, post-op instructions, and radio ads to promote the service in Iringa. The BCC pre-testing tools were designed to identify five measures of effectiveness: acceptability, comprehension, attraction, engagement, and persuasion.

Objective 5: Assist the Government of Tanzania in the development and rollout national systems as requested.

- In this period, MCHIP continued to provide technical support to the NACP to review and refine the final National VMMC tools by incorporating all the changes and corrections made by partners before the tools were sent for printing. Similarly, MCHIP supported the MOHSW/NACP to conduct a three-day technical meeting in Bagamoyo to add the national VMMC monthly site summary to the National DHIS 2. The meeting was attended by representatives from the MOHSW-HMIS department, University of Dar es Salaam computing department, NACP, and Jhpiego/MCHIP staff.

Payment for Performance (P4P)

The payment for performance program is implemented by Broad Branch Associates (BBA) and continues to be successful in strengthening the health system to achieve maternal, newborn, and child health results. BBA provides the MOHSW technical assistance in the design and implementation of a pilot for payment for performance in the Pwani region. The Pwani P4P model emphasizes improving the quality of care as well as the numbers of pregnant women, newborns, and children receiving rewarded services. The pilot began with very few deliveries accompanied by a partograph that was at least 80% complete. At baseline, roughly 12% of deliveries in the Pwani region used this valuable tool to manage labor and delivery and to identify emergencies. By Cycle 4, the proportion of deliveries accompanied by partographs that were at least 80% complete grew to reach 69%.

Priorities for Quarters 3 and 4

Voluntary Medical Male Circumcision

- Strengthen procurement systems.
- Improve coordination between the experiential media agency and community mobilizers.
- Train VMMC peer promoters to facilitate easy flow of older clients in the static sites, in Iringa, Njombe, and Tabora.
- Establish a VMMC adult-only clinic in Iringa.
- Conduct a study on the acceptability of EIMC in Iringa.
- Conduct a study on service delivery models for reaching older clients with VVMC in Iringa.

In Tanzania, MCHIP Supports Simultaneous Launch of Vaccines against Pneumonia and Diarrhea

by: Lindsay Bever Breithaupt, MCHIP Immunization/JSI

In December 2012, Tanzania became bustling hub for immunization activities as it officially introduced both pneumococcal conjugate vaccine (PCV-13) and rotavirus vaccine into its national immunization program.

On 5 December, the official launch of these two vaccines coincided with the GAVI Partners' Forum and the WHO African Regional Conference on Immunization, two critical international immunization meetings in Dar es Salaam from December 5–7 and December 10–13, respectively.

Woman and child in Tanzania. (Photo courtesy of Jhpiego.)

This simultaneous introduction demonstrated the commitment of the Tanzanian government to fight two of the greatest killers of children under the age of five: pneumonia and diarrhea. Pneumonia is the deadliest disease among children worldwide[1] and, in Tanzania, accounts for an estimated 18% of deaths in children under five.[2] Rotavirus is a diarrheal disease caused by a virus that infects the gastrointestinal tract. It is the most common cause of severe diarrheal disease in infants and young children worldwide, contributing to 41% of all diarrhea cases.[3]

However, the good news is that the PCV-13 and rotavirus vaccine are safe and cost-effective means to protect children who are at risk.

Tanzania was only the second country in the world, behind Ghana earlier in the year, to introduce two new vaccines at the same time. Tanzania looked to the Ghanaian experience to guide their introduction, gleaning the lessons learned and understanding the difficulties that may arise along the way.

While this simultaneous introduction was a major undertaking for the Tanzanian Ministry of Health and partners, given the high immunization coverage of other routine vaccines throughout Tanzania for the previous several years (such as DTP3 coverage sustained at over 85%), the integration of PCV-13 and rotavirus vaccine into the program is likely to significantly reduce morbidity and mortality due to vaccine-preventable diseases in children under five.

MCHIP is part of a multi-partner collaboration—including the GAVI Alliance, WHO, UNICEF, and other organizations—that is supporting the Government of the United Republic of Tanzania to plan, implement, and evaluate the introduction of these vaccines. To help the country prepare, MCHIP has been providing technical assistance to the Expanded Program on Immunization (EPI)/Ministries of Health in several countries with their applications for these new vaccines, immunization program readiness, and capacity building for health professionals.

Dr. K.O. Antwi-Agyei (Ghana's Expanded Programme on Immunisation Manager), Karan Singh Sagar (MCHIP/India), and Robert Steinglass (MCHIP and JSI) present "Innovative Approaches to Immunisation and Health Delivery," an afternoon workshop on the first day of the GAVI Alliance Partners' Forum.

In Tanzania, as elsewhere, MCHIP also continues to provide technical support after the launch to help further strengthen the routine immunization program. This is part of MCHIP's broader technical support to ensure that new vaccines are incorporated into routine immunization systems that provide safe, timely, and affordable protection against some of the major contributors to child death, such as pneumonia and diarrheal diseases.

Beyond the launch in Tanzania, incorporating two new vaccines into the routine immunization program requires sustained effort. All parties will need to harness the excitement of the vaccine launch to strengthen the delivery of all vaccinations into the new year and beyond.

[1] WHO fact sheet.
[2] Introduction of the Pneumococcal Vaccine in Tanzania Fact Sheet. Ministry of Health of Tanzania. 2012.
[3] Introduction of the Rotavirus Vaccine in Tanzania Fact Sheet. Ministry of Health of Tanzania. 2012.

Country Summary: Timor-Leste

Period: FY 2013, Quarters 1 and 2

Selected Health and Demographic Data for Timor-Leste	
GDP per capita (USD)	492.24
Total population	1,133,594
Maternal mortality ratio (deaths/100,000 live births)	370
Skilled birth attendant coverage	29.9
Antenatal care, 4+ visits	55.1
Neonatal mortality rate (deaths/1,000 live births)	27
Infant mortality rate (deaths/1,000 live births)	48
Under-five mortality (deaths/1,000 live births)	55 [54]*
Treatment for acute respiratory infection	71
Oral rehydration therapy for treatment of diarrhea	79
Diphtheria-pertussis-tetanus vaccine coverage (3 doses)	72
Modern contraceptive prevalence rate	21.1
Total fertility rate	5.7
Total health expenditure per capita (USD)	73.24

Sources: World Bank, Timor-Leste 2009 Demographic and Health Survey, WHO, UNICEF.
*UNICEF <5 mortality ranking (1=highest mortality rate)

Major Activities

- Stimulated community participation in immunization through the Uma Imunizasaun pilot project and training of community leaders
- Contributed to communications, training, and launch plans for introduction of pentavalent vaccine in October 2012
- Provided tools and procedures and contributed to implementation of supportive supervision on immunization

Program Dates	February 1, 2011–October 31, 2013					
PY 4 Budget	$1,017,849					
Total Mission (MCC) Funding to Date	$1,850,787					
Geographic Focus	National-level policy and coordination, with targeted geographic focus in seven (of 13 total) districts (Ainaro, Baucau, Dili, Ermera, Liquiça, Manufahi, and Viqueque)					
Geographic Coverage	No. (%) of provinces	13 (54%)	No. of districts	7	No. of facilities	34
MCHIP In-Country Contact	Dr. Ruhul Amin: ramin@jsi-timor.com					
HQ Managers and Technical Advisors	Robert Steinglass: rsteinglass@jsi.com Mike Favin: mfavin@manoffgroup.com Kelli Cappelier: kcappelier@mchip.net					

FY 2013, Quarters 1 and 2: Achievement Highlights

Funded by the Millennium Challenge Corporation (MCC) through USAID, the Imunizasaun Proteje Labarik (IPL), which translates to Immunization Protects Children, assists the Democratic Republic of Timor-Leste in its efforts to increase DPT3 and measles immunization coverage rates nationally to 81.5%. The project targets seven districts (Ainaro, Baucau, Dili, Ermera, Liquiça, Manufahi, and Viqueque), where more than 75% of unreached Timorese children under the age of one reside. A complementary goal is to strengthen the EPI so that it is able to sustain and expand the gains realized beyond this project.

IPL has built credibility among communities, partners, and the MOH by demonstrating measurable results through the implementation of evidence-based activities that are strengthening the routine immunization delivery system, while also integrating with other health interventions during outreach sessions. The MOH's health management information systems (HMIS) department has not published coverage reports since January 2012 because of issues with recent census results questioning the denominator (target population). In an effort to monitor and measure IPL's impact, IPL analyzed immunization coverage by numerator only (i.e., number of infants under one year of age being vaccinated) in Timor-Leste between January 2009 and June 2012. This analysis showed an increase of coverage for most antigens in IPL focus districts but a decrease in non-focus districts. As a result of this situation and to deliver services equitably, WHO and UNICEF have decided to transfer the success of IPL and support a similar package of interventions (e.g., micro-planning, supportive supervision, outreach, and support to integrated outreach) in the six non-IPL districts where coverage appears to have declined.

Objective 1: Strengthen service delivery to identify and reach unimmunized children at least five times per year.

- **Micro-planning** sessions were completed in all focus districts and sub-districts with health staff, community leaders, PSFs (community volunteers), and relevant partners. IPL also facilitated an orientation session on a micro-planning tool for the District Public Health Officers (DPHOs), and with assistance from the Health Improvement Project (HIP), has taken the initiative on developing an integrated Maternal and Child Health (MCH) micro-planning tool for the MOH.
- **Outreach and mobile clinics:** Continuing efforts to reach the hard-to-reach children, the IPL team supported 132 mobile clinics and 640 outreach sessions and 57 SISCas (integrated outreach sessions) in all focus districts. Priority mobile clinics and outreach sessions are identified through micro-planning and offer integrated MCH services. IPL also provided and monitors 28 motorcycles to the MOH to be used by health facilities to travel to hard-to-reach communities. Furthermore, IPL coordinated a visit by the 15th United States Marine Expeditionary Unit in October 2012 for different integrated outreach health activities. With the Marine Unit and the MOH, IPL carried out 10 integrated outreach activities in five out of seven IPL-focus districts.

- **Partnering with communities:** In collaboration with MOH colleagues, IPL created and implemented community leader training modules on immunization, training over 502 community leaders (including suco council members, community health workers, teachers, religious leaders, and other volunteers). To further facilitate community engagement in childhood immunization, IPL assisted with national and local training and materials to help communities themselves monitor their children's immunizations. The project adapted, printed, and distributed the Uma Imunizasaun tool ("my village is my home" tool) to communities in one sub-district of each focus district. The tool helps community volunteers monitor the immunization status of each infant in the community. An interim assessment showed that the tool has so far been successful in tracking infants and improving coverage and timeliness of vaccinations in the demonstration districts. To follow up, IPC engaged 317 community leaders in Quarter 1 and 273 in Quarter 2 to encourage an update in the Uma Imunizasaun tool to address findings from the assessment. IPL also established a partnership with the local NGO Clinic Café Timor, and provided the NGO with training to introduce this tool in 68 communities in three districts. As a result, Clinic Café Timor has integrated the Uma Imunizasaun tool into the Community Extension Program to ideally support this interactive tool beyond the life of the IPL project.
- **Implementation of the research study**, "Understanding the socio-cultural dynamics of urban communities and health system factors influencing childhood immunization in Dili, Timor-Leste." This study has been completed and an article describing the findings is in progress.

Objective 2: Strengthen district- and CHC-level program management capacity and technical skills among government health personnel.

- Working with partners and the MOH, IPL supported the national launch of the pentavalent vaccine and introduction in October 2012 by developing IEC materials, training, and monitoring the activities related to pentavalent launch and introduction.
- IPL supported DPHOs **to conduct EPI supportive supervision visits** in 23 health facilities in five of seven focus districts in Quarter 1, and 31 health facilities in Quarter 2. Significant improvements in vaccinator skills were observed; however, inadequate use of the EPI progress monitoring graph, inadequate knowledge and following of the multi-dose vial policy, improper recording of temperature of refrigerators, inadequate counseling, power outages, and stock-outs were found during these visits and require attention.
- To increase immunization coverage and community engagement in immunization programs, IPL supported the District Health Services (DHS) to organize and facilitate technical orientation sessions and advocacy meetings for the pentavalent introduction at DHS and community health center (CHC) levels.
- In conjunction with the MOH, IPL facilitated five refresher training sessions on Immunization in Practice and cold chain and vaccine management at sub-district level.

Objective 3: Strengthen SISCa as an effectively functioning community-based outreach mechanism for providing immunization and other health services.

- In Quarter 1, IPL provided technical assistance to 132 **outreach sessions** and 57 SISCas, prioritized through micro-planning in five of seven focus districts; in Quarter 2, 47 SISCas were conducted in all seven focus districts.

- In Quarter 1, 23 sessions to orient community leaders were organized in suco offices and facilitated by health staff from CHCs and DHSs, and in Quarter 2, 18 sessions were conducted. In all, 906 community leaders, including suco council members, PSFs, teachers, religious leaders, and other volunteers, participated actively. Some sessions were facilitated in local languages. At the end of the training, facilitators provided PSFs with a scaled-down version of the Uma Imunizasaun tool to identify dropout and missing infants by aldeia. The Baucau team **involved Traditional Birth Attendants (TBA)** in the community leader training and updating of the Uma Imunizasaun tool for the first time, as their involvement would contribute to tracking the newborns for vaccination and could potentially effectively promote vaccination.
- IPL collaborated with the Ministry of Education to provide immunization-related information to 202 schools in three of the seven focus districts, and encouraged students to share the information with their families and communities. IPL also developed an orientation package and job aids for immunization for junior high school students to encourage interest in immunization and community service.
- IPL organized an immunization film show in one district to inform communities about the benefits of vaccination and motivate them to immunize their children.

Objective 4: Strengthen program monitoring and reporting through better collection of routine data, and the routine analysis and use of that data for decision-making and targeted actions.

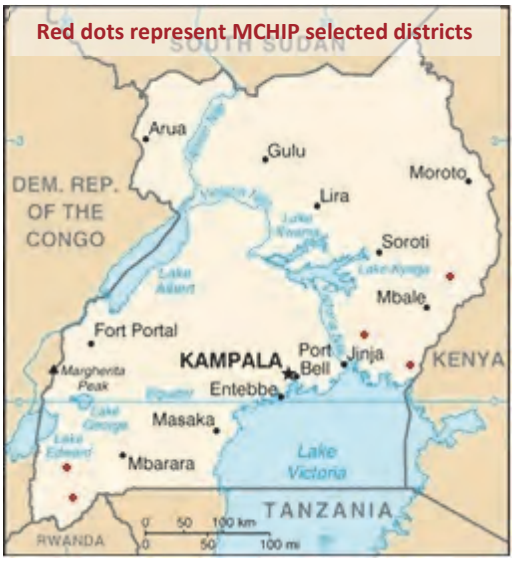
- IPL participated in monthly **EPI Working Group meetings** with all relevant partners.
- IPL finalized a supportive supervision package, which provides tools for entering data and monitoring progress and which will be socialized among the DPHOs and field-tested in 2013.
- IPL analyzed and presented the impact of the draft population projection on immunization coverage in Timor-Leste and worked with the HMIS department of the MOH, the Statistic Department of Timor-Leste, and WHO to address discrepancies in data. The MOH has finalized and published population projection by suco for 2013, and IPL socialized this data in the focus districts and sub-districts.
- To help improve reporting systems, IPL collected HMIS reports and identified gaps between district and MOH reports. The HMIS department sought support from IPL to work on improving data quality at different levels.

Priorities for Quarter 3 and 4

- Continue to participate in quarterly micro-planning reviews at CHCs with partners, community leaders, and PSFs to review the micro-planning progress and update plans as needed.
- Expand micro-planning tools to include indicators for other interventions including ANC, PNC, and skilled birth attendance.
- Support DHSs and CHCs to execute mobile clinics and EPI outreach planned in the micro-planning sessions at CHC level to reach the children in hard-to-reach areas.
- Continue updating the Uma Imunizasaun tool in seven selected sucos and expand to new sucos based on monitoring of current implementation. Support Clinic Café Timor on the continued use of the tool in their catchment areas.
- Train DHS and CHC staff and partners using MLM training modules by June 2013.
- Support IPL in working with the MOH and MOE to socialize the school health orientation materials and job aids.

- Expand use of the Uma Imunizasaun tool; continue support to the NGO Clinic Café Timor in using the tool in its catchment areas; evaluate the impact of community monitoring on coverage and timeliness of vaccinations.
- Continue to participate in quarterly micro-planning reviews at CHCs with partners, community leaders, and PSFs to review the micro-planning progress and update plans as needed.
- Continue quarterly meetings with suco councils in focus sucos.
- Train the MOH, partner staff, and CHC staff on Immunization in Practice and cold chain vaccine management. Finalize, print, and disseminate the supportive supervision checklist and data entry sheet. Provide updates and coaching to district and CHC staff on effective vaccine supply and cold chain management through supportive supervision.
- Assist DPHOs to conduct quarterly supervision visits to CHCs to improve the accuracy and timeliness of monthly HMIS, EPI, and SISCa reports in all focus districts.
- Advocate for, and assist in development of, a tracking system to identify unreached and drop-out children and implementation of the family health register to separately list children under one.
- Ensure that IPL develops an exclusive close-out plan to end activities by the end of October 2013, with an administrative close-out by the end of December 2013.

Country Summary: Uganda
Period: FY 2013, Quarters 1 and 2



Selected Health and Demographic Data for Uganda	
GDP per capita (USD)	1,310
Total population	33,425,000
Maternal mortality ratio (deaths/1000,000 live births)	310
Skilled birth attendant coverage	58.0
Antenatal care, 4+ visits	47.6
Neonatal mortality rate (deaths per 1,000 live births)	26
Infant mortality rate (deaths per 1,000 live births)	63
Under-five mortality rate (deaths per 1,000 live births)	99 [27]*
Under-five children with ARI symptoms taken to a health facility	73.0
Under-five children with diarrhea receiving ORT	48.2
Diphtheria-pertussis-tetanus vaccine coverage (3 doses)	82.0
Modern contraceptive prevalence rate	30.0
Total fertility rate	6.1
Total health expenditure per capita (USD)	128

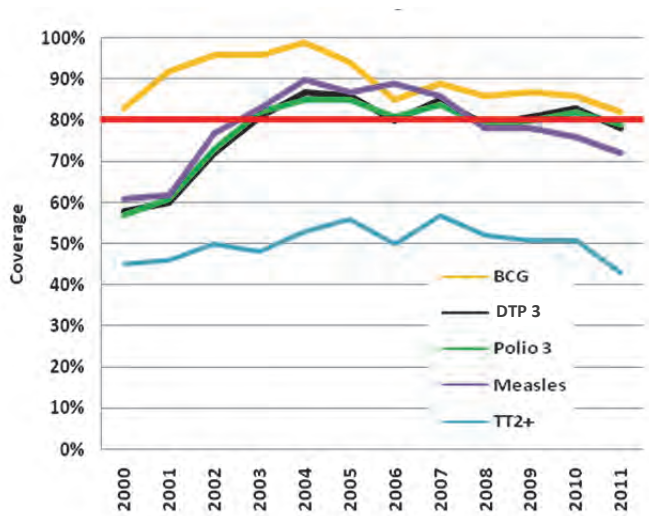
Sources: World Bank, WHO, UNICEF.
*UNICEF <5 mortality ranking (1=highest mortality rate)

Major Activities

- Work with the district to engage program partners, local government, traditional leaders and other community-based organizations
- Operationalize Reaching Every District (RED) in 5 districts and their sub districts, including "micro planning" and use of quality improvement methodologies to help spread ideas on affordable context-specific solutions
- Promote active monitoring and follow up of vaccine supply, vaccination coverage, and immunization drop-out rate
- Support preparations for the launch of the PCV 10 vaccine

Program Dates	June 2012–June 2013					
PY 4 Budget	$600,000; field; $300,000 core NUVI					
Total Mission Funding to Date	$900,000					
Geographic Focus	*National and District*					
Geographic Coverage	No. (%) of provinces	3 (17%)	No. of districts	5	No. of facilities	0
MCHIP In-Country Contact	Patrick Isingoma: pisingoma@mchip-uganda.net					
HQ Managers and Technical Advisors	Patricia Taylor: ptaylor@mchip.net Robert Steinglass: rsteinglass@mchip.net Jenny Sequeira: jsequeira@mchip.net Jennifer Melgaard: jmelgaard@mchip.net					

Figure 1. Immunization Coverage Trend for Various Antigens, 2000–2011, Based on Uganda MoH Administrative Data



As can be seen from Figure 1, childhood vaccinations have shown recent stagnation around the 80% coverage mark (red bar; administrative data). However, the 2011 Uganda Demographic and Health Survey (UDHS) showed that an estimated 93% of children are being reached for the first dose of DTP, 85% for the second dose, and 72% for the third dose. This illustrates Uganda's ability to access most of its children for vaccination, but its challenges with re-reaching them to ensure that they are fully protected against vaccine-preventable diseases. Figure 2 breaks down DTP3 survey coverage by various characteristics to better accentuate the country's situation surrounding equity in immunization. Readers should bear in mind that immunization survey data captures the coverage situation 1-2 years prior to the date of the survey.

Figure 2. Comparison of DTP3 Survey Coverage Data by Varying Characteristics; UDHS 2006 and 2011

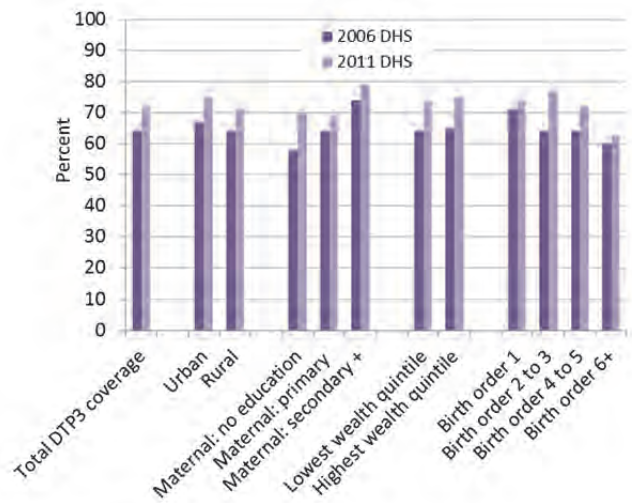


Figure 2 illustrates UDHS estimated DTP3 coverage by various characteristics that help tease out issues surrounding equity. While total DTP3 coverage shows an increase in 2011 compared to 2006, of note—unlike a number of sub-Saharan African countries (e.g., Ghana Tanzania, Zambia)—the coverage gap in Uganda between richer and poorer families with young children has consistently been minimal within each survey. But similar to many other countries, a noticeable gap exists in coverage within each survey between urban versus rural, maternal secondary+ education versus no education, and first child in birth order versus 6+ child. Progress in improved DTP3 coverage from 2006 to 2011 for all of these characteristics can be reviewed in the figure itself.

FY 2013, Quarters 1 and 2: Achievement Highlights

MCHIP's immunization program in Uganda, which started activities in June 2012, is supported by USAID with the focus of helping to strengthen the country's routine immunization system through providing technical assistance to the Uganda National Expanded Program on Immunization (UNEPI) at central level and in selected districts. The emphasis of the program is on operationalizing the Reaching Every District (RED) approach, including quality improvement techniques. To accomplish this, MCHIP works closely with UNEPI and technical program partners such as WHO, UNICEF, Uganda Pediatrics Association, Africa Field Epidemiology Network (AFENET), and Sabin Vaccine Institute.

At national level, MCHIP supports UNEPI in reaching high, sustained, and more equitable routine immunization coverage; maximizing investments in new and underused vaccines; improving the quality and use of data; improving vaccine and cold chain management; and encouraging more efficient use of available resources. In focus districts, MCHIP will begin in 2013 to contribute to improving the ability of the DHTs to provide long-term and affordable technical and managerial support to their health workers, to implement effective routine immunization service delivery strategies using RED and quality improvement approaches, and to sustainably improve their immunization coverage.

MCHIP/Uganda's Main Objectives

Objective 1: At national level, to improve the capacity of UNEPI to plan, manage, implement, monitor, and coordinate support for routine immunization.

Objective 2: In select Mission focus districts, to strengthen District Health Team (DHT) capacity to manage and coordinate support for routine immunization.

Priorities for Quarters 3 and 4

National:

- Support UNEPI and partners in the development of a quarterly newsletter and newspaper insert that include district league tables.
- Refine the RED + quality improvement methodology for selected districts; train a central team.
- Finalize district assessment baseline and periodic review tools.
- Promote better data use and follow-up using RED and quality improvement techniques, starting with micro-planning and Health Unit catchment area mapping (a particular issue in recent years due to a series of re-districting exercises).
- Assist UNEPI and partners with finalizing and following up on EPI policy.
- Collaborate with UNEPI and partners in following up with implementation of the two-year RI revitalization plan.
- Promote active use of data through supporting national-level, regular focus on data quality self-assessments and supportive supervision.
- Update the Performance Management Plan using baseline data.
- Work with MOH departments on the review of materials/status for Health Unit Management Committees (HUMCs) and Village Health Teams (VHTs) and support updates that focus on strengthening community partnerships in health, with implications on training and implementation in the project districts.
- Evaluate and supervise post- PCV introduction in Iganga District.

District:

- Work with UNEPI and districts, as needed, on solving gas cylinder problems without external inputs (tracking cylinders, update inventory, etc.).
- Support district-, health sub district- and sub county-level review meetings.
- Conduct training for health workers and VHTs focusing on EPI, RED, and introduction of quality improvement.

- Operationalize all components of RED, incorporating lessons learned from Masaka District with quality improvement (using Plan-Do-Study-Act cycles), including focus to:
  - Strengthen supportive supervision and follow-up, using supervisors as quality improvement coaches.
  - Improve how data are collected, analyzed, used, and followed up on (data quality).
  - Strategize with districts and their health units on how best to reach all of their target population with reliable static and outreach services, including a macro and micro catchment area mapping update exercise.
  - Build stronger community partnerships with health units; use key community and administrative members as an integral part of quality improvement teams at all levels.
  - Improve how routine immunization services are planned, managed, and resourced (human, financial, etc.).

Country Summary: Ukraine

Period: FY 2013, Quarters 1 and 2

Selected Health and Demographic Data for Ukraine	
GDP per capita (USD)	2,467.92
Total population	46,008,406
Maternal mortality ratio (deaths/100,000 live births)	26
Skilled birth attendant coverage	98.7
Antenatal care, 6+ visits	74.7
Neonatal mortality rate (deaths/1,000 live births)	9
Infant mortality rate (deaths/1,000 live births)	14
Under-five mortality (deaths/1,000 live births)	13 [130]*
Treatment for acute respiratory infection	--
Oral rehydration therapy for treatment of diarrhea	--
Diphtheria-pertussis-tetanus vaccine coverage (3 doses)	90
Modern contraceptive prevalence rate	79.3
Total fertility rate	1.2
Total health expenditure per capita (USD)	179.57

Sources: World Bank, Ukraine 2007 Demographic and Health Survey, WHO, UNICEF.
*UNICEF <5 mortality ranking (1 = highest mortality rate)

Major Activities

- Represent USAID in a multi-donor EPI review
- Prepare materials to support health professionals' training on immunization
- Prepare materials for health care providers and the public that support efforts to restore trust in immunization

Program Dates	Workplan drafted, not yet submitted. FY 2011–September 2013					
PY 5 Budget	$90,000 (FS) $10,000 (polio) $100,000					
Total Mission Funding to Date	$90,000					
Geographic Focus	National					
Geographic Coverage	No. of provinces	0	No. of districts	0	No. of facilities	0
MCHIP In-Country Contact	Fedir Lapii Ivanovich (Consultant)					
HQ Managers and Technical Advisors	Pat Taylor: ptaylor@mchip.net; Robert Steinglass: rsteinglass@mchip.net; Mike Favin: mfavin@manoffgroup.com; Kelli Cappelier: kcappelier@mchip.net					

FY 2013, Quarters 1 and 2: Achievement Highlights

Goal: Contribute to restoring public confidence in immunization.

Objective 1: Participate in a comprehensive, multi-agency review of the immunization program.

- MCHIP assisted in planning the review, including adaptation of the standard WHO instruments.
- Participated in the review (February–March 2012) and contributed to one regional report (for Lviv Oblast), the overall review report, and the PowerPoint presentation for the debriefing with the Government of Ukraine, particularly related to communication and advocacy.
- Based on participation in the assessment and discussion with UNICEF and WHO staff, developed a draft workplan for MCHIP activities.
- Reached verbal agreements with partners on collaboration on activities.

Objective 2: Prepare and/or select technical materials, with a focus on vaccine safety and benefits, for classroom use and as references for physicians' and nurses' pre-service and in-service training.

- MCHIP contracted with a very experienced Ukrainian consultant to review and finalize these draft materials in English.
- The consultant is reviewing, adapting, and preparing technical materials on immunization (documents, PowerPoint presentations) to support health professionals' in-service training and other learning opportunities (e.g., professional conferences).

Objective 3: Prepare materials for parents concerned with vaccine safety, benefits, and risks.

- Based on a desk review of similar materials from the U.S. and other countries: 1) drafted job aids and simple references to enable health workers to more effectively counsel parents, respond to difficult questions, and persuade parents to accept vaccination for their children; and 2) drafted job aids and simple reference materials to teach and remind health workers of correct technical information, e.g., on determining eligibility for vaccination, administering vaccinations, and ensuring injection safety.
- MCHIP contracted with a very experienced Ukrainian consultant to review and finalize these draft materials in English and to recommend additional materials. He also reached verbal agreements with the Ministry of Health on collaboration for the distribution of materials.
- The guidebook "Understanding Vaccines" was fully reviewed and translated into Russian and Ukrainian to communicate general information about vaccines, how they work, and why they are important. Other, shorter, materials have also been translated.

Priorities for Quarter 3 and 4

- Finalize all materials in English. Complete translations of all of the materials into Russian and Ukrainian.
- Work through the MCHIP consultant and partners to complete the technical review of the English materials (for facilities and training) in Ukraine.
- Pre-test materials with mothers and health care staff, with the assistance of partners and communications consultant, if necessary.

- Finalize all materials based on technical reviews and pre-test results.
- Work with MOH, UNICEF, and WHO to ensure wide distribution of the materials to training institutions and down to the rayon (second-level subdivision) level.

Country Summary: Yemen

Period: FY 2013, Quarters 1 and 2

Selected Health and Demographic Data for Yemen	
GDP per capita (USD)	1,361.2
Total population	24,799,880
Maternal mortality ratio (deaths/100,000 live births)	200
Skilled birth attendant coverage	35.7
Antenatal care, 4+ visits	
Neonatal mortality rate (deaths/1,000 live births)	32
Infant mortality rate (deaths/1,000 live births)	57
Under-five mortality (deaths/1,000 live births)	76.5
Treatment for acute respiratory infection	87.8
Oral rehydration therapy for treatment of diarrhea	38
Diphtheria-pertussis-tetanus vaccine coverage (3 doses)	81
Modern contraceptive prevalence rate	27.7
Total fertility rate	5.1
Total health expenditure per capita (USD)	88.4

Sources: World Development Indicators, 2011, World Bank; Global Health Observatory, 2010–2011, WHO, Countdown Profile 2012.

Major Activities

- *Yemen Maternal, Newborn and Child Health Situation Analysis* completed in October 2012
- Submission of revised workplan to USAID/Yemen based on feedback from MOPHP
- Submission of a concept note to USAID/Yemen for potential future activities
- Securing of MCHIP office space, equipment and supplies in Sana'a (co-located with USAID | DELIVER)

Program Dates	October 2012–September 2013					
PY 5 Budget	$1,000,000 Field Support Funds					
Total Mission Funding to Date	S1,000,000 Field Support Funds					
Geographic Focus	National					
Geographic Coverage	No. (%) of provinces	2 (9%)	No. of districts	0	No. of facilities	0
MCHIP In-Country Contact	George Sanad, Chief of Party: gsanad@jsi.com					
HQ Managers and Technical Advisors	Patricia Taylor, Country Support Team Leader: ptaylor@mchip.net Sheena Currie, Maternal Health Advisor: Sheena.Currie@jhpiego.org Anne Pfitzer, Family Planning Team Leader: Anne.Pfitzer@jhpiego.org Rae Galloway, Nutrition Team Leader: rgalloway@path.org Serge Raharison, Senior Child Health Technical Officer: sraharison@jsi.com Uzma Syed, Newborn Technical Advisor: usyed@savechildren.org Asnakew Tsega, Immunization Technical Advisor: atsega@jsi.com Victoria Rossi, Senior Program Officer: vrossi@mchip.net Nathalie Albrow, Senior Program Officer: nalbrow@mchip.net Kate Brickson, Senior Program Officer, kate.brickson@jhpiego.org Joanna Michler, Program Officer, jmichler@savechildren.org					

FY 2013, Quarters 1 and 2: Achievement Highlights

USAID/Yemen requested MCHIP to support its efforts to strengthen the maternal, newborn, and child health (MNCH), family planning (FP), and nutrition services of the Ministry of Public Health and Population (MOPHP). A Program Description explained that this field funding was intended to allow MCHIP to:

- Conduct a needs assessment and gap analysis for MNCH/FP and nutrition programming in Yemen
- Develop a concept paper for potential future activities
- Initiate the implementation of key MNCH/FP and nutrition activities in the country

Responding to USAID's Development Objective, MCHIP's ultimate goal is to improve the health and nutrition status of the Yemeni population, with a focus on the most vulnerable. During the Quick Start period, the focus is on getting in place a core team of advisors and the COP, who will oversee the following Quick Start technical support activities. Achievement highlights for each of the Quick Start activities are detailed below.

Activity 1: Project start-up.

- The *Yemen Maternal, Newborn, and Child Health Situation Analysis* was prepared summarizing the key information gathered, findings, impressions, and recommendations for MCHIP support that came out of the in-country needs assessment and gap analysis conducted in October 2012.
- Technical representatives from MCHIP travelled to Yemen from 9–20 March 2013 to finalize the workplan, initiate some of the Quick Start activities, and meet with the MOPHP, USAID, and other donors and nongovernmental organizations. As a result of new perspectives brought to MCHIP's work by the new Deputy Minister for Population and Reproductive Health at the MOPHP, Dr. Nagiba Al Shwafi, the MCHIP team revised and re-submitted the Quick Start workplan. Sana'a City, Dhamar Governorate, and possibly the city of Aden were identified as areas where MCHIP should work, and Dr. Nagiba asked that Hodeidah and Lahj Governorates be removed from the Quick Start activities.
- The MCHIP team submitted a Principal Cooperation Agreement between the Ministry of Planning and International Cooperation (MOPIC) and John Snow, Inc. (JSI), which will officially register JSI in Yemen. The team secured office space, equipment, and supplies for the opening of a joint office to house MCHIP and USAID | DELIVER in Sana'a. The MCHIP team short-listed and interviewed three COP candidates in collaboration with USAID/Yemen, and also conducted interviews for recruitment of the Senior Maternal and Newborn/FP Health Advisor.
- The MCHIP team submitted a concept note to USAID/Yemen for potential future activities.

Activity 2: Improve access to and the quality of services delivered by midwives (MWs) in Yemen.

- During the 9–20 March 2013 trip, the MCHIP technical team met with the MOPHP, USAID, and other organizations to discuss the proposed maternal and newborn health activities. They also met with Dr. Taha and staff at the Higher Institute of Health Sciences (HIHS) in Sana'a, which resulted in productive discussions for MCHIP to review and support the new three-year community midwifery education program. The MCHIP technical team visited three hospitals to meet with providers, gather data, and observe both in-service and pre-service training activities. A debriefing session was held with Dr. Nagiba (MOPHP) and Dr. Alia (USAID) on 19 March 2013. In addition to the points summarized above regarding the change in geographical areas, Dr. Nagiba requested support to improve training approaches and post-training follow-up as well as support for improving quality of care beginning in Al Sabeen Hospital in Sana'a.

Activity 3: Introduce community prevention of PPH.

- The MCHIP technical team communicated regularly with the Yemeni organization Yamaan Foundation regarding PPH activities, including distribution of misoprostol for prevention of PPH at community level. However, at the team's in-briefing meeting on 9 March 2013, Dr. Nagiba (MOPHP) requested that no activities around misoprostol be conducted until the drug is registered. The Quick Start workplan for the PPH activities was revised to include advocacy and preparation of IEC and training materials.

Activity 4: Assess the availability of and advocate and plan for evidence-based newborn care.

- The MCHIP technical team visited health facilities to discuss newborn care with providers. The Quick Start workplan for newborn health was updated to be in line with MOPHP strategies.
- The MCHIP technical team visited health facilities to discuss newborn care with providers.

Activity 5: Assess the accessibility and quality of long-acting reversible contraceptives (LARC) services in various settings, and initiate PPFP/PPIUD services and training at Al-Sabeen hospital.

During the 9–20 March 2013 trip, the MCHIP technical team met with the MOPHP and USAID to discuss the proposed long-acting reversible contraception (LARC) activity and to solicit their advice and counsel. Dr. Nagiba (MOPHP) clearly stated that she is opposed to community midwives being trained on contraceptive implants and informed the MCHIP team and Dr. Alia (USAID) that midwives using implants is not legal. She suggested that MCHIP identify the capacity of community midwives to provide intrauterine device (IUD) services and their rate of complications.

- The MCHIP technical team met with LARC trainers to observe a Pathfinder intrauterine device (IUD) training in their office. The team also visited Al-Sabeen facilities and the Director of Ob/Gyn, Dr. Tawfik, expressed interest in postpartum IUDs, inclusive of a Training of Trainers (TOT). The Director of Ob/Gyn at Al-Thawra Referral Maternity, which sees women with complicated pregnancies/labors, requested postpartum IUD training. The MCHIP technical team visited the District Hospital in Matnah, Sana'a Governorate, other sites, and some training activities with assistance from Dr. Lina Amin, a Yemeni pediatrician who has worked extensively with NGOs and MOPHP.
- The workplan for maternal health was revised to be in line with achievable Quick Start activities. The plan is to conduct a broader assessment of LARCs in Yemen, including issues of access and quality of services, with community midwives and public and private sector facilities being sampled for assessment. A concept paper is being drafted to lay out the evaluation questions and methodology for this assessment. It is anticipated that a study protocol will be developed.

Activity 6: Implement learning activities for integrated maternal, infant, and young child nutrition and family planning (MIYCN-FP).

- The MCHIP technical team identified and met with FP and nutrition stakeholders in Sana'a to discuss the current policy and program environment for nutrition and family planning. They also discussed the proposed MCHIP MIYCN-FP activity, which would use a methodology called Trials of Improved Practices (TIPs) to identify current MIYCN-FP practices and mothers' willingness and ability to make changes to their current practices. The study also includes interviews with key informants who are influential over maternal nutrition and infant and young child feeding and family planning. The team met with Dr. Ali Al-Assabri, a professor at Sana'a University in the Department of Community Medicine, and two nutritionists, Drs. Huda Basaleem (by phone) and Khaled Al-Gendari, who could give technical assistance to implementing the TIPs study. The MCHIP technical team worked on the draft protocol and instruments for the TIPs study. The MOPHP selected Dhamar Governorate as the Governorate where the study would take place. Tentative dates were identified when the MCHIP headquarters team could be in Yemen to conduct the training of the consultant(s).
- The MCHIP technical team discussed the MIYCN-FP component of the proposed MCHIP program with Save the Children (SC), and opportunities for collaboration within SC's existing health and nutrition programs were identified. They also discussed working in Dhamar. While SC does not work in Dhamar, the Governorate is close to Sana'a and SC is willing to provide support for this activity. The Team met with SC's Head of Security, who is from Dhamar and was very helpful in giving advice about working in Dhamar, and contact information was shared for the former DG for Health.
- Prior to the removal of Hodeidah from the Quick Start workplan, the MCHIP technical team met with the Hodeidah Governorate Health Office and other identified stakeholders. These stakeholders were supportive of the MIYCN-FP activity because there were few interventions to prevent malnutrition in Hodeidah. There is more information about malnutrition in Hodeidah than Dhamar, but because there are similar ecological zones in both Governorates (plains, valleys, plateaus, and mountains), information from Hodeidah was helpful in informing the design of the TIPs sampling frame for Dhamar.

Activity 7: Support the improvement of newborn and child health interventions, and immunization at peripheral health facility and community levels.

- During the 4–17 October 2013 trip for the needs assessment, the MCHIP technical team met with the Deputy Minister in charge of Primary Health Care (PHC) and with Dr. Ali Jahhaf, PHC Director at MOPHP, to agree on principles and to identify key priorities in child health and immunization.
- During the same trip, further discussions with Dr. Mohammed Alemad at WHO confirmed that the integrated PHC curriculum is the basis of all facility-level activities for all partners.
- Discussions with UNICEF and with the Nutrition Department at the MOPHP confirmed interest in requesting MCHIP's support to harmonize Community Health Volunteers' (CHV) interventions, including CCM and other services.
- During the same trip, initial discussions and several follow-up phone meetings with Dr. Ghada (manager of MOPHP's immunization program) allowed refinement of the role MCHIP can play to support the routine immunization program.
- The workplan for CH and immunization was developed and revised through multiple iterations to be in line with achievable Quick Start activities.

Activity 8: Assessments, advocacy, and technical support for increased political commitment and resource mobilization for High Impact Interventions (HII) in MNCH/FP and nutrition.

- The MCHIP technical team met with the DFID representative to discuss the Scaling Up Nutrition (SUN) activity, a multi-sector effort to scale up nutrition activities. USAID would like MCHIP to support this effort, which is just beginning.

Priorities for Quarters 3 and 4

Activity 1: Project start-up.

- Receive final approval from USAID (and MOPHP) for the Quick Start workplan.
- Receive final approval of the Principal Cooperation Agreement between MOPIC and JSI, which will officially register JSI in Yemen. Execute a Collaboration Agreement between MCHIP and MOPHP detailing MCHIP's plans for strengthening the capacity of MOPHP staff. Execute a Sub-Agreement between MCHIP and MOPHP for purposes of registering MCHIP (as a project) in Yemen.
- Complete COP recruitment and have him/her take up the post. Complete recruitment for the Senior Maternal and Newborn/FP Health Advisor.
- Develop a plan to transition selected Community Livelihood Project (CLP) activities to MCHIP.

Activity 2: Improve access to and the quality of services delivered by midwives (MWs) in Yemen.

- Support dissemination and utilization of MNH training packages.
- Build capacity of HIHS staff to support the rollout of the updated, three-year community midwifery program, including use of competency-based training.
- Support the evaluation of the Community-Based Maternal and Newborn Care program (in collaboration with UNICEF) with a view to scaling up successful elements of this program.
- Explore means to support capacity building of existing private midwives and explore expansion.
- Support quality improvement at Al Sabeen Hospital Sana'a in collaboration with GIZ.
- Draft a plan to guide long-term efforts of MCHIP to strengthen postabortion care (PAC) services in Yemen.

Activity 3: Introduce community prevention of PPH.

- Improve performance of community midwives in prevention and management of PPH. Plans for sustainable supply uterotonics are under way.

Activity 4: Assess the availability of and advocate and plan for evidence-based newborn care.

- Review documents that address newborn care messages, newborn danger signs, and newborn management protocols to assess the need for inclusion of updated evidence-based information for newborn care interventions.
- Establish a KMC unit in one governorate hospital.
- Work with stakeholders to develop a strategy for improving essential newborn care and care of sick newborns.

- Conduct a half-day stakeholders' meeting to catalyze interest in high-impact, evidence-based best practices for newborn health in Yemen.

Activity 5: Assess the accessibility and quality of long-acting reversible contraception (LARCs) services in various settings, and initiate PPFP/PPIUD services and training at Al-Sabeen hospital.

- Review national guidelines for the provision of both IUDs and implants in Yemen, and existing national training materials, and reach out to GIZ for any existing quality standards related to family planning and long-acting methods. This desk review is to inform the development of assessment tools.
- Develop a study protocol of service provision of long-acting methods (IUDs and implants) in Dhamar governorate to look at accessibility, safety, efficacy, equity, and competency of IUD and implant services for various types of service delivery points, including community midwives.
- Share the protocol with counterparts at the MOPHP and DG Health in Dhamar for review and input, and incorporate their ideas prior to submission for IRB approval.
- Carry out assessment as per protocol.
- Strengthen PPFP inclusive of PPIUD services at Al Sabeen Maternity hospital in Sana'a City and serve as a training facility in PPFP/PPIUD.
- Support the field-testing of PAC training materials and provide technical support in incorporating FP counseling and services (inclusive of FP at time of PAC services in lieu of referral).

Activity 6: Implement learning activities for integrated maternal, infant, and young child nutrition and family planning (MIYCN-FP).

- Complete the process of obtaining IRB approval for the MIYCN-FP Trials of Improved Practices (TIPS).
- Assess MIYCN and FP knowledge and practices and test new MIYCN-FP practices with mothers using the Trials of Improved Practices (TIPS) methodology.
- Identify barriers and facilitating factors related to optimal MIYCN-FP practices.
- Develop an MCHIP plan for dissemination of the results of TIPs to stakeholders.

Activity 7: Support the improvement of newborn and child health interventions, and immunization at peripheral health facility and community levels.

- Meet with the Dhamar regional team to define criteria and select two or three focus health facilities, conduct the assessment of availability and quality of services, review findings, and develop a strategy for improving services.
- Conduct refresher training, on-site mentoring, and provision of job aids, and improve collection and use of data for decision-making including death and/or near miss audits.
- Identify partners with relevant MNCH community-based projects in the catchment areas of the selected health facilities to review the components of partner community-based package for CHVs and provide technical assistance to strengthen interventions.
- Facilitate the review and, if necessary, the revision of the CHV national guidelines and develop training modules, supervision tools, data collection tools, counseling cards, and other job aids.

- Meet with the Dhamar regional team to define criteria and select one target district for immunization. Conduct a planning visit to help the targeted district adapt the RED approach, identify training needs, and develop a plan for an improved monitoring system for immunization.
- Provide assistance to the district, monitor and document the approach, and conduct a workshop to review lessons learned and develop an approach to support other districts in the Governorate.

Activity 8: Assessments, advocacy, and technical support for increased political commitment and resource mobilization for High Impact Interventions (HII) in MNCH/FP and nutrition.

- Support Scaling-Up Nutrition (SUN approach) in Yemen and define MCHIP's role in supporting SUN activities.
- Carry out a strategy workshop with the National Safe Motherhood Alliance.
- Initiate capacity building of MNCH-FP counterparts in MOPHP Reproductive Health Division.

Country Summary: Zambia

Period: FY 2013, Quarters 1 and 2

Selected Health and Demographic Data for Zambia	
GDP per capita (USD)	US$1,457
Total population	13,046,508
Maternal mortality ratio (deaths/100,000 live births)	591
Any antenatal care from a skilled provider	93.7
Antenatal care, 4+ visits	60.3
Delivery with skilled birth attendant	46.5
Any postnatal care	48.0
Births less than 2.5 kg (low birth weight)	4.4
Neonatal mortality rate (deaths/1,000 live births)	34
Total fertility rate	6.2
Modern contraceptive prevalence rate	32.7
Unmet need for family planning	26.5

Sources: Zambia International Monetary Fund; Zambia 2010 Census of Population and Housing Preliminary Results; 2007 Demographic and Health Survey.

Major Activities

- *Emergency Obstetric and Neonatal Care (EmONC)*:
  - In-service trainings
  - On-site mentorship
  - Site strengthening
- *"Helping Babies Breathe" (HBB) neonatal resuscitation program*:
  - Integration into national EmONC and ENC curricula
  - In-service training
  - On-site mentorship
- *Postpartum Family Planning (PPFP) and Long-Acting Reversible Contraceptives (LARC)*:
  - In-service trainings
  - On-site mentorship
  - Site strengthening
- *Postpartum Hemorrhage (PPH) Prevention, including Misoprostol*:
  - Development of national in-service training packages for health care providers and community mobilizers
  - In-service trainings
  - On-site mentorship

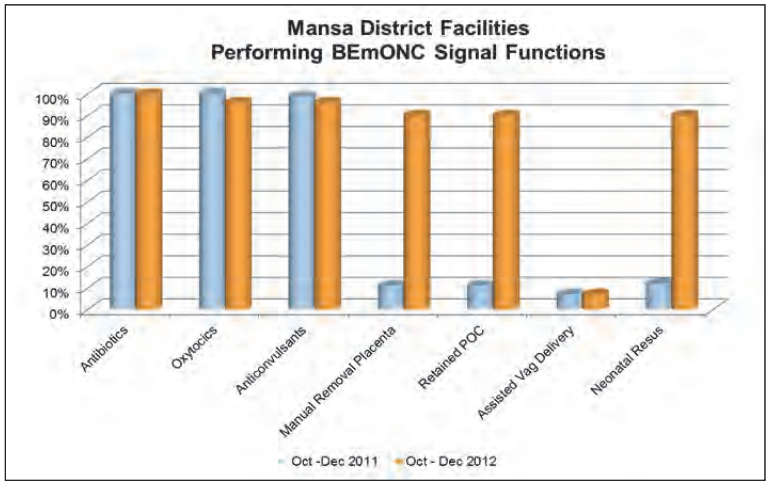
Program Dates	October 1, 2012–September 30, 2013					
PY 5 Budget	**$1,808,067** (MCH)					
Total Mission Funding to Date	$2,881,000 (obligated)					
Geographic Focus	*Kalomo, Lundazi, Mansa and Nyimba Districts*					
Geographic Coverage	No. (%) of provinces	3 (33%)	No. of districts	4	No. of facilities	113
MCHIP In-Country Contact	Kwame Asiedu, Country Rep., kasiedu@mchip.net Michelle Wallon, Project Manager, mwallon@mchip.net					
HQ Managers & Technical Advisors	Brenda Rakama, brenda.rakama@jhpiego.org; Patricia Gomez, patricia.gomez@jhpiego.org					

FY 2013, Quarters 1 and 2: Achievement Highlights

Under the USG-led "Saving Mothers, Giving Life" (SMGL) endeavor, MCHIP applies the **principles of country ownership and strategic coordination**, working in close partnership with Zambia's Ministry of Health and other USG-implementing partners in the design and implementation of SMGL interventions, toward achievement of the following objective:

Objective 1: Increase the quality of labor/delivery and postpartum/postnatal care services in MOH facilities in SMGL target districts.

- **MCHIP strengthens comprehensive emergency obstetric and neonatal care (CEmONC) at Mansa General Hospital:** Mansa General Hospital is the primary referral center in the MCHIP-supported SMGL district of Mansa. While significant gains in quality of basic EmONC services have been seen in the district's health centers, the general hospital continued to struggle despite monthly on-site mentorship. Therefore, in Quarter 2, MCHIP **conducted a CEmONC/Helping Babies Breathe (HBB) training for Mansa General Hospital**, working with nurses and midwives in the labor/delivery ward to strengthen key, basic skills and working with physicians on conducting cesarean sections and blood transfusions. This training was immediately followed by a **three-week, on-site mentorship by a midwife-physician team chosen from among Zambia's most adept national EmONC trainers**. This team paired with a midwife-physician mentor team from the hospital and, within days, had the staff proficiently conducting manual vacuum aspirations and cesarean sections and even inserting postpartum IUCDs during cesareans. The hospital's mentor team continues to mentor their providers with support from the MCHIP team in Mansa.



- **MCHIP continues to support EmONC district mentorship teams to conduct monthly visits to all facilities conducting deliveries:** In Year 4, MCHIP trained 16 mentors—District Medical Office (DMO), Provincial Medical Office, and implementing partner staff—to conduct on-site mentorship in EmONC to the 28 target facilities in Mansa District. A strong leader in this program from the outset, **the Mansa DMO has taken responsibility for coordination of this program** in the first half of Year 5, drafting the monthly mentorship schedule, organizing mentor teams, and arranging transport. The results of this work have been remarkable: **over 80% of facilities conducting all relevant EmONC functions minus assisted vaginal delivery; increase in the proportion of deliveries with a partograph from 0.06% to 52% (92% filled out correctly); 84% of women giving birth in target facilities receiving a uterotonic immediately following birth; 95% of women with PPH receiving care according to national standards and; decrease in overall case fatality rate from 4% to 2.3%.**

Objective 2: Build capacity of MOH facilities in Mansa District to increase uterotonic coverage through use of AMTSL and through distribution of misoprostol for home birth.

- **MCHIP begins drafting Zambia's national in-service curriculums for prevention of postpartum hemorrhage (PPH), including misoprostol:** In 2010, two pilots on the use of misoprostol to prevent PPH at home deliveries were completed in Zambia. In 2012/2013, MCHIP received funding to begin scaling up this intervention beyond the original 16 pilot districts. As a national in-service training package had yet to be developed, **MCHIP is currently developing two training packages—one for facility-based health care providers and one for community Safe Motherhood Action Group educators**—to ensure that a standard curriculum utilizing a holistic approach to prevention and management of PPH will be utilized across the country, regardless of the implementing partner. These drafts will be piloted in Mansa District in Quarter 3.

Objective 3: Expand the availability of quality postpartum family planning services in MOH facilities in Mansa District.

- **MCHIP trains Mansa District mentors in postpartum family planning (PPFP) and long-acting reversible contraceptives (LARC):** In Year 5, the Zambia program is rolling out PPFP and LARC to selected target facilities in Mansa District. With technical assistance from MCHIP's Senior MNH Advisor and a senior trainer from the Kenya office, **MCHIP trained 15 active district mentors in all LARC and postpartum methods, including the Jadelle implant, interval intrauterine contraceptive device (IUCD), and postpartum IUCD (PPICUD)**. In the past, LARC training programs in Zambia have been challenged by a lack of available clientele for clinical practice and by a lack of ongoing support for providers when they return to their facilities. MCHIP is overcoming the former challenge by training at clinical sites where LARC and PPIUCD services have been previously established by other partners. MCHIP is addressing the latter challenge by **first training the district mentors to ensure they can integrate mentorship in family planning into their routine, monthly EmONC mentorship**. Training of providers will begin in Quarter 3.

Priorities for Quarters 3 and 4

- Integrate HBB into the national EmONC and ENC in-service curriculums.
- Conduct HBB trainings for additional providers in Kalomo, Lundazi, and Nyimba Districts.
- Pilot the draft national curricula for PPH prevention including misoprostol, and train health care providers and community Safe Motherhood Action Groups (SMAGs) at seven health facilities in Mansa District.
- Conduct two trainings in PPFP and LARC for service providers in Mansa District.
- Continue to support DMO-led, on-site monthly mentorship in Mansa District.

Country Summary: Zimbabwe

Period: FY 2013, Quarters 1 and 2

Selected Health and Demographic Data for Zimbabwe	
GDP per capita (USD)	449.18
Total population	12,522,784
Maternal mortality ratio (deaths/100,000 live births)	790
Skilled birth attendant coverage	68.5
Antenatal care, 4+ visits	71.1
Neonatal mortality rate (deaths/1,000 live births)	23.8
Infant mortality rate (deaths/1,000 live births)	59.9
Under-five mortality (deaths/1,000 live births)	80 [37]*
Treatment for acute respiratory infection	26.3
Oral rehydration therapy for treatment of diarrhea	70
Diphtheria-pertussis-tetanus vaccine coverage (3 doses)	73
Modern contraceptive prevalence rate	58.4
Total fertility rate	3.8
Total health expenditure per capita (USD)	66.42

Sources: World Bank, Zimbabwe Demographic and Health Survey, WHO, UNICEF.
*UNICEF <5 mortality ranking (1=highest mortality rate)

Major Activities

- Maternal Health:
  - Standards-Based Management and Recognition (SBM-R) and PQI
  - Emergency obstetric and newborn care (EmONC)
- Newborn Health:
  - Kangaroo Mother Care (KMC)
  - Helping Babies Breath (HBB)
- Child Health:
  - Diarrhea case management, ORT/zinc
  - Malaria community case management (CCM)
- Immunization:
  - NUVI (PCV-13 and Rotavirus introduction)
  - Routine immunization: Reaching Every District (RED)
- Nutrition
- IYCF

Program Dates	October 1, 2010–September 30, 2013					
PY 5 Budget	$4,233,575 (MCH: $3,385,835; FtF: $159,450; PMI: $388,291; NUVI: $300,000)					
Total Mission Funding to Date	$9,375,000: MCH:$8,750,000 ($6,000,000 FY09 and FY10 plus $2,750,000 FY11); FtF: $450,000; PMI: $425,000)					
Geographic Focus	*National, provincial, district, and community; District learning sites: Mutare and Chimanimani*					
Geographic Coverage	No. (%) of provinces	1 (12%)	No. of districts	2	No. of facilities	277
MCHIP In-Country Contact	Dr. Rose Kambarami: rose@mchipzim.org					
HQ Managers and Technical Advisors	Patricia Taylor, ptaylor@mchip.net; Nathalie Albrow, nalbrow@mchip.net; John Varallo, jvarallo@mchip.net; Dyness Kasungami, dkasungami@mchip.net; Rae Galloway, rgalloway@mchip.net; Asnakew Tsega, atsega@mchip.net; Sheena Currie, scurrie@mchip.net; Stella Abwao, sabwao@mchip.net; Rebecca Levine, rlevine@mchip.net					

FY 2013, Quarters 1 and 2: Achievement Highlights

Objective 1: Support the Ministry of Health and Child Welfare (MOHCW) to formulate national health policies, strategies, and programs that increase the population's access to affordable, evidence-based, high-impact maternal, newborn and child health/family planning (MNCH/FP) interventions.

- MCHIP supported the National Integrated Health Facility Assessment/Equity and Quality of Care **(NIHFA/EQOC) Task Force** by contributing to sections on maternal and newborn health quality of care in the finalized NIHFA/EQOC report and supporting the MOHCW with dissemination. MCHIP will continue to package and disseminate information on QOC to facilitate action toward **quality improvement of health services**.
- MCHIP provided technical assistance to the **MOHCW** for national-level trainings and trainings of trainers, including: holding **three national Effective Vaccine Management / Reaching Every District (RED) trainings** in advance of the introduction of the rotavirus vaccine; supporting **four participants on a two-week inter-country Mid-Level Manager immunization training** conducted by WHO; conducting supportive supervision (SS) for health facilities (HFs) in five districts focused on **Helping Babies Breathe (HBB) and Kangaroo Mother Care (KMC)** services; and supporting several national **EmONC trainings** for health workers (HWs) and tutors. In sum, a total of **30 trainers** and **450 HWs** have been trained in MNCH training packages with MCHIP support thus far.
- A major achievement in collaboration with the MOHCW Reproductive Health Unit was the finalization of the national **maternal and perinatal mortality audit guidelines** and review of the maternal and perinatal death notification forms.
- MCHIP continued to support the **MOHCW National Nutrition Department** in developing an **Implementation Matrix** to accompany the National Food and Nutrition Security Policy; finalizing key nutrition reports including the **Infant and Young Child Feeding (IYCF) Program Review** and the **National IYCF Policy**; and participating in the National Nutrition Review and Planning meeting in Mutare. The launch of the Food and Nutrition Security Policy is anticipated in Quarter 3.
- Regarding the **oxytocin potency study**, MCHIP conducted a joint training for enumerators with the Medicines Control Authority of Zimbabwe.
- MCHIP formulated **IEC/BCC materials** and child health and HW job aids for distribution in Manicaland Province in Quarter 3. Topics covered included pneumonia, measles, 17 key household practices, the new immunization schedule, and HW guidelines for diarrhea prevention and management in children under five.
- In support of the MOHCW Quality Assurance Unit, MCHIP provided technical and financial assistance to **QA/QI Technical Working Group (TWG) meetings** and is participating in two sub-TWG groups on Standards and Health Worker Performance. Having brought together multiple stakeholders to draft the **National QA/QI Policy**, MCHIP will go on to work closely with others on the development of a QA/QI Strategy.
- MCHIP developed a national training package for Malaria Community Case Management for the **National Malaria Control Programme**.
- MCHIP contributed to finalization of the **MOHCW's Health Information Unit's** annual 2013 Work Plan, and supported both the training of HWs in Manicaland Province on the District Health Information Software version 2 **(DHIS 2)**, and conducted **PTFU visits in three districts** to assess progress and challenges in the DHIS 2 pilot. An evaluation of the DHIS 2 pilot is envisioned for Quarter 4 and findings will inform national DHIS 2 rollout. In addition, MCHIP continues to participate actively in the **National Health Information System Steering Committee**.

- To strengthen partnerships for MNCH, MCHIP has participated in a **Joint Review Mission for the Health Transition Fund (HTF)** to assess HTF implementation and progress nationally; supported **the Integrated Support Programme launch** and the **Absolute Return for Kids Project** launch; and has been working closely with the new Director of Family Health and Child Survival Technical Working Group Chair to resume progress in **national-level leadership and coordination in MNCH**.

Objective 2: Improve the quality of maternal, newborn, and child health services at health facilities in learning sites and support national-level scale-up plans.

- MCHIP continued to provide substantial technical and financial assistance to the MOHCW for provincial- and district-level trainings by: **training 20 HWs in Integrated Management of Newborn and Childhood Illness (IMNCI)** in Mutare and Chimanimani and following up in Quarter 2 with post-training follow-up (PTFU) and SS for IMNCI; **training 22 HWs in malaria case management**, including use of the IMNCI strategy and the Rapid Diagnostic Test (RDT) to screen for malaria, with PTFU; supporting the provincial EPI team in carrying out integrated EPI and child health SS/data verification in **16 HFs in four districts**; training nurses from Nyanga HFs in **Provincial Effective Vaccine Management**; and supporting several important meetings, such as the EPI Review Meeting and the Provincial Maternal and Perinatal Mortality Audit Meeting.
- MCHIP supported Baby Friendly Hospital Initiative (BFHI) training at Mutambara Mission Hospital in Chimanimani, in which **48 clinical staff, 18 managers, and 33 support staff** participated. This training was aimed at equipping hospital staff with knowledge and skills to implement 10 steps to successful breastfeeding, in preparation for certification as a "baby friendly hospital." **At the MOHCW's request**, MCHIP will support an additional BFHI training in Chimanimani in Quarter 3, at Rusitu Hospital.
- MCHIP continues to support **Standards-Based Management and Recognition (SBM-R) quality improvement** processes being implemented in Mutare and Chimanimani via HW performance assessments and facility action plan revisions. An SBM-R "Module 3" workshop elicited stakeholder agreement on the value of linking SBM-R outcomes with health outcome data, as well as agreement on "recognition" criteria for HFs who meet performance standards. Overall, MCHIP-supported SBM-R facilities continue to show improvements: at baseline (November/December 2010), 14 of 17 facilities scored "0" in meeting performance standards; currently, **100%** of the 17 HFs in our two learning districts reach at least **80%** of MNH performance standards.
- MCHIP conducted **KMC training** for HWs in Mutare and Chimanimani, an opportunity also to pre-test the **revised KMC training package**, which is envisioned to be finalized in Quarter 3. The training at the Mutare Provincial Hospital took place in the newly refurbished KMC unit, supported by MCHIP, which will be **ready to admit low birth weight babies** by Quarter 3.
- MCHIP led **HBB trainings** in newborn resuscitation for **43 Chimanimani and 58 Mutare maternity ward HWs** from **17 SBM-R sites**.
- MCHIP supported the Manicaland Provincial Health Executive in conducting the **first ever province-wide integrated Data Quality Self-Assessment (DQS)** that assessed the quality of both EPI and MNCH indicators. The DQS report will be finalized and disseminated in Quarter 3 and MCHIP is planning to support the PHIO in leading a provincial-level stakeholder meeting.
- MCHIP continued to support PHE/DHEs in conducting PTFU and SS with **eight IMNCI-trained Registered General Nurses** and **19 HWs** in malaria case management in Chimanimani, and in integrated SS for both districts.

Objective 3: Improve the coverage and quality of high-impact MNCH/FP interventions provided by health care workers in the community, including VHWs and other agents.

- Overall, **204 Village Health Workers (VHWs)** were trained in community MNCH services (including malaria testing using RDT and a refresher of cMNCH) within MCHIP districts, which is double the target of 100 VHWs for the year.
- MCHIP conducted **community HMIS training for 94 VHWs** participating in the "intervention arm" of **performance quality improvement (PQI)** in Mutare and Chimanimani, as well as supported **20 VHWs** in Peer SS, all of which will contribute toward VHWs being able to accurately report community health data and provide SS to VHW peers.
- Following recommendations from the VHW baseline assessment done in Mutare and Chimanimani in August 2012, MCHIP developed a procurement plan for **essential VHW supplies** and supported a **handover ceremony** in Chimanimani District. During the ceremony, which was **attended by MOHCW representatives**, MCHIP handed over equipment and supplies such as bicycles, aprons, thermometers, methylated spirit, cotton wool, and other first aid supplies. These supplies will go a long way toward **improving VHWs' ability to perform** their duties effectively, while also boosting morale.
- Based on results from MCHIP's **Performance Quality Improvement (cPQI) baseline assessment** in August 2012, MCHIP supported **refresher training for 64** (including 10 newly trained) VHWs from St. Andrews, Mutare.
- MCHIP provided much-needed **emergency response support** to Manicaland during a malaria outbreak through support for HW/VHW training, as well as support for **27 malaria community sensitization meetings** reaching **515 community leaders** in Mutare and Chimanimani. MCHIP also provided technical and coordination assistance to the National Malaria Control Program, the PHE/DHEs, and other partners.

Objective 4: Increase routine immunization coverage in Manicaland Province and support the nationwide introduction of pneumococcal vaccine by 2012 and rotavirus vaccine by 2013.

- Overall, MCHIP is continuing to strengthen immunization services through training of HWs and routine immunization activities in all **seven districts in Manicaland**.
- MCHIP supported the MOHCW Expanded Program on Immunization (EPI) department in implementing a national **Post Introduction Evaluation (PIE)** for the pneumococcal conjugate vaccine (PCV 13). Findings from this evaluation will inform the upcoming rotavirus vaccine introduction, scheduled for early 2014. MCHIP also provided substantial technical support to the MOHCW in the finalization of its **Annual Progress Report and Joint Reporting Form** submissions to GAVI. Finally, MCHIP's CH/Immunization Advisor participated in **EPI Review Meetings** for the Southern and Northern Regions, where routine national immunization data were presented along with findings from PIE and other activities.
- To assist the Mutare District team in carrying out EPI outreach, MCHIP facilitated **four days of outreach activities**, contributing to reaching the district's total monthly target of 1,208 children vaccinated.
- MCHIP/Zimbabwe staff participated in the **Eastern and Southern African EPI Managers Meeting** in Harare together with other national and HQ MCHIP staff. An opportunity for **south-south collaboration** occurred when the MCHIP/Malawi Immunization Officer visited MCHIP-supported sites and learned about immunization work in Zimbabwe, taking lessons back to Malawi for implementation. Following the meeting, the MCHIP/HQ Immunization Advisor stayed on to assist with ongoing immunization and new vaccine introduction activities.

Priorities for Quarters 3 and 4

- Continue to support MOHCW with the review/operationalization of national MNCH policies and the MNH Road Map, participation in MNCH WGs, and national commemoration activities (e.g., Africa Vaccination Week).
- Continue to support both internal and external M&E, research, and reporting-related activities to inform decision-making and learning.
- Monitor the link between progress in PQI and selected health indicators; explore platforms for scaling up PQI/cMNCH at the national level through VHWs; support PQI for KMC; and track progress in PQI/Malaria and selected caseload indicators.
- Help package and disseminate NIHFA/EQOC results and recommendations for action.
- Contribute to preparations for the Food and Nutrition Security Policy launch.
- Distribute IEC/BCC materials on child health and HW job aids in Manicaland Province.
- Finalize the integrated DQS report for Manicaland PHE and disseminate findings, perhaps in collaboration with the PHIO through a provincial-level stakeholder meeting.
- Follow up on success of Baby Friendly Hospital Initiative (BFHI) training at Mutambara Mission Hospital by conducting a BFHI training at Rusitu Hospital in Chimanimani.
- Continue to assist DHEs to plan KMC scale-up at district and health center level and finalize the revised KMC training for use in new and existing KMC units in Mutare and Chimanimani.
- At the request of the national-level Director of Family Health, provide technical and financial support to capacity-building/refresher training for all new Provincial Maternal and Child Health Officers (Manicaland and other provinces) in the areas of IMNCI and EPI.
- Support an evaluation of the DHIS 2 pilot in Manicaland, whose findings will be used to inform national DHIS 2 rollout.
- Continue to provide support to Mutare Provincial Hospital (MPH) and other facilities in management of obstetric complications, in addition to supporting MPMA meetings so that HWs can review mortality cases and use the data for decision-making and action.
- Implement SBM-R Modules 3 and 4 and continue to conduct SBM-R/MNCH internal self-assessments and SS visits; track and report on links between MNCH health outcome indicators and changes in SBM-R performance improvements.
- Provide ongoing technical assistance to the MOHCW for RED implementation in all seven districts, including support of training of nurses in IIP in Manicaland, PTFU of IIP-trained supervisors, and support outreach in hard-to-reach areas.
- Continue contributing to the development of the rotavirus vaccine introduction plan, providing technical assistance to the MOHCW in updating data collection and reporting tools, as well as training materials and national-level orientation for EPI managers, as needed.
- Continue to support the advancement of the oxytocin study.

Improving Access to Malaria Treatment in Remote Areas of Zimbabwe

Utseya Village is situated about 10 miles from Biriiri Rural Hospital in Chimanimani District. The surrounding terrain is mountainous, making the village difficult to access.

Village Health Worker (VHW) Rebecca Mahwerera lives here. She is one of 215 VHWs in Chimanimani and Mutare districts trained in Malaria Community Case Management by the Ministry of Health & Child Welfare's National Malaria Control Program with support from MCHIP. The 35-year-old is considered a "hero" in her community. The work of VHWs like Rebecca is contributing to malaria management in the area and helping to reduce deaths from the disease. Growing faith in Rebecca's skills has also increased demand for VHW services and strengthened the referral system at the community level.

On her way home from a recent health meeting for VHWs, Rebecca passed the home of Rena Dhakama, who works as a caregiver in the community. Rena had felt sick and was feverish. By morning, her condition had deteriorated and she was vomiting. A neighbor sent word to Rebecca and the Village Head about Rena's illness and, as she had been trained to do, Rebecca packed her malaria kit and rushed to Rena's home. On arrival, she saw that the house was full of community members whispering that Rena had been attacked by spirits.

"When I got to Mrs. Dhakama, she was complaining about vomiting and had difficulty talking," recounts Rebecca. "I quickly decided to do a Rapid Diagnostic Test to test for malaria. Her test came back positive and I explained the result to her and her husband."

Rebecca gave Rena a dose of antimalarial medicine, but the woman was having difficulty swallowing the pills. "I crushed and dissolved them in water for her to drink before she left for the hospital with her referral note," Rebecca said.

Under Rebecca's guidance, several community members and the Village Head made a stretcher to carry Rena to the main road, and donated money to pay for her transport to the hospital. Rena soon arrived at Biriiri Hospital and was referred to Mutambara Hospital for further management, where she remained under treatment for two weeks.

After the ordeal, community member John Simango expressed gratitude to Rebecca for her quick assistance and mobilization of the community. "I now understand the value of having a community fund for transport," he said. "From now on, I will assist her to mobilize the community to have these funds available, in case we have another emergency like this in our village."

Since April 2012, a total of 719 malaria cases have been managed by VHWs in these districts—and the number will likely increase as the malaria season continues. Thankfully, having witnessed several of their own being treated and cured of malaria, community members are now requesting Rebecca's services whenever she returns from health trainings. "People have gained more confidence in my work and many have been asking for my help," she said.

Community member John Simango, VHW Rebecca Mahwerera, and the MCHIP Community Officer.