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Maternal and Child Survival Program

MCSP Annual Report

Year One

October 1, 2014 – September 30, 2015

Maternal and Child Survival Program Year One Annual Report

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Jhpiego Corporation in cooperation with
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Along with
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Abbreviations

3MDG	Three Millennium Goal Development Fund
AA	Associate Award
AAP	American Academy of Pediatrics
ACNM	American College of Nurse-Midwives
ACOG	American Congress of Obstetricians
ACS	Antenatal corticosteroids
ACT	Artemisinin-based combination therapy
ADMSA	Advanced distribution of misoprostol for self-administration
AMTSL	Active management of the third stage of labor
ANC	Antenatal care
AOL	Augmentation of labor
AOR	Agreement Officer's Representative
APC	Advancing Partners & Communities
ART	Antiretroviral therapy
ASC	Community Health Worker
ASRH	Adolescent sexual and reproductive health
ASSIST	Applying Science to Strengthen and Improve Systems
BBA	Broad Branch Associates
BCC	Behavior change communication
bCPAP	Bubble continuous positive airway pressure
BEmONC	Basic emergency obstetric and newborn care
BMGF	Bill & Melinda Gates Foundation
BP	Blood pressure
CBC	Competency-based midwifery curriculum
CBD	Community-based distribution
CBNC	Community-Based Newborn Care
CCM	Community case management
CDC	Centers for Disease Control and Prevention
CECAP	Cervical cancer prevention
CEmONC	Comprehensive emergency obstetric and newborn care
CHMT	County Health Management Team
CHN	Community health nursing (Ghana)
CHP	Community Health Platform
CHPS	Community-Based Health Planning and Services
CHV	Community health volunteer
CHW	Community health worker
CHX	Chlorhexidine
CI	Communications Initiative
COP	Community of practice
CRMA	Caribbean Regional Midwives Association
CSE	Civil society engagement
CSHGP	Child Survival and Health Grants Program
CSIS	Center for Strategic and International Studies
CSO	Civil society organization
CSPro	Census and Survey Processing System
CYP	Couple years of protection
D&A	Disrespect and abuse
DC	Demand creation
DCEI	Interagency Strategic Consensus for Latin America and the Caribbean
DDS	Departmental Health Directorate
DFID	Department for International Development
DHS	Demographic and Health Survey
DQA	Data Quality Assessment
DRC	Democratic Republic of the Congo
DRH	Directorate of Reproductive Health
ECEB	Essential Care for Every Baby

ECSB	Essential Care for Small Babies
EMOC	Emergency obstetric care
EmONC	Emergency obstetric and newborn care
ENAP	Every Newborn Action Plan
ENC	Essential newborn care
EPCMD	Ending preventable child and maternal deaths
EPI	Expanded Program on Immunization
EPMM	Ending preventable maternal mortality
ESA	East and Southern Africa
EVD	Ebola Virus Disease
EWEC	Every Woman Every Child
FLHW	Frontline health worker
FMOH	Federal Ministry of Health
FP	Family planning
FP2020	Family Planning 2020
FY	Fiscal year
GA	Gestational age
GBV	Gender-based violence
GF	Global Fund
GHS	Ghana Health Services
GTR	Regional Maternal Mortality Reduction Task Force
HBB	Helping Babies Breathe
HBS	Helping Babies Survive
HC3	Health Communication Capacity Collaborative
HEP	National Health Extension Program
HEW	Health extension worker
HFA	Health facility assessment
HIS	Health information system
HMIS	Health management information system
HMS	Helping Mothers Survive
HQ	Headquarters
HRH	Human Resources for Health
HS	Health systems
HSA	Health Surveillance Assistant
HSS	Health systems strengthening
HSS/E	Health systems strengthening and equity
iCCM	Integrated community case management
IFA	Iron-folic acid
IFHP	Integrated Family Health Program
IIP	Immunization in Practice
IIP	Institute for International Programs
IMAM	Integrated management of acute malnutrition
IMCI	Integrated management of childhood illness
IPC	Infection prevention and control
IPLS	Integrated Pharmaceutical and Logistics System
IPTp	Intermittent preventive treatment in pregnancy
IPTp-SP	Intermittent preventive treatment in pregnancy with sulfadoxine-pyrimethamine
IPV	Inactivated polio vaccine
IR	Implementation research
IRB	Institutional review board
IT	Information technology
ITN	Insecticide-treated net
IYCF	Infant and young child feeding
JHSP/IIP	Institute for International Programs
JHSPH	Johns Hopkins Bloomberg School of Public Health
JHU	Johns Hopkins University
JSI	John Snow, Inc.
KAP	Kangaroo Mother Care Acceleration Partnership
KM	Knowledge management
KMC	Kangaroo mother care
KPC	Knowledge, practices, and coverage
L&D	Labor and delivery
LAC	Latin America and the Caribbean
LAM	Lactational amenorrhea method
LARC	Long-acting reversible contraceptive
LGA	Local Government Authority
LiST	Lives Saved Tool

LLIN	Long-lasting insecticide-treated net
LOE	Level of effort
LRP	Learning resource package
M&E	Monitoring and evaluation
MAL&OPDD	Malaria and Other Parasitic Diseases Division
MAMA	Mobile Alliance for Maternal Action
MCDMCH	Ministry of Community Development, Mother and Child Health
MCH	Maternal and child health
MCHIP	Maternal and Child Health Integrated Program
MCPC	Managing Complications in Pregnancy and Childbirth
MCSP	Maternal and Child Survival Program
MDG	Millennium Development Goal
MDR	Maternal Death Review
MDSR	Maternal Death Surveillance and Response
MEC	Medical Eligibility Criteria
MH	Maternal health
MHTF	Maternal Health Task Force
MICS	Multiple indicator cluster survey
MIP	Malaria in pregnancy
MIYCN	Maternal, infant, and young child nutrition
MLM	Mid-Level Manager
MMEL	Measurement, monitoring, evaluation, and learning
MMI	Model Maternity Initiative
MNCH	Maternal, newborn, and child health
MNH	Maternal and newborn health
MNMA	Myanmar Nurses and Midwives Association
MNMC	Myanmar Nurse and Midwife Council
MOH	Ministry of Health
MOHSS	Ministry of Health and Social Services
MOHSW	Ministry of Health and Social Welfare
MOU	Memorandum of understanding
MPDSR	Maternal and perinatal death surveillance and response
MRN	Model referral network
MSD	Measles Second Dose
MSH	Management Sciences for Health
MSPP	Ministry of Public Health and Population
MTOT	Master Training of Trainers
MTUMA	Mbinu Timilifu kwa Usimamizi wa Mifumo ya Afya
NB	Newborn
NEGA	Newborns in Ethiopia Gaining Attention
NFM	New Funding Mechanism
NGO	Nongovernmental organization
NMCP	National Malaria Control Program
NSV	No-scalpel vasectomy
NTC	National Training Center
OR	Operations Research
ORS	Oral rehydration solution
ORT	Oral rehydration therapy
PAC	Postabortion care
PAS	Professional association strengthening
PCV	Pneumococcal conjugate vaccine
PDQ	Partnership-Defined Quality
PDSR	Perinatal Death Surveillance and Response
PE/E	Pre-eclampsia/eclampsia
PEI	Polio Eradication Initiative
PEPFAR	United States President's Emergency Plan for AIDS Relief
PHCU	Primary health care unit
PMI	President's Malaria Initiative
PMNCH	Partnership for Maternal, Newborn and Child Health
PMP	Performance monitoring plan
PMTCT	Prevention of mother-to-child transmission of HIV
PNC	Postnatal care
PNDA	Perinatal death audit
PPE	Personal protective equipment
PPFP	Postpartum family planning

PPH	Postpartum hemorrhage
PPIUCD	Postpartum intrauterine contraceptive device
PPIUD	Postpartum intrauterine device
PSBI	Possible Severe Bacterial Infection
PTB	Preterm birth
PTFU	Post-training follow-up
PY	Program year
Q	Quarter
QI	Quality improvement
QoC	Quality of care
R/CHMT	Regional and Council Health Management Team
R4D	Results for Development
RBM	Roll Back Malaria
RDT	Rapid diagnostic test
REC	Reaching Every Child/Community
RED	Reaching Every District
RH	Reproductive health
RHSA	Rapid Health Systems Assessment
RI	Routine immunization
RMC	Respectful Maternity Care
RMNCH	Reproductive, maternal, newborn, and child health
SBC	Social and behavior change
SBCC	Social and behavior change communication
SBM-R	Standards-Based Management and Recognition®
SCHMT	Sub-County Health Management Team
SDG	Sustainable Development Goal
SEC	Essential Community Package
SES	Socio-economic status
SHOPS	Strengthening Health Outcomes through the Private Sector
SMAG	Safe Motherhood Action Group
SMC	Seasonal malaria chemoprevention
SMGL	Saving Mothers Giving Life
SP	Sulfadoxine-pyrimethamine
SPHCDA	State Primary Health Care Development Agency
SRH	Sexual and reproductive health
SSQH	Services de Santé de Qualité pour Haïti
SUN	Scaling Up Nutrition
TA	Technical assistance
TAG	Technical Advisory Group
TF	Task Force
TOR	Terms of reference
TOT	Training of trainers
TRT	Technical reference team
TWG	Technical working group
UBT	Uterine balloon tamponade
UDV	Universidad da Vinci
UI-FHS	Universal Immunization through Improving Family Health Services
UNFPA	United Nations Population Fund
US	United States
USAID	United States Agency for International Development
USG	US Government
VIA	Visual inspection with acetic acid
WASH	Water, sanitation, and hygiene
WHO	World Health Organization

Introduction

The Maternal and Child Survival Program (MCSP) is a global $500 million, five-year, U.S. Agency for International Development (USAID)-funded cooperative agreement to introduce and scale up high-impact health interventions in the 24 priority countries with the ultimate goal of ending preventable child and maternal deaths (EPCMD) within a generation. MCSP supports programming in reproductive, maternal, newborn, and child health (RMNCH); immunization; family planning (FP); nutrition; water, sanitation, and hygiene (WASH); malaria; and HIV prevention, care, and treatment. MCSP engages governments, policymakers, health care providers, civil society, faith-based organizations, and communities in adopting and accelerating proven approaches to address the major causes of maternal, newborn, and child mortality, and improve the quality of health services from household to hospital. MCSP further focuses on cross-cutting areas, such as health systems strengthening (HSS), household and community mobilization, gender integration, social and behavior change communication (SBCC), measurement and use of data for decision-making and learning, and eHealth. MCSP is implemented by a consortium of agencies, which is led by Jhpiego in partnership with Save the Children, John Snow, Inc. (JSI), PATH, ICF, Results for Development (R4D), Population Services International (PSI), the Core Group, Johns Hopkins Bloomberg School of Public Health, Institute for International Programs (JHSP/IIP), Avenir Health, the Communications Initiative (CI), and Broad Branch Associates (BBA).

Program Year 1 (PY1), covering October 1, 2014 to September 30, 2015, coincided with the last months of the Millennium Development Goals (MDGs). Based on the final Countdown to 2015 Final Report, MDGs 4 and 5—where MCSP's attention has largely been focused—were not achieved by many countries despite global and national efforts. USAID's 2015 *Acting on the Call* report showed that substantial progress has been made across the 24 USAID MCH priority countries as of 2015, but more remains to be done (see text box).

Status of MDG Goals 4 and 5 in the 24 USAID MCH Priority Countries at End of 2015

- 14 of the 24 USAID MCH priority countries achieved the 4.4% annual rate of reduction in under-5 mortality that was needed to reach MDG 4 in 2015, including Bangladesh, Ethiopia, Indonesia, Liberia, Madagascar, Malawi, Mozambique, Nepal, Rwanda, Senegal, Tanzania, Uganda, Yemen, and Zambia.
- 2 EPCMD countries – Rwanda and Nepal—achieved the 5.5% annual rate of reduction need to achieve MDG 5.

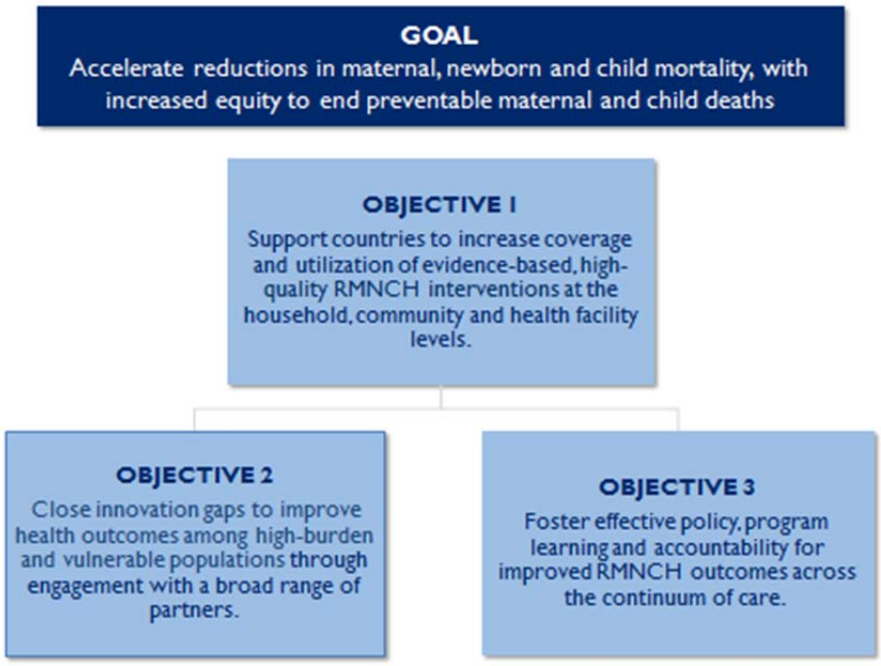
Source: http://www.countdown2015mnch.org/reports-and-articles/2015-final-report

While Sustainable Development Goals (SDGs) launched in September 2015 encourage a greater focus on equity and integration, only two of the 17 goals are health-related. MCSP will need to work with countries to both advance the SDGs and continue the momentum on reaching specific MNCH targets to end preventable child and maternal mortality. There is also growing recognition of the need to hold key stakeholders accountable for their expected contributions in achieving these results. MCSP will also work, in partnership with others, to improved RMNCH measurement, monitoring, evaluation, and learning (MMEL) at the global and country levels.

In PY1, MCSP initiated 22 country programs, 16 of which are among the 24 USAID MCH priority countries. Several countries have multiple workplans, representing different timeframes, technical focus, and scale of implementation. Despite the complexity, MCSP started implementation in a number of field programs representing [redacted]% of overall program expenditures in PY1. Subgrants were established with 47 local partners.

Developing a diverse field portfolio alongside strategic investments of core funds at the global, regional, and country levels during PY1 provides MCSP a strong platform on which to realize its overall vision of self-reliant countries equipped with the analytical tools, effective systems, and technical and management capacity to eliminate preventable maternal, newborn, and child deaths (see Figure 1).

Figure 1. MCSP's Overall Goal and Program Objectives

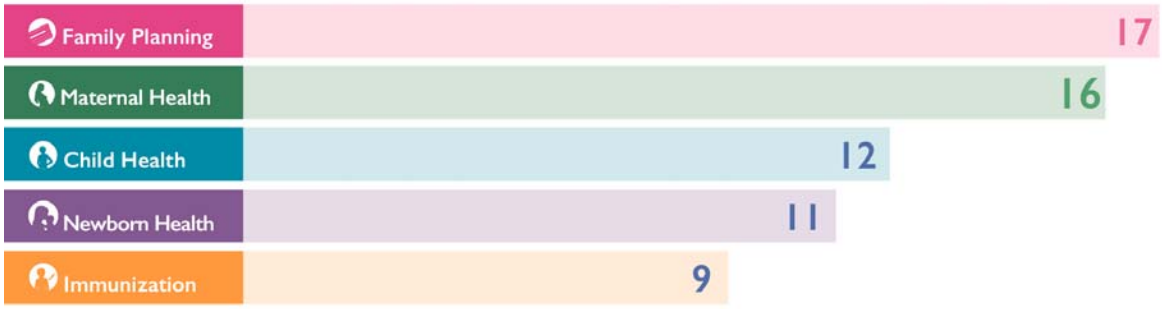


The narrative below includes a brief description of selected achievements organized by Strategic Objective. Detailed summaries of achievements by technical and cross-cutting areas follow.

MCSP by the Numbers

Number of Countries Where MCSP is Working: **22**

Number of Countries Working in Each Technical Area



Improved RMNCH Service Delivery[1]

Nearly **292,000** clients accepted a family planning method during a MNCH service visit

Over **170,000** women received a uterotonic in the 3rd stage of labor in MCSP-supported areas

Over **900** babies who weren't breathing at birth were resuscitated

Over **727,000** children received a DPT3 from MCSP-supported immunization programs

Nearly **18,000** HIV-positive pregnant women received antiretrovirals (ARV) to reduce risk of mother-to-child transmission

Increased Capacity and Strengthened Systems for RMNCH

Strengthening pre-service education to improve RMNCH services with MCSP support in **6 countries**

Over **9,000** participants were trained with skills and knowledge to improve quality of RMNCH services

Improved Policy Environment for RMNCH

9 policies developed in 6 MCSP countries

Because of assistance provided to 21 countries an estimated **$212 million** has been committed to implement iCCM in 12 countries

[1] These data represent 16 countries (19 workplans) reporting by the end of September 2015. Because each country is at a different stage of workplan and performance monitoring plan (PMP) development, not all have data to report this period.

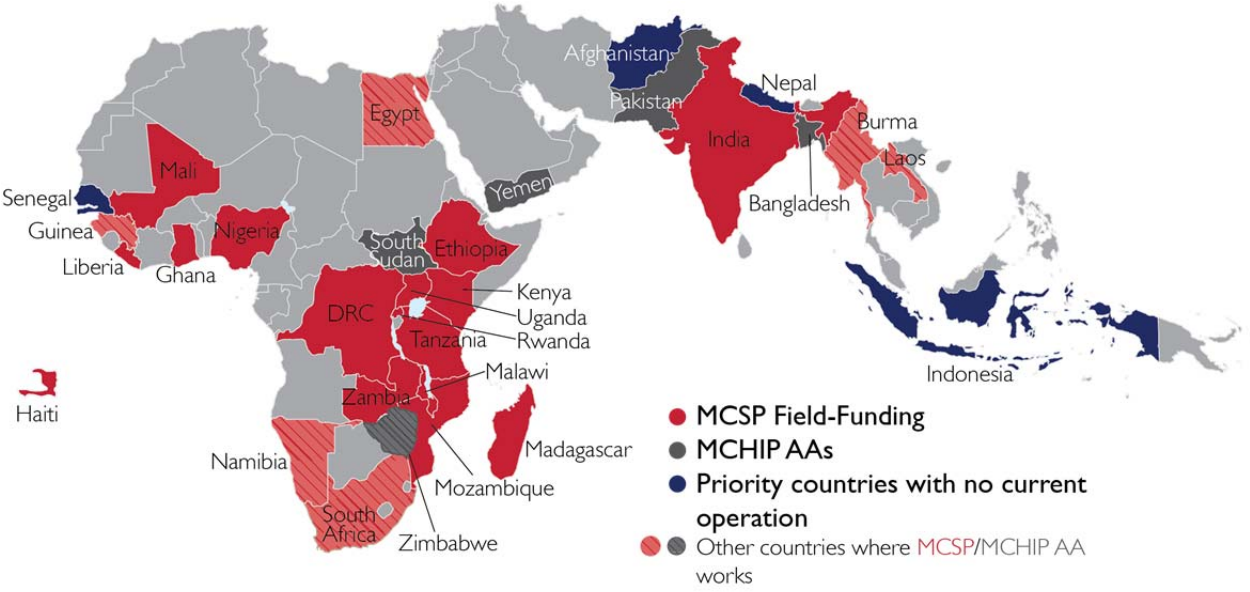
Objective 1: Support countries to increase coverage and utilization of evidence-based, high-quality RMNCH interventions at the household, community, and health facility levels

Much of MCSP's efforts focused on improving the quality and equity of delivery of high-impact interventions already at scale or to scale up those interventions not already being delivered at scale to address the leading causes of serious morbidity and mortality. (See high-impact intervention section below.) MCSP supported countries with the introduction and expansion of high-impact interventions by: strengthening service delivery with integrated packages of health care services; advocating for and increasing demand and access for high-impact interventions; ensuring inclusion of key issues such as gender, SBCC, and equity within program design and implementation; and focusing on HSS issues as part of reaching EPCMD goals.

Supporting Program Design and Implementation in 22 Countries

PY1 saw a rapid growth in the number of field-funded MCSP programs. In PY1, 34 field-funded workplans in 22 countries—16 of which are USAID MCH priority countries—were initiated. See Figure 2 for the list of countries in which MCSP is currently working. Countries in which Maternal and Child Health Integrated Program (MCHIP) Associate Awards (AAs) continue are also listed as MCSP seeks to coordinate and collaborate with these programs to maximize sharing of learning and best practices.

Figure 2. 24 Priority MCH USAID EPCMD Countries



The technical focus of MCSP's support in a particular country is shaped largely by the country context, priorities of host country government, USAID Mission priorities, and previous program successes. MCSP country portfolios range from single technical area programs (e.g., immunization support in Uganda and Malawi and FP support in India) to multi-technical area programs (the largest of which are in Rwanda, Haiti, Mozambique, Nigeria, and Tanzania)—all designed to contribute to achieving ambitious EPCMD goals. As part of scaling up high-impact interventions, many MCSP country programs include important components of policy work at the national level to create an environment that is conducive to scale-up. Issues around HSS and community engagement form key aspects of the comprehensive programming. Other programs, such as those in Kenya and Tanzania, focus on building county- and district-level leadership and target subnational actors as key stakeholders.

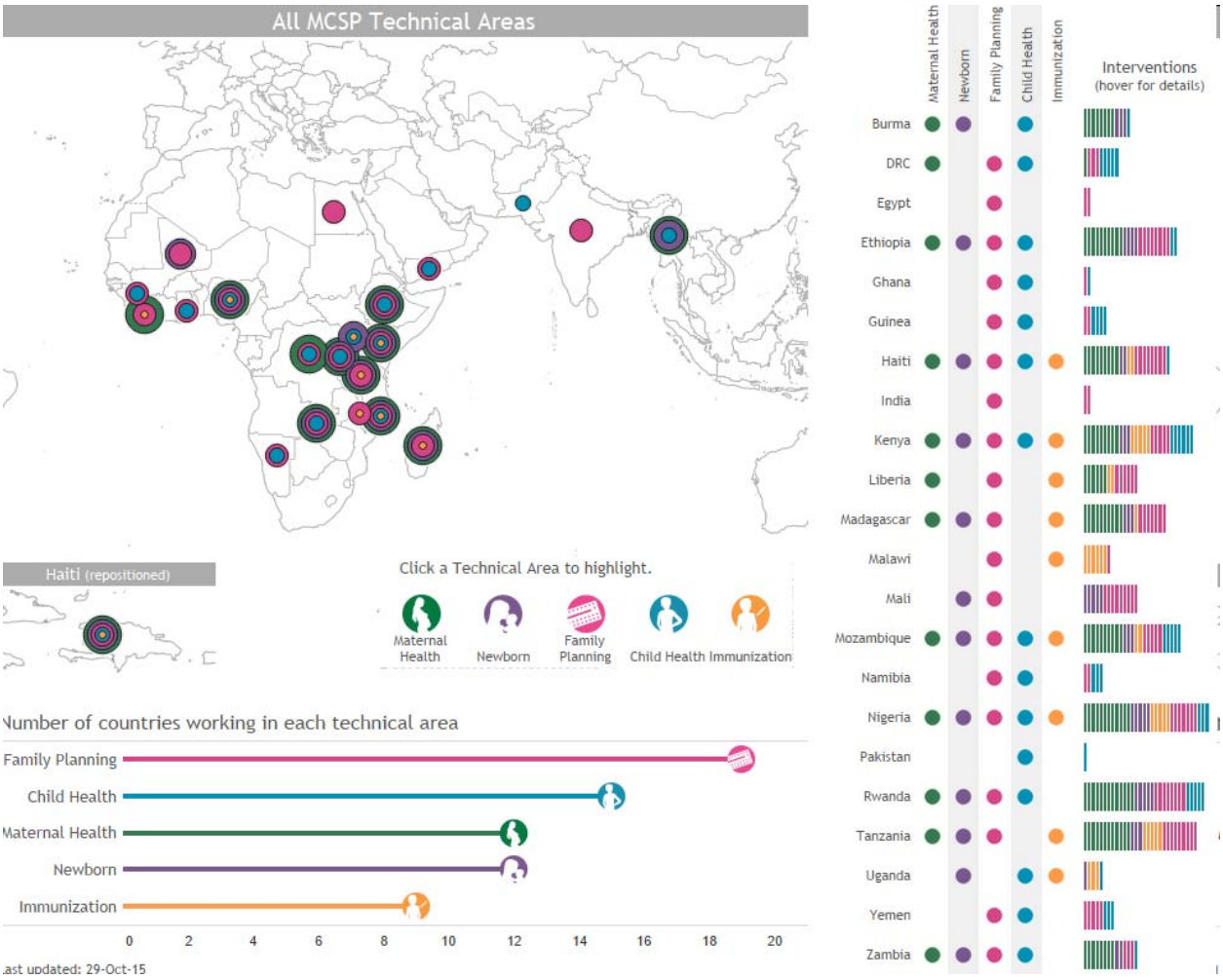
See Country Summary Addendum for more detailed information on country program objectives and achievements for this reporting period.

Increasing Coverage of High-Impact Interventions

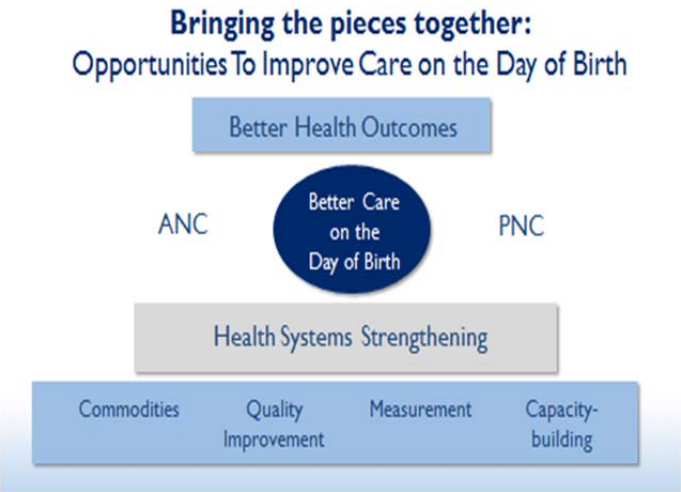
As noted above, the majority of MCSP's efforts focuses on improving the quality and equity of delivery of high-impact interventions already at scale or to scale up those interventions not currently being delivered at scale to address the leading causes of serious maternal and child morbidity and mortality. MCSP supports host country governments to implement programs with USAID Mission funds and also through other collaborative mechanisms. For example, through the integrated community case management (iCCM) Financing Task Team, MCSP was part of the technical assistance (TA) support to MCH priority countries interested in integrating iCCM into their malaria and/or HSS Global Fund (GF) New Funding Mechanism (NFM) concept notes. As a result of the assistance provided to the 21 countries, 18 have submitted iCCM-enhanced concept notes to the GF and an estimated USD 212 million has been committed to implement and scale up iCCM in 12 countries. With respect to FP, MCSP is also scaling up access to PPFP through engagement with global and local actors. In June, MCSP conducted a successful global meeting in Chiang Mai, Thailand, with 173 attendees from 16 countries. The meeting was jointly organized by MCSP and Jhpiego under the aegis of FP2020, with funding from MCSP, the Bill & Melinda Gates Foundation (BMGF), the World Health Organization (WHO), the Packard Foundation, and UNFPA. Each country team in attendance developed action plans to accelerate access to PPFP. (See Family Planning section for more details.)

To track the work MCSP is doing to support counties in scaling up high-impact interventions, as well as improve the quality of those interventions at scale, a series of interactive global MCSP-specific dashboards were developed to assist with program management, monitoring, and knowledge management. Figure 3 provides a sense of how these dashboards organize information and gives an "at-a-glance visual" of the work in which MCSP is engaged. Figure 3 reflects the major technical interventions MCSP supports and the countries in which they are supported.

Figure 3. MCSP Dashboard of Technical Interventions



MCSP is working with Ministries of Health (MOHs), WHO, UN agencies, and local organizations to scale up high-impact interventions. In an effort to guide and inform the scale-up process and document and share learning, MCSP and USAID have identified specific high-impact interventions (see box) and countries in which to focus a life-of-project learning activity on systematic support and study of scale. Each of the interventions has a clear equity and quality focus, addresses a leading cause of mortality, and has been shown to be highly effective. The four interventions considered together represent a diverse group that touches on various aspects of scale-up, allowing wide-ranging learning that will be useful across MCSP and beyond. Support for scale-up will be studied in up to three countries for each intervention; the approaches and lessons learned will also be disseminated for use in supporting scale-up of these and other high-impact interventions in other countries.



Achieving Better Integration of Services to Improve Health Outcomes

Given the technical breadth and reach of MCSP, the program is well-positioned to contribute to understanding how to maximize contacts that individuals and families may have with the health system. During PY1, MCSP defined core and context-specific high-impact intervention packages for improved care during the antenatal period, Day of Birth, and postnatal periods, including indicators for program monitoring. These approaches were developed with the intention that they be further informed and refined through country-level implementation. For example, the field-funded maternal and newborn health (MNH) workplan in Nigeria provided a strong platform on which to support better care on the Day of Birth. During PY1, the priorities identified in Nigeria suggested that while the focus at the health facility level would remain clinical quality improvement (QI) and supportive supervision, addressing managerial and other non-clinical support is critical to ensure that local system factors that influence effectiveness, efficiency, and client-centeredness of services on the Day of Birth are addressed. This includes: worker motivation and effective teamwork; local commodities management; leadership and management; and organization and coordination of MNH services across system levels (e.g., from primary health care to general hospital). Addressing QI in coordination with local HSS efforts will be needed to support and sustain better integration of services on the Day of Birth and to improve health outcomes. A similar process was initiated in Madagascar in PY1. The FP and Immunization teams further collaborated to incorporate integrated immunization and postpartum FP (PPFP) programming into country workplans in Ethiopia, Tanzania, and Malawi. In Tanzania, the FP and Nutrition teams are collaborating on an assessment of community perceptions of PPFP and maternal, infant and young child nutrition (MIYCN).

High-impact interventions included in systematic support and study of scale:

- Prevention of postpartum hemorrhage (PPH), focusing on advance distribution of misoprostol for self-administration after home birth;
- Application of chlorhexidine to the umbilical cord to prevent newborn sepsis;
- Basic newborn resuscitation in health facilities, including the Helping Babies Breathe (HBB) approach;
- iCCM of childhood illness.

Objective 2: Close innovation gaps to improve health outcomes among high-burden and vulnerable populations through engagement with a broad range of partners

MCSP worked closely with USAID to develop a working definition and key questions and criteria to be used as a basis for identifying, monitoring, and prioritizing innovations across the program. Each innovation addresses a major cause of maternal, newborn, or child mortality or a bottleneck to achieving high coverage, quality, or equity with currently deployed interventions. The prioritized list of seven innovations for focus over the life of the program includes:

Focus Product Innovation

1. Bubble nasal continuous positive airway pressure (bCPAP) to improve outcomes for preterm newborns
2. Uterine balloon tamponade (UBT) to manage and treat PPH
3. Improved pneumonia diagnostics to improve child health outcomes

Focus Process Innovations

4. Managing possible severe bacterial infection (PSBI) in newborns and young infants 0–59 days when families do not accept or cannot access referral care: MCSP will support operationalization of the recent WHO guidelines in countries where field funds are available and receives approval from the government to move forward with this activity
5. Gestational age (GA) estimation to inform clinical decision-making
6. Ensure that first-time and young parents have access to RMNCH information and services
7. Reaching Every Community (REC)/ QI approach to ensure equitable coverage of quality immunization services

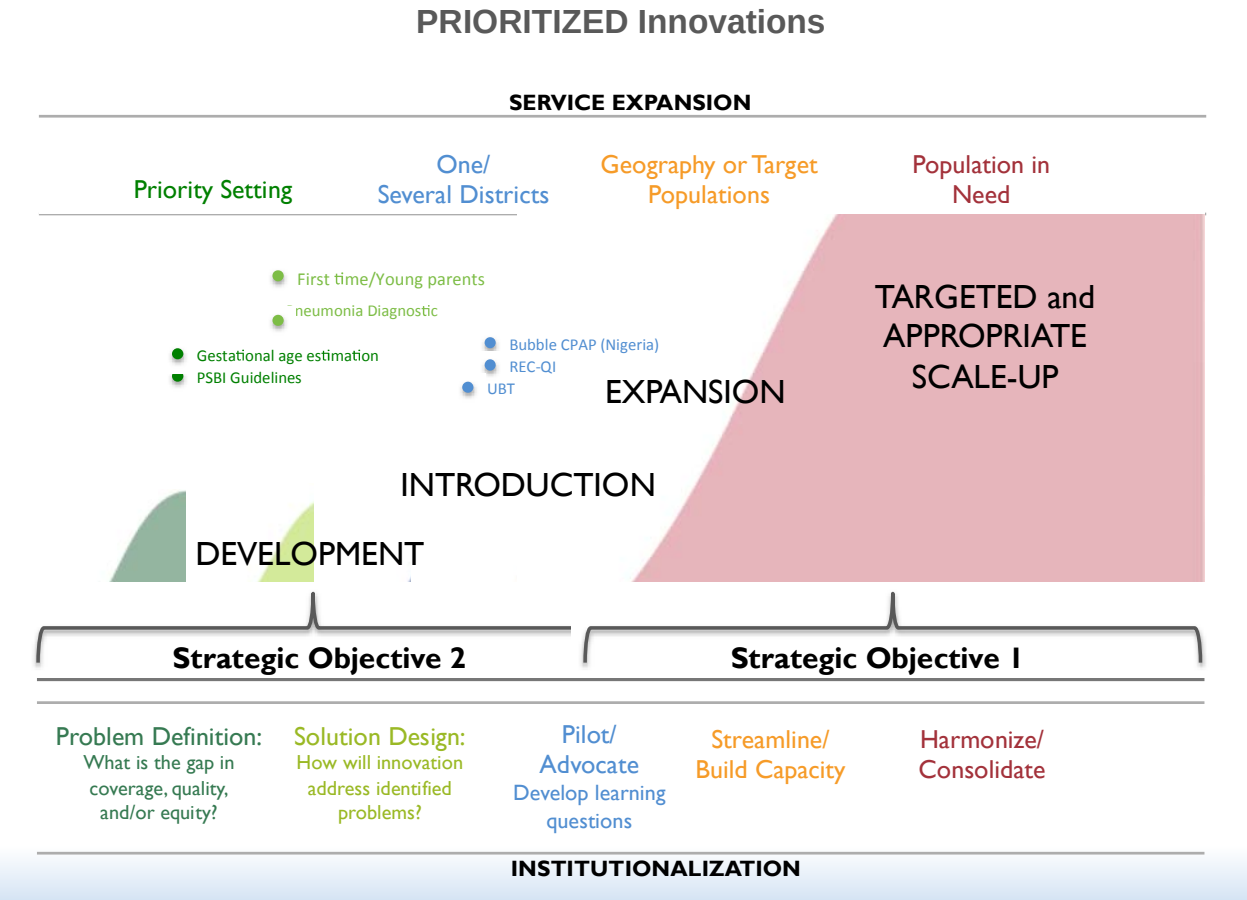
MCSP's work supports 4 types of innovations:

1. **New products:** Introducing a product or drug that may be new to a particular program or service delivery system.
2. **New uses of existing products:** Using an existing or known product in a new way or application or by a new user.
3. **New "processes":** Implementing a new process aimed at improving coverage, quality, and/or equity for one or more high-impact interventions on which MCSP is focusing.
4. **New configuration or combination of existing "processes":** Delivering a package of high-impact interventions that have not been combined previously in that setting or have not been combined effectively.

This preliminary list has been identified and agreed upon in consultation with USAID, and reflects an interest in capturing the range of technical areas, practical considerations of country programs, as well as an effort to prioritize product or process innovations thought to have the highest potential for impact and contributing to EPCMD, even though many are still in early stages of development. MCSP will track the progression of these innovations through the pathway and capture different activities, geographies, and learning questions to enrich our understanding of how these products or process innovations can eventually reach scale-up, or adapt to solve the identified problem.

To reflect the relationship to Strategic Objective 1, a pathway or framework by which innovations can be "mapped" (see Figure 4) was also developed. Recognizing that not all innovations may reach scale nor is progress achieved in a linear fashion, MCSP will contribute to, support, and advance promising innovative approaches or products throughout the life of the award.

Figure 4. MCSP Pathway from Innovation to Impact at Scale



Objective 3: Foster effective policy, program learning, and accountability for improved RMNCH outcomes across the continuum of care

MCSP worked at the international, national, and local levels to: improve the policy environment for RMNCH; increase accountability for RMNCH through better metrics with a focus on data visualization as a means to increase sharing and use of data; and share and apply action-oriented learning throughout our program to support, improve, and strengthen program implementation and thereby accelerate the achievement of EPCMD. MCSP engaged with international partners such as WHO, UN, GF, Scaling Up Nutrition (SUN), Every Newborn Action Plan (ENAP), Every Woman Every Child (EWEC), and Roll Back Malaria (RBM) to: 1) provide technical leadership and advocacy through participation on a wide variety of strategic global initiatives, international working groups, and technical bodies; 2) increase the body of knowledge on RMNCH interventions and what works; and 3) translate knowledge and emerging policy evidence into clear content and actionable formats for countries to use.

Advancing RMCNH Policy through Global Technical Leadership


World Health Organization
USAID
Maternal and Child Survival Program
August 2015
www.mcsprogram.org
WHO Recommendations on Interventions to Improve Preterm Birth Outcomes
Highlights and Key Messages from the World Health Organization's 2015 Global Recommendations
Key Messages
Preterm birth is the single largest cause of perinatal and neonatal mortality and morbidity and the leading cause of death in children under the age of 5.
Infant deaths and long-term disabilities following preterm birth can be reduced when interventions are appropriately provided to the mother at imminent risk of preterm birth and to the preterm infant after birth.
Interventions are most effective when applied within a continuum that integrates management of women at risk of imminent preterm birth with postnatal care of preterm infants.
Accurate gestational age dating is essential to guide appropriate care. Careful attention should be paid to dating of pregnancy with the best method available during early visits for antenatal care.
Background
Preterm babies are prone to serious illness or death during the neonatal period. Without appropriate treatment, those who survive often face lifelong disability and poor quality of life. Complications of prematurity are the single largest cause of neonatal death and currently the leading cause of death among children under 5 years. Therefore, global efforts to further reduce child mortality demand urgent actions to address preterm birth.
Infant death and morbidity following preterm birth can be reduced through interventions provided to the mother at imminent risk of preterm birth and to the preterm infant after birth. These interventions target immediate and future morbidities of the preterm infant, e.g. lung immaturity, susceptibility to infection and neurological complications. The guidelines focus on care of pregnant women at imminent risk of preterm birth (birth <37 weeks gestation) and care of preterm babies during the newborn period, with the aim of improving outcomes for preterm infants. The guidelines do not address prevention of preterm birth.
Highlights of recommended and non-recommended practices to improve preterm birth outcomes
For women with imminent preterm birth (within 7 days)
For preterm infant (early newborn period)
Recommended
Antenatal corticosteroids (ACS) from 24 to 34 weeks in eligible women, provided certain conditions are met
Antibiotics for preterm prelabour rupture of membranes (PPROM)
MgSO4 for fetus neuroprotection <32 weeks if preterm birth is likely within 24 hours
Kangaroo mother care when infant weighs 2,000 g or less and clinically stable
Continuous positive airway pressure (CPAP) for preterm infants with respiratory distress syndrome (RDS)
Surfactant for preterm infants with RDS in facilities meeting minimum criteria
Start oxygen therapy with 30% oxygen or air (if blended oxygen is not available) during ventilation of preterm infants born ≤32 weeks
Progressively higher concentrations of oxygen for neonates undergoing oxygen therapy per defined criteria
Not recommended
Tocolysis (acute or maintenance) for purpose of improving neonatal outcomes
Antibiotics for preterm labour with intact membranes
ACS in women with chorioamnionitis likely to deliver preterm
Prophylactic surfactant before diagnosis of RDS
Start 100% of oxygen during ventilation of preterm infants born ≤32 weeks
Recommendations for Preterm Birth
1

Collaborations with WHO represent an important opportunity to make contributions to global initiatives including development or revision and dissemination of updated WHO guidelines and reference materials. MCSP served on the WHO-led expert group tasked with advancing a WHO Quality of Care (QoC) MNH framework and associated implementation and learning platform. This framework includes quality indicators (under development) for use by frontline teams to improve quality of MNH care. As part of its engagement in this expert group, MCSP contributed significant learning from MCSP country experience to inform development of a country-centered QoC MNH framework. MCSP continued to work closely with the WHO to update the WHO's Managing Complications in Pregnancy and Childbirth guide, a vital clinical resource for health care providers around the world. MCSP also contributed to the development and interpretation of global newborn health guidelines by developing a policy brief on the WHO postnatal care (PNC) and preterm birth (PTB) guidelines. Through MCSP's leadership in the RBM MIP Working Group, MCSP collaborated on the development of two consensus statements and a brief that advocate for the continued prioritization of key actions to accelerate MIP program implementation coverage and advance MIP prevention and control. In PY1, MCSP provided inputs, lessons learned from country-level experiences, and best practices to WHO's Vision and Mission in Immunization and Vaccines 2015–2030, and UNICEF's Communication for Development Guidelines for Immunization.

Translating Global Policy into Local Action

MCSP, with a vast reach of 22 implementing countries, contributed to the dissemination of relevant policy and guidelines for countries to act on. For example, in June, MCSP disseminated the WHO's update to the Medical Eligibility Criteria for Contraceptive Use at the Global PPFP Conference in Chiang Mai, Thailand. As a result, the Government of Kenya immediately moved to update national guidelines, and the MCSP/Kenya team was tasked with drafting a chapter on PPFP for the new national guidelines. MCSP also completed a multi-country study on leveraging the Global Fund NFM for child health (iCCM). With child health stakeholders increasingly focused on mobilizing resources to scale up iCCM as an important strategy to complement investments at the facility level, a close look at these country stories provided valuable lessons about ways to increase the likelihood of integration to ensure that all children have access to lifesaving medicines or services. In Nigeria, MCSP is collaborating with

the Federal Ministry of Health (FMOH) to develop a national Quality of MNCH Care policy framework, informed by the WHO QoC framework. The Federal MOH is expected to officially endorse this framework as national policy in 2016. In turn, learning in Nigeria to improve quality of MNH services in Ebonyi and Kogi states is contributing to a WHO implementation platform under development for the WHO QoC MNH framework. MCSP will continue to advocate for and disseminate international policies and guidelines, and leverage its country presence to inform policy recommendations at the national level.

Action-Oriented Learning in Support of Implementation

Throughout PY1 as country programs developed, country-specific implementation and learning priorities were identified. Seven program-wide themes emerged to guide the global MCSP learning strategy for the remainder of the project.

Seven Learning Themes

1. **Achieving sustainable impact at scale.**
   MCSP is examining how countries can accelerate achievement of high and effective coverage and institutionalization of high-impact interventions through systematic management of the scale up process by the MOH and partners and in doing so reach the vision of ending preventable child and maternal deaths.
2. **Quality improvement.**
   MCSP's implementation and learning in this area are focused on identifying the most effective and sustainable QI approaches for RMNCH service provision in various contexts.
3. **Equity, including gender equity.**
   Equity includes focusing on groups marginalized by socioeconomic and geographic status. Here MCSP is focusing attention on those interventions and approaches designed and implemented by countries to be pro-equity (e.g., iCCM, REC-QI, etc.) MCSP is also examining gender-transformative interventions to determine how countries can implement them in a way that improves utilization, quality and acceptability of RMNCH services for women and their partners (including adolescents).
4. **Local HSS, including private sector and capacity-building.**
   MCSP is working to identify effective and focused approaches for health system strengthening to sustainably improve service delivery at the district or its equivalent at the lower levels of the health system.
5. **Community action for health including behavior change.**
   MCSP's efforts are directed at identifying effective community-based strategies, including behavior change interventions for health promotion, community-based service provision through CHWs, and community mobilization/support.
6. **Innovations to address key gaps in coverage, quality, or equity.**

MCSP will track the progress and the supports needed for a systematic approach to supporting promising innovations, contributing to progress on the pathway from development and introduction to expansion and full scale-up.

7. **Measurement and data use for action and accountability.**
   MCSP is examining how use of relevant, well-presented, and timely information on RMNCH care processes and/or outcomes will help drive better practice at community, facility, district, and/or national levels.

Emerging qualitative and quantitative information attained from the action-oriented learning activities under MCSP is reviewed and fed back into programming in short cycles to encourage timely uptake of lessons learned and corresponding improvements to programming and implementation support. Short-cycle learning will be achieved through routine monitoring and reporting, coordination with the field through the cross-cutting working groups, and strategic capture and dissemination of learning results, with key learning products disseminated to main stakeholders for application in local, national, and international settings.

Metrics for Management and Accountability (Data for Action)

Over the past year, MCSP contributed to the development of practical data collection tools, such as the Knowledge, Practices, and Coverage (KPC) household survey, as well as improved RMNCH indicators and processes for visualizing those indicators. MCSP contributed to the development of the ENAP and ending preventable maternal mortality (EPMM) metrics for global monitoring by countries. Plans also advanced for testing RMNCH QoC indicators, including facility perinatal mortality and newborn resuscitation, in collaboration with WHO, MEASURE Evaluation, and MCSP country programs. MCSP further convened a successful technical consultation on maternal mortality mapping—bringing together global health organizations, government agencies, donors, universities, and other groups—which formulated recommendations and next steps for mapping maternal deaths to track progress toward global targets and share country case studies.

MCSP contributed the Lives Saved Tool (LiST) analyses for the 24 USAID EPCMD priority countries for a report in honor of the second anniversary of the "Acting on the Call" for child survival in 2015 to draw global attention to progress made and remaining gaps, modeling what could be achieved under different intervention coverage scenarios. New national models include updated coverage and country-specific maternal cause of death data. In Egypt, subnational analysis using LiST enabled data-driven decision-making regarding priority interventions during meetings between MCSP and the Ministry of Health (MOH).

To monitor project performance and support program management (such as progress toward scaling up high-impact interventions and support for improving the quality of scaled interventions, as discussed under Objective 1, and support for innovations under Objective 2), MCSP developed a series of internal management dashboards in Tableau that describe where MCSP is implementing technical activities and interventions around the globe.

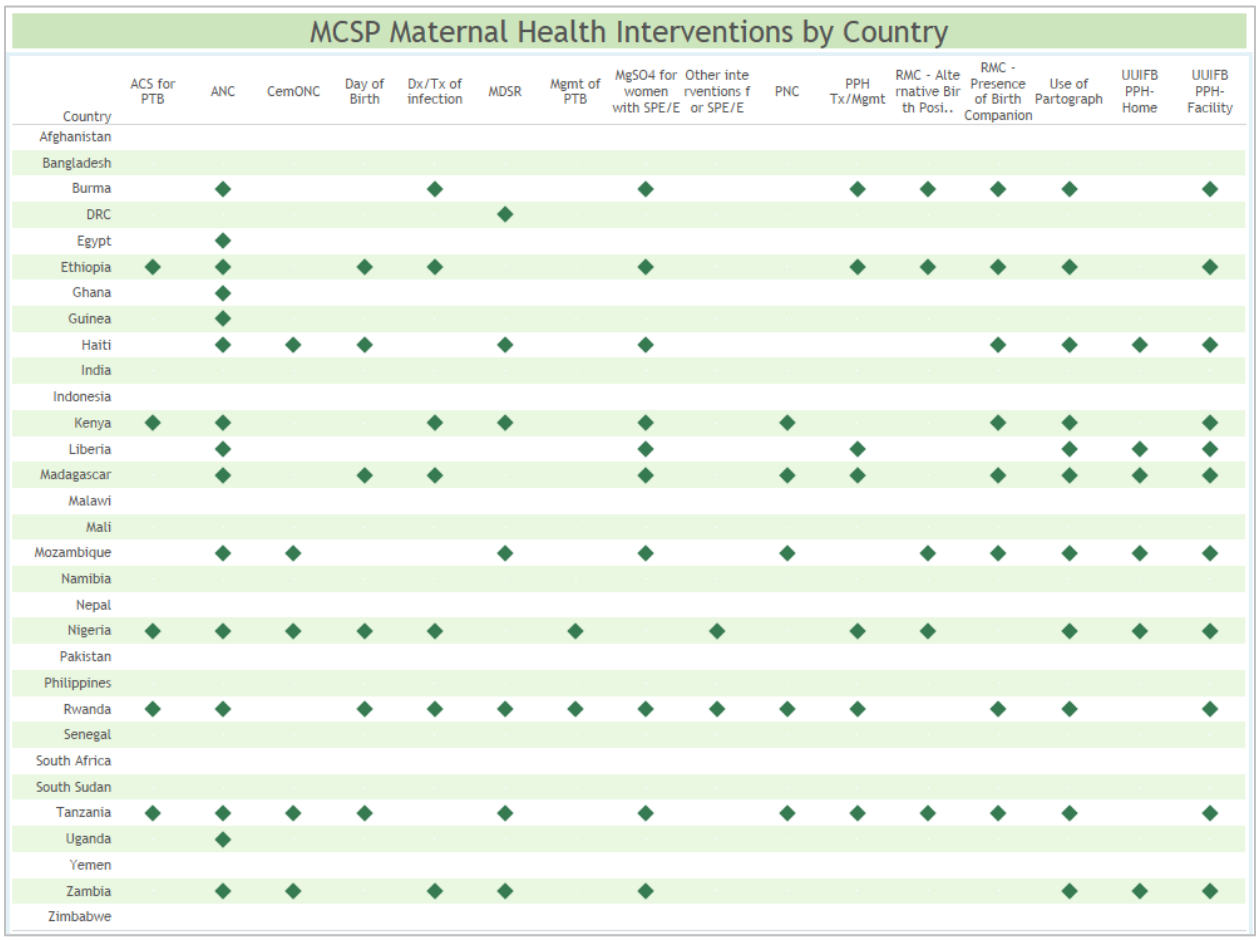
Summary of Achievements by Technical Area

The following sections are organized by the technical areas outlined in our first PY core-funded workplan. These sections provide some context for our work and highlights of first year accomplishments in support of MCSP objectives. Accomplishments primarily supported through field funds are included as the Addendum.

Maternal Health

MCSP's strategic approach for maternal health (MH) aligns with and supports USAID's Maternal Health Vision for Action and emphasizes an outcomes-focused, systems-oriented approach to reducing the most important direct and indirect causes of maternal morbidity and mortality. MCSP MH work targets strategic technical global leadership and advocacy, country support for implementing interventions, and action-oriented learning to help target countries accelerate reductions in maternal mortality and morbidity. Figure 5 illustrates where MCSP is supporting key MH interventions.

Figure 5. MCSP Maternal Health Interventions by Country



Accomplishments

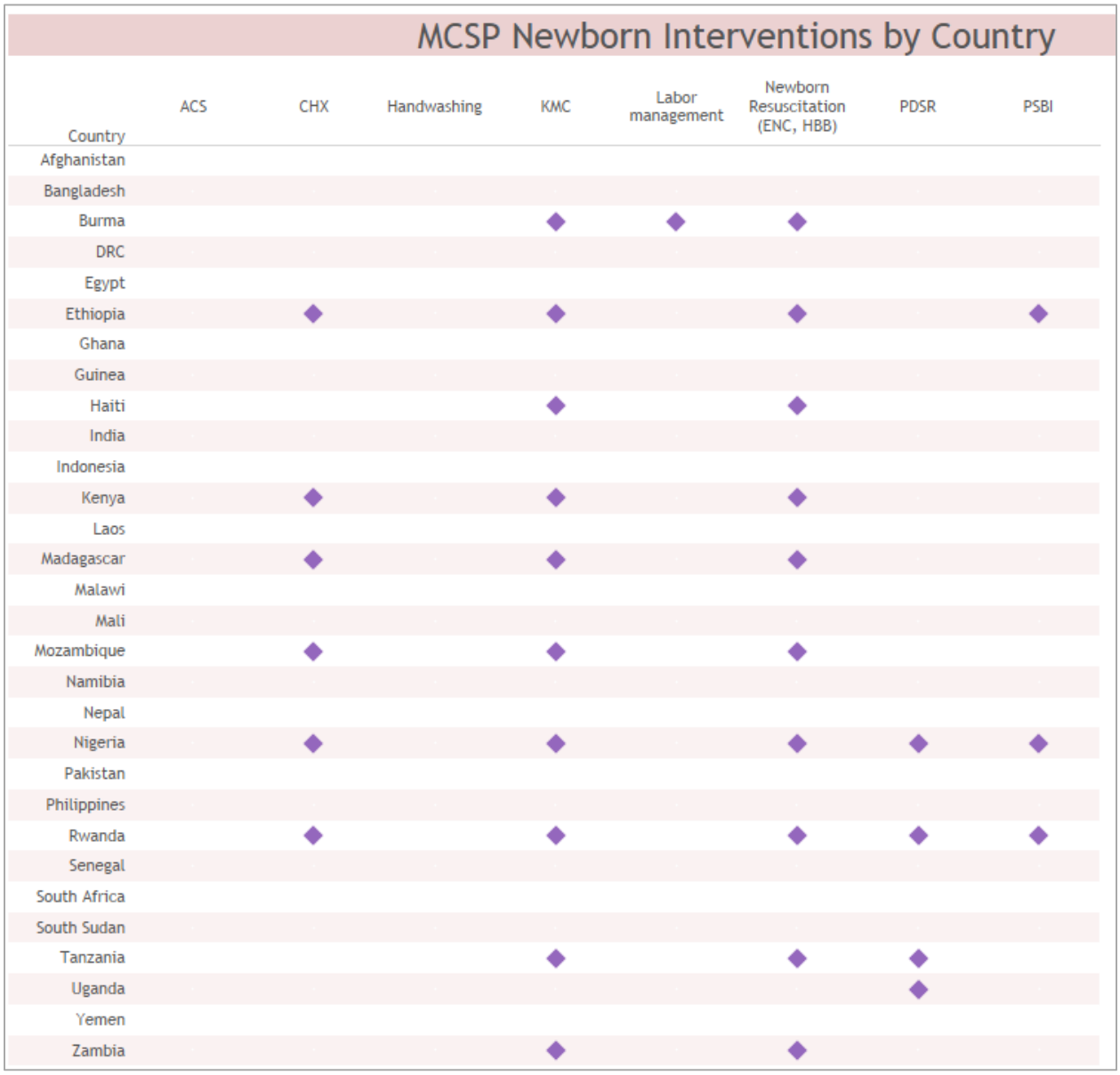
- MCSP has continued to demonstrate technical leadership through close partnership with and support of WHO efforts to develop and disseminate key technical guidelines and recommendations. MCSP contributed significantly to the WHO MH guideline development and summary briefers for: PTB, augmentation of labor (AOL), postnatal MNH care, and peripartum maternal infections. The briefs were released directly by the WHO, alongside the full recommendations, and are hosted on WHO's external website. MCSP also developed implementation support materials related to the new recommendations for PNC (job aids) and PTB (training package with Survive & Thrive partnership).
- MCSP made notable progress in collaboration with WHO toward updating selected chapters of the 2007 WHO Managing Complications in Pregnancy and Childbirth (MCPC) in collaboration with WHO with inputs from the Newborn team on newborn chapters. To inform the update process, MCSP surveyed MCPC users to identify priority sections for update and to solicit feedback on structure and layout. Several new clinical chapters have been identified, including GA assessment, PPFP, GBV, and chronic diseases in pregnancy and childbirth. Revision to priority chapters was under way at the close of PY1.
- MCSP participated in an expert group, convened by WHO, to advance a WHO QoC MNH framework, including aspirational statements and indicators for high-quality clinical and client-centered care.
- In partnership with the WHO, Maternal Health Task Force (MHTF), and USAID, the MH and MMEL teams co-convened an expert consultation to define a set of MH indicators for global monitoring as part of a broader EPMM metrics framework (see MMEL section of annual report for more details).
- MCSP convened a high-profile regional meeting in Tanzania with implementers and researchers to review available evidence related to respectful maternity care (RMC) and mistreatment in childbirth in Tanzania and the region, and to distill learning related to implementation approaches that can best reduce mistreatment. An important outcome of this meeting was consensus on promising approaches for reducing mistreatment and increasing RMC in Tanzania and beyond. Meeting results are available in the meeting report at (http://www.mcsprogram.org/wp-content/uploads/2015/10/MCSP-Tanz-RMC-report_Final.pdf).
- MCSP, in collaboration with two Survive & Thrive partners, the American College of Nurse-Midwives (ACNM) and the American Congress of Obstetricians (ACOG), MCSP led the development of a global training PTB package as part of the Helping Mothers Survive (HMS) and Helping Babies Survive (HBS) series. This training package is based on the WHO PTB guidelines released in 2015 and emphasizes intrapartum interventions to improve MNH outcomes for pregnant women with threatened PTB. (See Survive & Thrive section for more information).
- Guidance and tools for process documentation and routine monitoring for the Systematic Support and Study of Scale-Up of Misoprostol for PPH Prevention activity were developed and piloted in Afghanistan in PY1, including a national planning workshop. The workshop was convened by the Directorate of Reproductive Health (DRH) and was attended by nearly 30 representatives from the Ministry of Public Health, WHO, UNICEF, MSI, MSF, and others. The workshop resulted in a commitment to pursue a national scale-up strategy and develop a costed plan for implementation, which was finalized in Q4. An operational and monitoring and evaluation (M&E) plan for the strategy is under development. This scale-up activity has been included in the draft MCSP-Mozambique workplan, in close alignment with planned community advanced distribution of misoprostol for self-administration (ADMSA) activities. A scope of work for in-country implementation has been drafted, with implementation expected to begin in PY2, pending approval of the country.

Newborn Health

The Newborn Health team's strategy to contribute to EPCMD has focused on strengthening country-led program planning, implementation, and M&E of quality, high-impact newborn health interventions to address the three major causes of newborn death—intrapartum-related complications, newborn infections, and complications from prematurity—and reduce the incidence of stillbirths. These efforts are framed within the context of the ENAP. The Newborn team collaborates with MCSP technical and cross-cutting teams, country programs, and across five strategic areas including: global leadership and learning; strengthening country plans and strategies; improving data collection and use; strengthening training, supervision, and QI; and, strengthening service delivery. The team works at the global, regional, and country levels to contribute to and advance key newborn health priorities, and to build a foundation for future MCSP-supported efforts. In addition, the team works closely with the Maternal

Health team to initiate USAID Asia and Africa Bureau-funded activities, including a study of PNC in India and support to maternal and perinatal death surveillance and response (MPDSR) activities in Uganda and Nigeria.

Figure 6. MCSP Newborn Interventions by Country



Accomplishments

- MCSP contributed to the development and interpretation of global newborn health guidelines, including input into the WHO MCPC guidelines on neonatal sepsis and developing a policy brief on the WHO PNC and PTB guidelines. Through engagement with country programs, MCSP continues to support the dissemination of key newborn health guidelines and recommendations to encourage uptake and implementation of evidence-based programming at the country level. MCSP will continue its work with WHO to develop two additional briefs in PY2.
- Through its engagement with the ENAP country implementation group, MCSP contributed to the development and finalization of the ENAP tracking tool and design of the ENAP MNCH technical mapping, including identification of indicators to monitor country-level ENAP progress. The team also developed a mechanism for monitoring how countries complete the ENAP tracking tool and utilize the data. This work will continue in PY2, and MCSP aims to learn from country experiences, using the tracking tool, and foster improved utilization of data for program planning.
- As part of the Kangaroo Mother Care (KMC) Acceleration Partnership (KAP), the MCSP Newborn team contributed to the selection of indicators for tracking KMC progress and the seven focus countries,[2] where some of the indicators will be tested. MCSP also completed a review of newborn resuscitation indicators, drawing on experiences from Bangladesh and Malawi. A summary report was drafted and includes recommendations that will be shared with partners, including USAID, the ENAP metrics group, and the resuscitation technical resource team (TRT). The review documents the lack of established measures for delivery of newborn resuscitation services.
- MCSP convened a regional HBS workshop in Dhaka, Bangladesh, from April 8–13, 2015. The workshop was a collaborative effort among global partners MCSP, UNICEF, WHO, and the American Academy of Pediatrics (AAP); its goal was to introduce participants to the Essential Care for Every Baby (ECEB) and Essential Care for Small Babies (ECSB) training curricula and to discuss health system bottlenecks and solutions to strengthen newborn care in the Asia region. Eleven countries participated and seven of these committed to action plans developed during the workshop. Since the workshop, quarterly calls provide an opportunity to review progress on country action plans and discuss streamlined support for the rollout of HBS. MCSP also established a mechanism for ENAP partners supporting the countries to implement their action plans, and a knowledge-sharing platform for countries and ENAP partners to share experiences implementing HBS.
- Following the release of the WHO guidelines on management of neonatal sepsis, the Newborn Health team developed an approach to study the management of PSBI at peripheral health facilities. The study aims to assess the feasibility of implementing a simplified regimen for neonatal sepsis, thereby providing critical evidence on the operationalization of the guidelines for managing neonatal sepsis at lower levels of the health system. MCSP is in the process of identifying potential countries for implementation of the study.
- The Newborn team collaborated with the Maternal Health team and Saving Newborn Lives to explore opportunities to support MPDSR efforts in Nigeria and Uganda. In PY1, MCSP reviewed a national integrated MPDSR guideline in Nigeria, and developed an approach to define potential MCSP support for updating the national MPDSR guidelines in Uganda. Further activities, including a national review of Maternal Death Reviews (MDR) and perinatal death audit (PNDA) systems in Nigeria, are planned with Africa Bureau funding for PY2.
- Plans for supporting scale-up of newborn resuscitation/HBB and chlorhexidine interventions were developed through consultations with country teams. Additionally, in coordination with the Maternal Health team, the Newborn team designed an assessment of the effects of integrated MNH training on providers' competencies in Zambia and Ethiopia, which will be implemented in PY2.

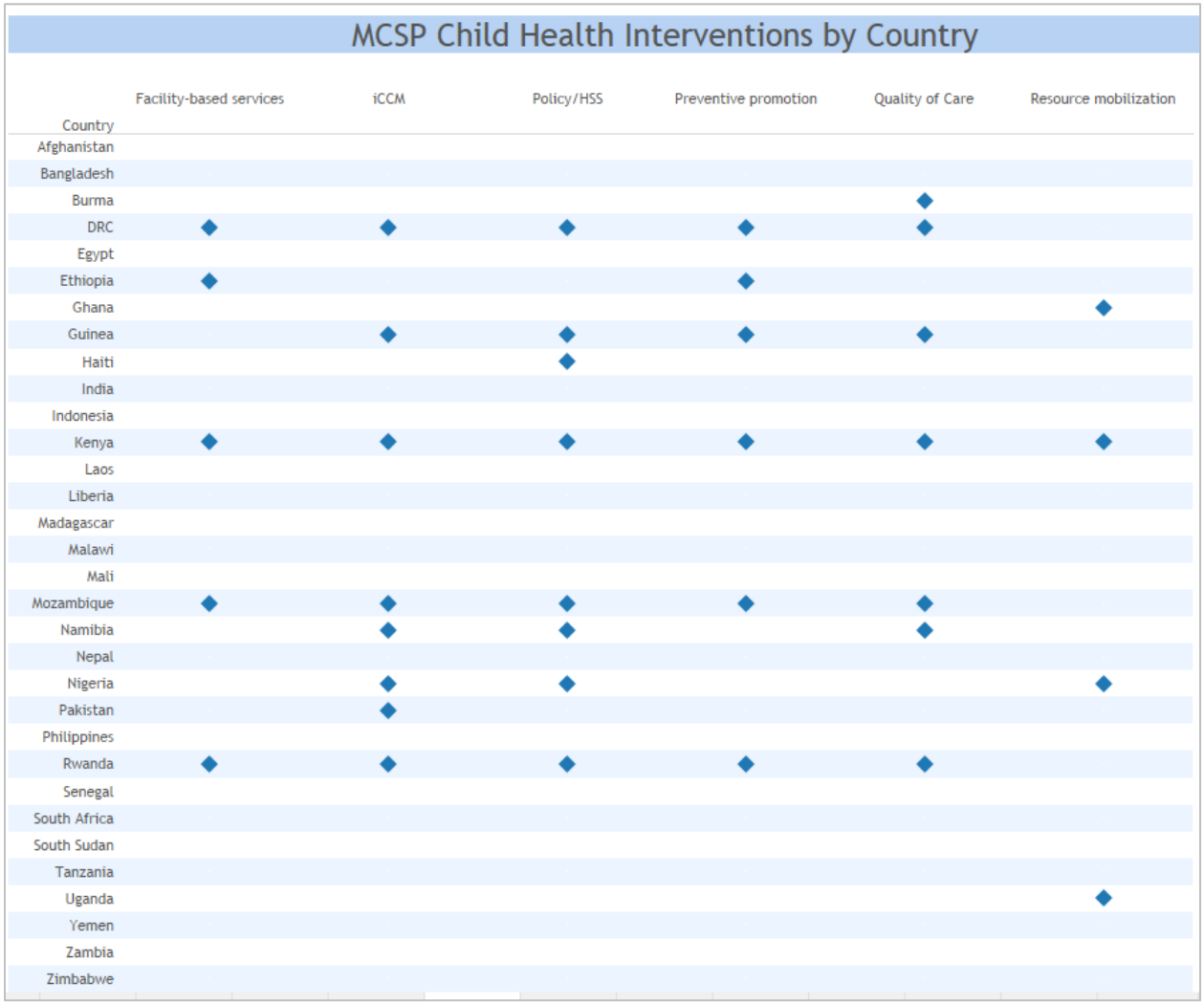
Child Health

MCSP is working with host country governments to support efforts to reduce child mortality to 20/1,000 live births or below by 2035. During PY1, MCSP areas of focus included developing new approaches to: 1) improve the quality of community- and facility-based care for infants and young children; 2) integrate pneumonia, diarrhea, and malaria case management with preventive and promotive interventions such as immunization, WASH, infant

[2] India, Bangladesh, Indonesia, Nigeria, Malawi, Ethiopia, and Rwanda.

and young child feeding (IYCF) and birth spacing; 3) address health systems issues that affect the availability, quality, utilization, and sustainability of child health services; and 4) improve the development of materials for training and implementation of integrated management of childhood illness (IMCI) and iCCM, and support countries to implement and scale up these strategies. MCSP's child health support emphasizes research and analysis to provide the evidence base for policies, operational planning, and scale-up of interventions. The team is involved in several collaborative studies and developed applicable guidance for strengthening implementation of child health programs.

Figure 7. MCSP Child Health Interventions by Country



Accomplishments

- As a core member of the iCCM Financing Task team, MCSP helped provide TA support to 21 priority countries to integrate iCCM into their malaria and/or HSS Global Fund NFM concept notes. As a result, 18 countries have submitted iCCM-enhanced concept notes to the GF. To date, based on the approved concept notes and the additional leveraged co-financing data, an estimated USD [redacted] has been committed to implement and expand iCCM in 12 countries. Based on experience providing support to countries (Ghana, Kenya, Nigeria, Uganda, and Zambia) that applied for funding through the NFM, and key informant interviews, MCSP has generated lessons learned and recommendations for strengthening partner coordination and developing stronger concept notes for future funding. Application of these recommendations will facilitate more equitable access to integrated care for under-5s. These reports are being finalized for dissemination in early PY2.

- MCSP also provided targeted support to countries that submitted successful Global Fund NFM concept notes (DRC [redacted], Nigeria [redacted] Ethiopia [redacted] Uganda [redacted] and Zambia [redacted]) to develop operational plans, identify iCCM indicators to monitor implementation, sign grants with the Global Fund, and initiate implementation.
- MCSP completed the 18-month prospective (January 2013, under MCHIP, to June 2015) iCCM Research Study in Bondo, Kenya "Feasibility Study of the Implementation of Integrated Community Case Management in Bondo: Leveraging Existing Systems." See study results in accompanying text box.
- From July to August 2015, MCSP's Child Health, Nutrition, and WASH teams completed Phase I of the oral rehydration therapy (ORT)/corner review in Igembe and Bondo, Kenya. Phase I evaluated if, and to what extent, ORT/corners were still operating in accordance with national guidelines. MCSP also reviewed a sample of registries capturing ORT corner data from the MCHIP intervention clinics in Igembe North and Bondo sub-counties, Kenya, to better understand what types of data were captured over the last two years. This initial phase was to determine an effective approach to revitalizing ORT uptake. Phase II, which would explore the impact of ORT corners on behaviors relevant to prevention and treatment of diarrheal disease, is contingent upon further funding after Phase I results are shared. The Phase I report findings will be available in Q2 of PY2.
- To inform global iCCM scale-up efforts, MCSP is conducting a prospective look at scaling up iCCM in DRC and Namibia: *Enabling Factors that Support Scale-Up of Integrated Community Case Management of Childhood Illness*. This study will take place over the life of the program with the potential for including additional countries. Work will begin in both countries in PY2.
- The Child Health team informed and contributed to the development of many country workplans and activities (see Figure 7). Through these activities, the team supported country activities to strengthen provider capability, sharpen strategies to implementing child health interventions, deliver and monitor child health and iCCM interventions, and create enabling policy environments for the implementation of iCCM that are key to increasing access to services for the underserved. The team has been providing guidance to several countries migrating to DHIS2 on appropriate child health indicators, in particular, iCCM indicators for the community modules.
- As Secretariat of the iCCM Task Force, MCSP ensured that the seven subgroups have terms of reference (TORs), webpages on CCMCentral.com (knowledge management portal), and hold regular teleconferences to share best practices and resources for iCCM programs. During PY1, the M&E Subgroup initiated the revision of the iCCM Indicator Guide developed under MCHIP. Based on the child health community interest, the Nutrition and Workforce Issues subgroups were created. The Nutrition Subgroup addresses the weak integration of nutrition as part of iCCM and is currently exploring priority research questions and areas of interest (in coordination with the MCSP Nutrition team). The Workforce Issues Subgroup discussed methods to reduce attrition and increase motivation, and explores training and supervision issues.

Results of iCCM Research Study in Bondo, Kenya

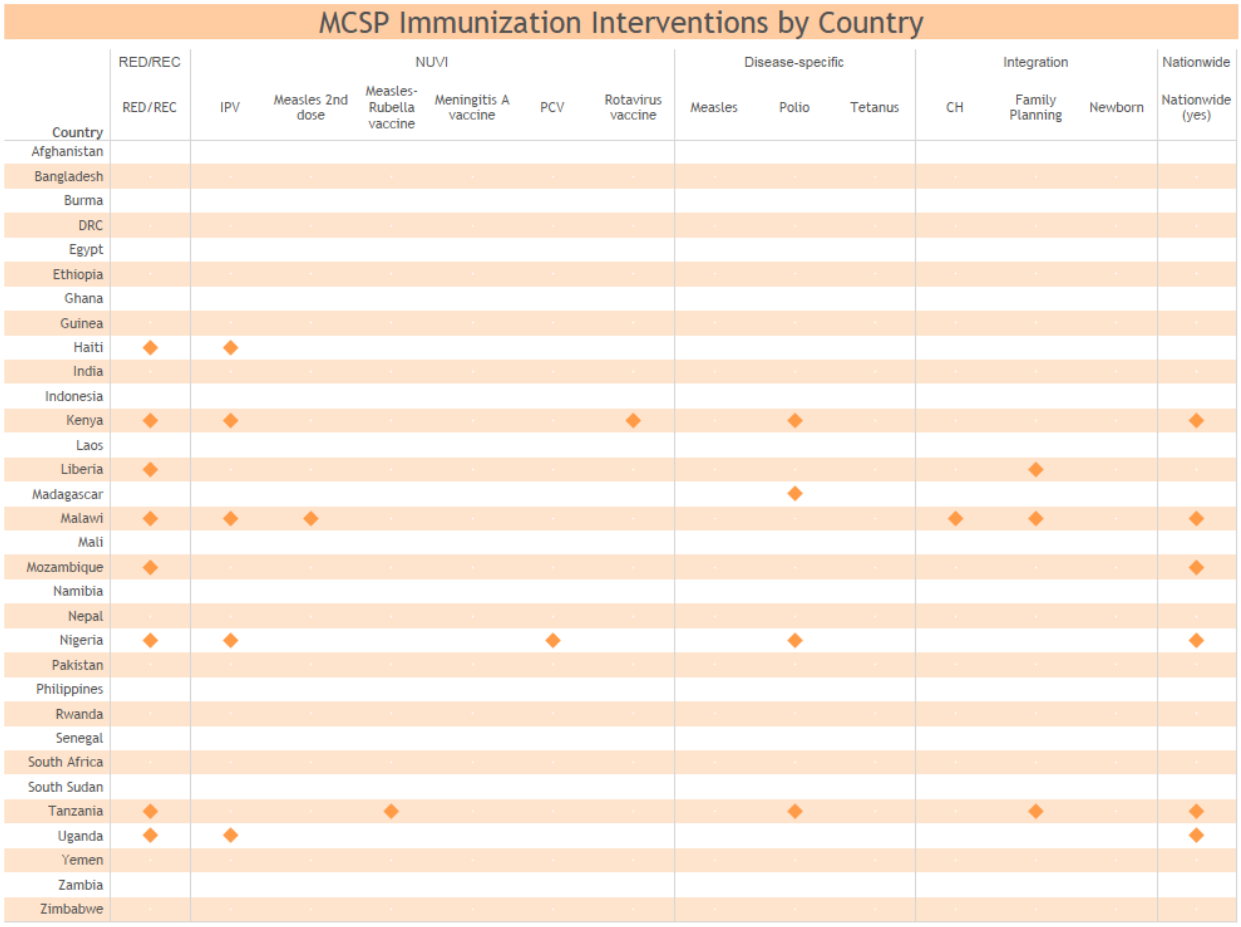
- Children taken to a provider on the first day of developing fever increased by 53%.
- 16% of children on antimalarial treatment were visited at home by a community health volunteer (CHV) within 3 days compared to only 5% at baseline.
- Most caregivers who were referred (92%) received a follow-up visit from the CHV within 3 days of sick child referral.
- CHVs demonstrated ability to correctly follow the iCCM algorithm, from the identification of danger signs to the classification of illness for treatment at community level or for referral.
- Assessment of danger signs improved significantly from 32% at baseline to 93% at endline.
- 96% of CHVs correctly performed and interpreted results from malaria rapid diagnostic tests (RDTs).
- 53% of childre with diarrhea received the recommended treatment of both oral rehydration solution (ORS) and zinc and at the correct doses and duration for age.

Immunization (including polio eradication)

The year 2015 was an important year in immunization. It marked the mid-point in the current so-called Decade of Vaccines, the end of the previous WHO guiding framework Global Immunization Vision and Strategy, the end of the MDGs, and the year of intense planning for the new five-year Gavi Business Strategy. As such, MCSP was particularly active in influencing the vision and future work of partners, such as the BMGF, WHO, UNICEF, and Gavi. Our contributions will affect the routine immunization (RI) services provided in many MCSP

priority countries. MCSP has operationalized USAID's longstanding commitment to the strengthening of RI systems by building the capacities of MOHs and partners to design, implement, and monitor RI systems that, in turn, provide timely, safe, equitable, and uniformly high vaccination coverage at scale year after year.

Figure 8. Immunization Dashboard



Accomplishments

- MCSP documented and shared inputs, lessons learned from country-level experiences, and best practices to support WHO's Vision and Mission in Immunization and Vaccines 2015–2030, and UNICEF's Communication for Development Guidelines for Immunization. MCSP also contributed to international efforts to strengthen data quality, demand generation, and disease-specific initiatives such as Polio Legacy Planning.
- MCSP supported country-led implementation of RI activities in numerous countries (see Figure 8). For example, MCSP is working on RI strengthening in Bauchi and Sokoto states, Nigeria, through an innovative high-level, country-owned partnership between USAID/Nigeria, the Bauchi and Sokoto state governments, BMGF, and the Dangote Foundation.
- In Tanzania, MCSP helped develop the Vaccine Information Management System in collaboration with the MOH and other international partners. MCSP worked with Kenya's MOH to outline a framework for school-based, long-term tetanus toxoid prevention.
- MCSP supported the transition from Reaching Every District (RED) to REC approaches in Uganda, Kenya, Tanzania, Malawi, and Zimbabwe, helping these countries to move beyond their narrow implementation of RED to mount efforts to identify and target underserved populations in partnership with communities. MCSP also supported cross-learning between MCSP and the companion Gates-funded SS4RI program in Uganda, and between the Gates-funded Universal Immunization through Improving Family Health Services (UI-FHS) program in Ethiopia and MCSP in Uganda.
- MCSP supported the introduction of (inactivated polio vaccine) IPV in Nigeria and Malawi by reviewing training manuals and working with the MOH in preparing for this new vaccine. Best practices of new vaccine

introductions were also communicated to national counterparts. In addition, MCSP evaluated Mali's response to the vaccine-derived poliovirus outbreaks that took place earlier this year.

- The Communications Initiative (CI) supports priority polio endemic and at-risk countries with advice and guidance on the planning elements of their polio communications process and ensures wide dissemination of polio communication knowledge. As a participant and member of the June 2015 Pakistan and Afghanistan Technical Advisory Group (TAG) meetings, each country's polio program was reviewed and recommendations were made on the communication.
- CI supported the Horn of Africa polio programs (Kenya, Ethiopia, and Somalia) to assess and review the polio outbreak responses and the communication efforts that accompanied this health intervention. Information on polio was disseminated through various communication and media platforms (knowledge summaries, network building, E-magazine, E-newsletters, Polio News, and blogging) to share and encourage engagement of polio communication research, evaluation, and program activities with the international technical community.

Family Planning

MCSP's strategic approach to FP centers on preventing unintended pregnancies, focusing on those linked with poorer health outcomes, such as women who give birth too soon after a prior pregnancy, high-parity women, older women, and girls. The following key strategies will be implemented to achieve FP2020 and EPCMD goals:

- Expand and scale up PPFP and integration of FP along the maternal, newborn, and child health (MNCH) continuum of care;
- Expand FP and PPFP method choices; and
- Reach young girls/adolescent mothers, their partners, and gatekeepers with targeted FP communications and services (linked when appropriate with MNCH services).

Accomplishments

- The MCSP FP team is expanding or scaling up access to PPFP by engaging with global and local actors. In June, MCSP conducted a successful global meeting with 173 attendees from 16 countries. The meeting was jointly organized by MCSP and Jhpiego under the aegis of FP2020 with funding from MCSP, BMGF, WHO, Packard Foundation, and UNFPA. During the meeting, country teams developed action plans to accelerate access to PPFP, with emphasis on multiple contact points along the continuum of care. (See Table 1 that illustrates selected themes in the country action plans.) MCSP followed up with the 16 country delegations on their action plans, which have now been posted publicly on the FP2020 website (http://www.familyplanning2020.org). The International Steering Committee established to set up the meeting (FP2020, USAID, UNFPA, WHO, and BMGF) continues to meet and now includes the Department for International Development (DFID). The committee focuses on monitoring progress and assisting countries. This effort has resulted in new donor funding, for example, UNFPA Bangladesh will support implementation and WHO will send a representative to Bangladesh to address concerns over the changes in medical eligibility.

Table 1. Selected Concepts/Themes Reflected in PPFP Country Action Plans

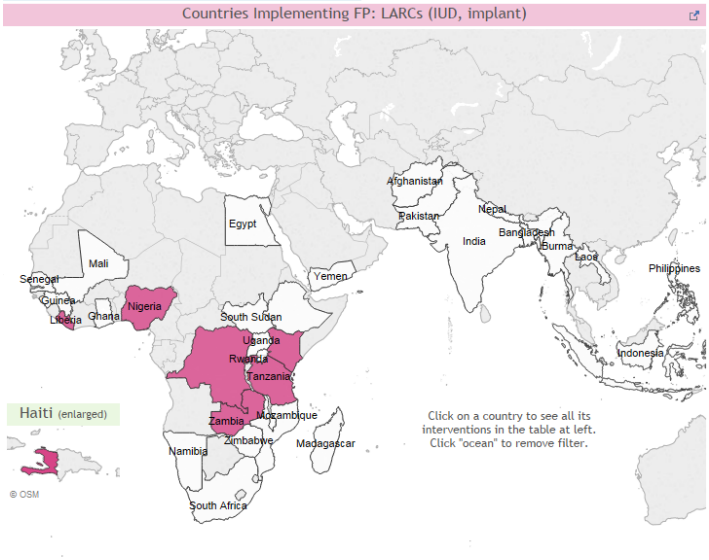
Country	Updating Nat'l SD Guidelines	LARCs on Day of Birth	Lactational Amenorrhea Method (LAM) Promotion	Postabortion Care (PAC) / Strengthen PAFP	FP-Immunization	PPFP Counseling by CHWs	Permanent Methods
Afghanistan	●	●	●		●	●	
Bangladesh	●		●		●	●	
Burkina Faso		●					
DRC		●			●		
Ethiopia		●			●		
India		●		●	●	●	

Country	Updating Nat'l SD Guidelines	LARCs on Day of Birth	Lactational Amenorrhea Method (LAM) Promotion	Postabortion Care (PAC) / Strengthen PAFP	FP-Immunization	PPFP Counseling by CHWs	Permanent Methods
Indonesia	●	●			●		
Kenya	●	●	●		●	●	
Madagascar		●	●				
Nigeria	●	●	●		●		
Pakistan	●	●		●		●	
Rwanda		●					
Tanzania		●			●	●	
Uganda	●	●	●		●	●	●
Zambia		●			●		

- MCSP supports country implementation goals of expansion of FP and PPFP method choices in Madagascar, Tanzania, Ethiopia, and Nigeria. One approach to reach this goal is to design or implement PPFP programming that includes long-acting reversible contraceptives (LARCs) on the Day of Birth. In Tanzania, MCSP led a five-day training on postpartum intrauterine devices (PPIUDs) in July, with approximately 25 participants from Mara, and then subsequently in Kagera. The training emphasized effective counseling on FP methods, given that ANC counseling on PPFP, including PPIUD, is very important for uptake.
- The FP team is coordinating closely with colleagues working in maternal health, newborn health, and QI/HSS to develop an integrated package for routine care on the Day of Birth. In July, national- and state-level stakeholders reviewed the draft WHO Principles of Quality Improvement and adopted the framework as relevant and useful for implementation in Nigeria. In Kogi state, stakeholders set four improvement goals for the Day of Birth Indicators were agreed to along with a target for the percentage of women who are counseled on PPFP before discharge. The Nigeria team has integrated aspects of PPFP service documentation and measurement into PPFP counseling training, which began and will be followed up with PPIUD training for an initial cohort of facilities. MCSP/Nigeria envisions rolling out PPFP counseling at scale in all 120 MCSP/Nigeria facilities, although operationalization may not always be through stand-alone PPFP counseling training in favor of the integrated package for routine services.

- To reach young girls/adolescent mothers, MCSP initiated development of age and life-stage provider counseling tools as one approach to improve information and services on adolescent sexual and reproductive health (ASRH) in Kogi and Ebonyi states, Nigeria. A desk review of available ASRH counseling materials was conducted and local state data were collected and used to develop counseling tools. Following the pre-test, MCSP will package together the age and life-stage counseling tool in November and December, and will design and implement a training curriculum and train providers in pilot facilities on use of the tools.

Figure 9. Countries Implementing FP: LARCs (IUD, implant)



- Regarding learning on key topics for improved implementation, the MCSP-FP team, in collaboration with other teams, designed five research studies, including the age-and-stage counseling work in Nigeria, the Tanzania SBCC study, and the implant failure study, as well as an FP-Immunization study, and an Ethiopia PPFP study. The team also contributed to study design for similar work on ASRH in Madagascar (field-funded) aimed to contribute to the team's action-oriented learning goals. In collaboration with MCSP/Tanzania, the FP team developed a study to design and test new SBCC strategies for improving understanding of return to fecundity, increasing timely uptake of modern FP methods after childbirth, and promoting optimal maternal, infant and young child nutrition (MIYCN) practices. The study's first phase is formative research around sociocultural cues, barriers, and facilitating factors for optimal MIYCN and FP practices. Another study aims to investigate contraceptive failure of levonorgesterol and etonogestrel implants for women on antiretroviral therapy (ART), particularly Efavirenz-containing regimens. Supplemental core funds were made available to allow for record reviews and exploration of ART-related implant failures in Kenya, taking advantage of their electronic medical record system. Implementation for these studies will take place in PY2.

Malaria

The MCSP strategic approach for malaria recognizes that malaria is a MNCH disease, disproportionately affecting pregnant women and young children. MCSP targets two key technical areas of malaria prevention and control—malaria in pregnancy (MIP) and iCCM. Our malaria strategy recognizes the dynamic partnership between global-level guidance and country-level implementation. MCSP works at both levels, in partnership with the RBM MIP Working Group and the global iCCM Task Force in advancing the global dialogue as well as with MOHs, to accelerate country-level implementation and ensure quality malaria services.

Accomplishments

Malaria in Pregnancy

- MCSP's Malaria team Lead was elected as co-chair of the RBM MIP working group this year. Through MCSP's leadership in the RBM MIP Working Group, MCSP's Malaria and Nutrition teams collaborated on the development of two consensus statements[3] and a brief[4] that advocate for the continued prioritization of key

[3] Roll Back Malaria Partnership Malaria in Pregnancy Working Group: Consensus Statement on Folic Acid Supplementation During Pregnancy;Continuous Distribution of Long-Lasting Insecticidal Nets in Africa Through Antenatal and Immunization Services: A Joint Statement by the Roll Back Malaria Working Groups on Malaria in Pregnancy and Vector Control and the Alliance for Malaria Prevention.

[4] Controlling Maternal Anemia and Malaria Ensuring Pregnant Women Receive Effective Interventions to Prevent Malaria and Anemia: What Program Managers and Policymakers Should Know

actions to accelerate MIP program implementation coverage, reinforce WHO policy and target policymakers and program managers with key information to advance MIP prevention and control. The documents were disseminated to all the RBM MIP WG partners, MCSP country teams, Jhpiego's Malaria Community of Practice, and posted to the RBM Partnership website (http://www.rollbackmalaria.org/).

- MCSP collaborated with the President's Malaria Initiative (PMI) to finalize the MIP case management job aid, developed under MCHIP, with WHO review and input, as a tool to aid service providers who care for women of reproductive age and improve correct diagnosis and treatment of P. falciparum MIP. The job aid will be field-tested for acceptability and feasibility in PY2. The countries have yet to be identified.
- MCSP supported Tanzania to help finalize MIP training materials to be incorporated into a national ANC training package. In Madagascar, the malaria team helped finalize the WHO intermittent preventive treatment during pregnancy with sulfadoxine pyrimethamine (IPTp-SP) guidelines to help train providers on the new guidelines and advance the MIP agenda in the country.

Global Fund Malaria Technical Advisors

- In support of USAID's objective to help support GF grants, MCSP worked with PMI to develop a two-year workplan for the GF Malaria Technical Advisors proposed for Nepal and India. The Nepal GF Malaria Technical Advisor has been hired with a start date of February 1, 2016. The MCSP Malaria Program Officer attended the first quarterly meeting with PMI and another USAID-implementing partner to share lessons learned and challenges from the Technical Advisors in the field.

iCCM activities are co-funded by the Malaria and Child Health teams and are reported fully under the Child Health section above. Notable achievements include five draft country case studies on the coordination between EPCMD and malaria programs, completion of the endline iCCM feasibility study in Bondo, Kenya, inclusion of iCCM into the Global Fund NFM concept note for malaria participation and active participation in the iCCM Task Force Secretariat and M&E subgroup.

Child Survival Health Grant Programs

- A total of 12 Child Survival Health Grant Programs (CSHGP) with malaria interventions received one or more of the following forms of TA: support for writing operations research (OR) reports and briefs, development of final evaluation briefs, and participation in an MCSP-led workshop on developing theories of change. See the Community Health section for additional information.[5]

Nutrition

The MCSP Nutrition team works to support new and existing evidence-based intervention approaches to reduce malnutrition in the first 1,000 days—during pregnancy through 2 years of age—by integrating nutrition into MNCH platforms. With a focus on USAID priority countries, MSCP is identifying and disseminating ways to improve the effectiveness of programs by addressing barriers to and promoting facilitating factors for iron-folic acid (IFA) supplementation, maternal diet, and IYCF practices.

Accomplishments

- The Nutrition team continues to identify and disseminate ways to improve the effectiveness of programs by addressing barriers to and promoting facilitating factors for IFA supplementation, maternal diet, and IYCF practices. The K4Health Anemia Prevention and Control Toolkit was updated with information on steps that Kenya has taken to improve its anemia control program and giving the correct dose of folic acid during pregnancy with IPTp-SP as an antimalarial.

[5] Two CSHGP projects are fully malaria focused: Catholic Relief Services (CRS) and Mother and Children Support International (MCSI) Benin. The 10 other projects that include malaria programming are: Concern Niger and Sierra Leone, Save the Children Zambia and Malawi, World Vision South Sudan, Africare Liberia, CHS-URC Benin, CRS Ghana, HealthRight Kenya and HAI East Timor. More information about these projects, and others, can be found at: www.mcsprogram.org/CSHGPproducts.

- The nutrition team worked with country teams in DRC, Haiti, Ghana, Kenya, Malawi, Mozambique, Pakistan (under MCHIP), and Tanzania to develop plans to integrate nutrition into MNCH, water and sanitation, malaria, and FP program platforms. The team also supported evidence-based intervention approaches in the same countries for facility- and community-level development and adaptation of training curriculums, guidelines, program tools; conducted desk reviews; and carried out formative research that will inform on program design and "the how" of program implementation.

Kate Holt/Jhpiego-MCSP

- Two technical briefs were completed. A brief on Adolescent and Maternal Nutrition will be disseminated to support the implementation of the USAID Multi-Sectoral Nutrition Strategy. This brief includes integrating nutrition with other sectors. Additionally, a brief on giving the correct dose of folic acid in pregnancy to ensure the effectiveness of IPTp-SP as an antimalarial was written in collaboration with the MCSP Malaria team (as noted above) and disseminated by the RBM Partnership, MCSP, PMI, other partner channels, and through the K4H Anemia Prevention and Control Toolkit.
- Four publications were completed, three of which were related to IYCF practices and malnutrition in Egypt and published in online peer-reviewed journals. The fourth article was submitted for publication to Public Health Nutrition and examines community-level perceptions in Kenya of maternal anemia and pre-eclampsia and the implications for service delivery. The Egypt articles were disseminated to USAID Missions, USAID/Washington, UNICEF Egypt, and other key contacts in Egypt. All articles present implications for improved nutrition programming. A full list of the publications can be found in Annex F.
- MCSP developed and implemented a cross-sectoral (Nutrition, WASH, Child Health) phase 1 assessment of the degree to which "ORT Operational Guidelines," developed by Kenya's MOH in collaboration with MCHIP, were implemented (see WASH section for more details).
- Progress was made on all four of the MCSP Nutrition team learning priorities: improving IYCF and maternal nutrition by examining breastfeeding practices, junk food consumption among young children, maternal intake during pregnancy, and the experience with CBD of IFA supplements. The list of the nutrition learning questions can be found in Annex C. Literature reviews and policy and strategy reviews for at least 10 USAID priority countries have been conducted for MCSP Nutrition team's four learning questions on community-based IFA supplementation, the prevalence and factors associated with junk food consumption, and barriers to exclusive breastfeeding and maternal diets. Initial data consolidation and analyses have been conducted on junk food consumption prevalence in relation to nutrition status and rates of exclusive breastfeeding before 6 months of age in the 24 USAID priority countries. Four landscaping interviews have been conducted with Nutritionists from MOHs to assess junk food consumption in children younger than five years, and major barriers to and factors facilitating/motivating exclusive breastfeeding in the first six months. An analysis of nutrition policies, strategies, and guidelines in selected USAID priority countries has been conducted to determine if countries have written guidance on CBD of IFA supplements.

Water, Sanitation, and Hygiene

The primary objective of the MCSP WASH activities is to make WASH a normative part of MNCH programming to EPCMD by supporting country programs to increase coverage and utilization of evidence-based, high-quality RMNCH interventions. MCSP WASH works with households, communities, and facilities to prepare for a clean and healthy birth and newborn experience, reduce infections to mother and newborns during the peri- and postnatal periods, and reduce stunting in children under 2 years of age and diarrheal disease in children under 5 years of age.

Throughout 2015, the MCSP WASH program primarily supported two MCSP technical teams—Newborn Health and Child Health. WASH supported the Newborn Health team's activities by targeting infection reduction on Day of Birth and during the first month of life through improved handwashing. The WASH team's child health work

focused on finding opportunities to reduce stunting in children under 2 and diarrheal disease in children under 5 by integrating with other technical sectors, most notably nutrition.

Accomplishments

- The WASH team supported Mozambique, Haiti, Ghana, DRC, and Kenya throughout the year to integrate WASH technical approaches with country programs and to focus on key issues, such as clean clinics.
- The WASH team developed a newborn handwashing study in partnership with Unilever to evaluate the effectiveness of three levels of intensity of handwashing promotion—communication at clinics alone, communication at clinics with communication at households, and communication at clinics with communication at households and provision of a handwashing device for households. In PY1, the 12-month study was set up that will run in PY2. Procurements of a research firm and local staff to run the program were completed in Kenya. Testing of and revisions to the communications materials were consolidated and under way at the end of PY1.
- The team developed and implemented a cross-sectoral (Nutrition, WASH, Child Health) phase 1 assessment of the degree to which "ORT Operational Guidelines," developed by Kenya's MOH in collaboration with MCHIP, were implemented. During phase 1 of this projected two-phase effort, the team developed and pre-tested a study design. The data collected during PY1 will be analyzed in PY2 Q1. Assuming positive outcomes of Phase 1 (i.e., the corners were implemented as designed), a phase 2 study will be developed to assess the impact.
- The WASH team conducted a literature review and key informant interviews to investigate the relative importance and impact of WASH toward EPCMD. The aim of this work is to develop better country support, while also providing MCSP and USAID WASH advisors support for describing the importance of WASH within RMNCH. Results from this work are expected in PY2 Q1.

Summary of Achievements by Cross-Cutting Area

Measurement, Monitoring, Evaluation, and Learning

MCSP has advanced its MMEL priorities for PY1, including:

1. Providing global leadership for improved metrics, tools, and methodologies;
2. Strengthening country-level routine data collection, quality, visualization, sharing, and use;
3. Enhancing information for program planning, performance monitoring, and accountability; and
4. Supporting action-oriented learning to improve RMNCH outcomes.

Key strategies to achieving these priorities include linking global and country experiences; enhancing country M&E systems and practices; leveraging routine data and process documentation; and creating a thoughtful, explicit, and organized learning strategy to guide project-wide implementation research generation and use.

Accomplishments

M&E

- MCSP convened a Technical Consultation for Mapping of Maternal Mortality on January 12 and 13, 2015, with experts from various disciplines to formulate recommendations and next steps for mapping maternal deaths to track progress toward global targets. The Technical Consultation included 55 participants and 26 presenters and provided an opportunity for geographers, public health practitioners, epidemiologists, and statisticians to share technical updates and progress on use of maps to facilitate decision-making and promote accountability. A follow-up conference call was held with the Steering Committee: next steps were delineated and efforts were catalyzed to develop a manuscript as an output of the Technical Consultation. The Post-Consultation report was finalized, approved, and circulated. Work on a journal commentary based on the meeting report progressed.
- The MCSP MH and MMEL teams worked with WHO, USAID, and the MH Task Force to host an EPMM metrics meeting in September 2015, which aimed to reach consensus on a core set of priority, methodologically robust MH indicators to propose for global monitoring and reporting by all countries, a critical step in the work toward developing global goals for EPMM. The meeting included participation of about 30 experts from multiple countries representing donor agencies, research and academic institutions, and international nongovernmental organizations (NGOs). By the end of the EPMM meeting, consensus had been reached on a set of 12 indicators that included input, coverage, and impact indicators largely following the format used by the ENAP group. Three indicators are in common with the ENAP indicator list and six are linked to the WHO core list of 100 indicators. The indicators will be presented at the next UN General Assembly Board Meeting for consideration. The group's work is now focused on developing a comprehensive monitoring framework for EPMM.
- MCSP led the newborn resuscitation task team of the ENAP metrics working group, which put forward definitions for core ENAP coverage and process indicators related to newborn resuscitation. These indicators were published in *BMC Pregnancy and Childbirth* as part of the Every Woman, Every Newborn supplement (Count every newborn; a measurement improvement roadmap for coverage data. BMC Pregnancy Childbirth 2015; 15(S2):S8.) and are being recommended by WHO for global monitoring across countries.
- The "2015 Acting on the Call" report was released in August 2015, with outputs from revised LiST models in country-specific profiles for 24 USAID EPCMD priority countries. LiST models examine missed opportunities and impact of MNCH combined with FP interventions. During PY1, the LiST team created and analyzed national models in Senegal and Lao People's Democratic Republic and subnational models in Egypt, Rwanda, and DRC.
- The KPC household survey tool was strengthened and streamlined, and an umbrella protocol was developed and approved by a Johns Hopkins IRB. MMEL provided TA to countries to develop country-specific protocols, including development of a workbook and country protocol template to help guide survey design. Ethiopia KPC data collection commenced in June 2015, and the report will be finalized in

PY2. Protocols were also developed for Kenya, Mozambique, and Tanzania to be implemented in PY2. Work continued to update and develop KPC modules, through consultation with USAID and other technical experts, including WASH, Gender, and Nutrition/IYCF and socio-economic status (SES). An initial mobile application for KPC background and MNC modules was developed.

- Data collection for the MNCH HMIS analysis continued, with 22 countries having submitted at least some of the requested forms. Work is currently under way to collect child health recordkeeping forms from priority countries. An online survey on use of MNCH HMIS data was also conducted.

Action-Oriented Learning and Knowledge Management

- Several learning activities were completed during PY1, including the Feasibility Study of the Implementation of iCCM in Bondo Sub-County, Kenya, and further analysis of the MCHIP-sponsored Healthy Fertility Study, both initiated under MCHIP, as well as an Evaluation of Seasonal Malaria Chemo Prevention Implementation in Mali. Findings are described in the Child Health and FP sections, and Mali Country Summary annex to the Annual Report, respectively.
- MCSP supported the Afghanistan MOH by facilitating a National Scale-Up Workshop in June 2015. As a result, the Afghanistan MOH developed a National Scale-Up Plan for PPH Prevention. MCSP also supported the Nigeria country program in advance of the national Chlorhexidine Scale-Up Review Stakeholder Meeting convened by the Nigeria Federal MOH in September 2015, and collaborated with USAID's Center for Accelerating Innovation and Impact to provide feedback for the resulting country-level scaling tool.
- MCSP reached consensus with USAID and core teams on the scope of the Program-wide learning agenda, as well as developing guidance, processes, templates, and tools for operationalizing the learning agenda. Approximately one-third of Program-wide learning agenda activities have progressed to the implementation stage. Systematic support for and study of scale-up advanced with an agreed-upon framework and set of tools to be used in the planning, tracking, and monitoring of scale-up developed, as well as interventions and countries agreed upon with USAID.

Health Systems Strengthening (including Quality, Gender, and Equity)

The Health Systems Strengthening and Equity (HSS/E) team aims to support countries to achieve and sustain equitable coverage of high-quality, evidence-based, high-impact RMNCH interventions by applying an HSS/E lens across MCSP's work. This approach includes developing methodologies and strategies to address health systems challenges that affect priority interventions and prevent equitable improvements in health. It also entails a strong focus on QoC as part of HSS, recognizing the importance of quality for achieving positive RMNCH health outcomes.

The HSS/E team ensures that health systems considerations are part of MCSP country program approaches, and has supported building the capacity of district managers and MCSP staff to more effectively address health systems issues that are barriers to improving outcomes. The team also prioritizes the integration of equity and gender considerations and analysis into MCSP activities, with particular attention to promoting and measuring equitable coverage of high-quality services. MCSP's work in health equity focuses on both the improvement of a health outcome of a disadvantaged group, as well as a narrowing of the difference of this health outcome between advantaged and disadvantaged groups—without losing the gains already achieved for the group with the highest coverage. MCSP further recognizes that enhancing the health and saving the lives of women, girls, and families requires an understanding of gender-based needs, preferences, constraints, and opportunities of males, females, and other gender identities.

Accomplishments

- The Comprehensive Approach to Health Systems Management concept, framework, and briefing materials were developed, with inputs from MCSP technical and country teams, USAID, and related initiatives such as the Whole Market Approach and UNICEF's District Health System Strengthening.
- Pilot-testing of the Comprehensive Approach was initiated in Tanzania, with the framework adapted to the Tanzanian context (where it is called Mbinu Timilifu kwa Usimamizi wa Mifumo ya Afya [MTUMA]). MCSP achieved buy-in from the regional and district health managers in Mara Region for its implementation. A

three-day local health systems mapping workshop was held, during which more than 15 health managers from two districts in Mara Region, Musoma Municipal Council and Butiama District Council identified a priority list of health systems initiatives, tailored according to local needs and representing opportunities to proactively address challenges and maximize the value of national and donor programs. The health managers expressed enthusiasm about the planning and prioritization skills gained as well as new knowledge on existing tools and programs available to them.

- The Rapid Health Systems Assessment (RHSA), which is a tool that can support the Comprehensive Approach as a diagnostic tool, was applied in Kogi and Ebonyi states, Nigeria, in coordination with two QI workshops held at the national level in Abuja and in Kogi state. Preparations are under way for implementation of the RHSA tool in Rwanda and Tanzania in PY2.
- As part of the revitalization and strengthening of Community Health Platforms (CHPs), the HSS/E team worked with the Government of Ghana and key stakeholders to develop the costing methodology in line with national-level costing plans. Data collection was completed in all but one region by October. Data cleaning and analysis will commence in Q1 of PY2 with preliminary findings and a draft-costing tool available by the end December. The tool has received high-level endorsement at the MOH and is eagerly awaited by the stakeholders who plan to utilize it.

Quality

- MCSP defined a set of core QI principles common to most QI approaches to guide its QI efforts across technical areas at the country level including for FP, Child Health, Maternal and Newborn, and nutrition improvement work.
- MCSP applied these QI principles in several country programs, including Nigeria and Madagascar, emphasizing a process of country adaptation focused on existing QI strategies, local QI assets, and context.
- MCSP provided technical support for development of the WHO MNH QoC framework (quality statements, measures, implementation roadmap) with which MCSP QI principles are very complementary.

Gender

- Overall, MCSP is addressing gender issues through specific strategies or interventions in 10 country programs, ranging from strengthening GBV services through designing trainings or QI approaches; implementing standards for gender-sensitive, respectful care; or engaging men in maternal health and FP at both the facility and community levels.
- At the country level, gender has been integrated into the QoC study in Nigeria and the KPC survey in Tanzania. Questions have been designed to collect data to inform gender-related constraints and opportunities in improving gender-sensitive, respectful, health service delivery and demand creation. The analysis of these data will help inform design of activities and interventions in these country programs.
- Assessments of GBV services in health facilities were conducted in Madagascar, Rwanda, and Guinea. These assessments will help inform the strengthening of GBV service delivery and response in ANC, PNC, and FP in these countries. As resources are finalized, approved, and made ready for public consumption, they will be available on the MCSP internal and external sites and shared at Gender Working Group meetings.
- Gender training materials have been developed for community health workers (CHWs) and midwives in Ghana and Tanzania. In Ghana, a GBV e-learning module, currently in final draft form, was developed for pre-service training for community nurses and midwives. In Tanzania, gender training materials were developed and implemented with 548 CHWs in the four districts where the project works in Mara and Kagera; the training materials are now being reviewed and validated by the Ministry of Health and Social Welfare (MOHSW) gender technical working group (TWG). Furthermore, eight civil society organization (CSO) partners (four in Mara and four in Kagera) were trained on gender integration and supported to mainstream gender into their narrative and budget plans. Among the role of trained CSOs is overseeing CHW gender work at the community level, including establishing and mobilizing gender dialogue groups and conducting dialogue sessions.
- At the global level, resources were developed to help technical teams better integrate gender with their programs, including a primer for gender analysis and a gender integration pathway for MCSP.

Equity

- Questions on beneficiary assets were included in baseline household surveys in Kenya, Tanzania, and Mozambique. The inclusion of these questions is necessary to construct SES profiles of beneficiaries that can inform how program work can be targeted to reduce inequities.
- Training material for SES profile methodology was developed and tested at a side meeting at the 3rd Health Systems Research Symposium in Cape Town, South Africa. The effect of reducing the number of questions needed to make sufficiently informed policy and strategy decisions was explored using data from Honduras MCHIP activities. This will enable the continued implementation—and adaption and improvement—of SES profile tools in MCSP countries.
- Equity considerations were added to the qualitative interview guides for the RMNCH RHSAs. As mentioned previously, assessments in Rwanda and Tanzania are planned for PY2.

Community Health and Civil Society Engagement

MCSP's vision is to promote the institutionalization of community health as a central component of country health systems by equipping national efforts with tools and strategies supporting the development of viable and integrated CHPs.

MCSP is supporting community health and/or civil society engagement (CSE) components into country MCSP programs, and to CSHGP grantees, some of which are in overlapping countries. CORE Group, a critical member of the MCSP Community Health and CSE team, helped test, evaluate, introduce, and/or expand use of evidence-based innovations and knowledge-sharing through its Community Health Network. This involvement included sharing of CSHGP approaches, products, and technologies that can accelerate progress in EPCMD, especially for the most vulnerable, hard-to-reach populations.

Accomplishments

- CORE Group successfully led two Global Health Practitioner Conferences; CORE Group working groups were restructured and MCSP staff liaisons were linked to their activities; and there were significantly more diffusion seminars sponsored by CORE Group for the global health public. CORE Group provided 14 seminars during this program year. Topics included improving local supply chain management, effectively measuring social and behavior change (SBC) and WASH activities, preventing contagious diseases, ensuring QI, and sharing state-of-the-art publications on emerging global health topics.
- The CHW Capacity and Coverage Tool (C3 tool), which has potential for global application, was developed and tested in Tanzania, in conjunction with discussions held with the MOH on benefits of using the tool. This tool assists with analysis and modeling of different scenarios related to CHW workload capacity and population coverage. Variables include the scope of work/activities to be performed by CHWs, time available for dedicating to activities (including time spent in travel and training), and the number of CHWs relative to the population in need. The tool was reviewed at MCSP HQ by representatives from technical teams with CHW experience and feedback was provided to Avenir Health, which is working on revisions based on this feedback and the field test.
- MCSP collaborated with the Advancing Partners & Communities (APC) project to expand the content of its existing online Community Health Systems Catalog (www.advancingpartners.org/resources/chsc). APC has collected and posted FP and RH information for nearly all of USAID's 24 priority countries to an online database. MCSP is collaborating with APC to add questions about community to data collection tools and to include this information in the database. Revisions include additional information on other RMNCH intervention areas, CHW typologies, and engagement of civil society and community groups in community health policy.
- The community health team developed program materials related to community health platforms and CSE to guide EPCMD efforts. A paper was developed on operational principles of viable and integrated CHPs, which is intended to be a living document that will continue to be adapted and revised as it is being applied at the country level. The document was also shared at the CORE Group Fall Global Health Practitioner Conference at a New Information Circuit table. MCSP produced a reference document on the role of civil society in health, leading to the development of a draft civil society strategy for EPCMD. Some aspects of the Community Health Platform Principles document have been incorporated into country workplans, including in Rwanda, Egypt, and Tanzania.

- From March 4–6, 2015, team members also participated in a workshop in Ethiopia to engage MOH and civil society partners to plan newborn health activities and messages for pilot implementation in underserved pastoralist areas through a civil society network.
- The Community Health team provided support to CSHGP grantees, including OR support post-Encompass for strengthening final evaluations and communication of findings/results. In February, MCSP hosted a workshop for the active CSHGP grantees on developing theory of change for the OR component of their projects. This workshop provided an opportunity for the grantees to interact with and receive feedback from the various technical teams, including nutrition, FP, and newborn health, at MCSP.

Social and Behavior Change Communication

MCSP recognizes the importance of: implementing strategic, contextualized, and evidence-based approaches to promote RMNCH SBC across the continuum of care. MCSP's SBCC efforts address the priority behaviors outlined in USAID's Behavior Change Framework and MCSP's PMP aligns with those behaviors. Much of MCSP's SBC/SBCC work is driven by field program priorities and related funding. Core funds are also used to support staff with demonstrated expertise in SBCC to facilitate coordination, documentation and dissemination, capacity-building, and application of evidence-based practices across the program.

Accomplishments

- MCSP initiated a FP and nutrition implementation research study to design and test new SBCC strategies for improving the understanding of return to fecundity, increasing timely uptake of modern FP methods after childbirth, and promoting optimal MIYCN practices in Lake Zone, Tanzania. The first phase of formative research aims to re-envision the way PPFP and MIYCN information is communicated by identifying socio-cultural cues to birth spacing or positive deviant nutritional behaviors, simplifying the messages, and using innovative SBCC approaches/platforms for communicating about PPFP and MIYCN to catalyze behavior change. After an initial scoping visit by representatives from MCSP's FP and nutrition teams, national and regional stakeholders in Tanzania expressed strong support for the study. Pending approvals, study implementation is planned for PY2.
- Other SBCC accomplishments included: the completion of the SBCC for PPFP e-Learning course, available at http://reprolineplus.org/SBCC-PPFP-course; strong links with the CORE SBC Working Group; provision of SBCC technical support during country work planning; participation in USAID/WHO/ Norwegian Agency for Development Cooperation/ Partnership for Maternal, Newborn and Child Health (PMNCH) discussions on evidence for SBC interventions.

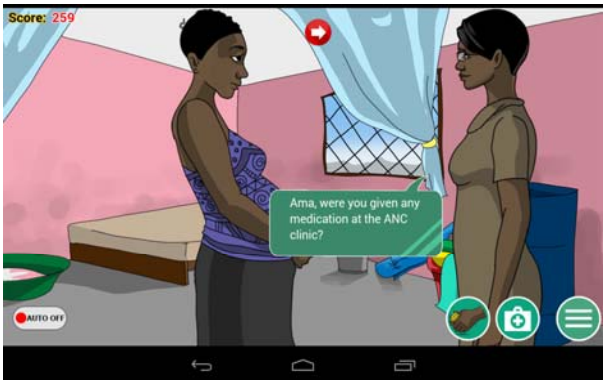
eHealth

MCSP's eHealth goal is to support the integration of effective mobile technology solutions to help achieve country program objectives.

Accomplishments

- MCSP helped coordinate the inaugural two-day Global mHealth Forum in conjunction with the world's largest mobile health event, the sixth annual mHealth Summit. The Forum brought together over 550 implementers, private sector partners, and ministry officials to enhance their capacity to design, implement (including scale up), and evaluate mHealth initiatives in developing countries, share state-of-the-art mHealth, and explore emerging trends. There were seven concurrent tracks covering the topics of access, design, ecosystems, evidence, finance, innovation, and local ownership. Over 80 presenters spoke in these concurrent sessions, representing 77 organizations from 24 countries.
- MCSP undertook a variety of eHealth efforts at the country level. For example, the eHealth team supported the Ethiopia Community-Based Newborn Care/Newborns program on ways to integrate mHealth into a patient tracking framework. MCSP designed an mHealth activity focusing on improving surveillance and tracking pregnancies and childbirths, both from the community through the health development army and from health centers to the health extension workers (HEWs) for facility deliveries. The purpose of this initiative is to help HEWs receive timely information on pregnancies and births in the community in order to

initiate home visits for ANC and PNC, thereby helping to increase the provision of essential health services for mothers and newborns. While this initiative continues to receive interest from within MCSP, USAID, and the Ethiopia FMOH, the activity will not take place in Year 2 due to limited funding; MCSP is exploring other possible resources to support this work in the future.



- In Ghana, MSCP has been developing eLearning modules for pre-service education in prevention of mother-to-child transmission of HIV (PMTCT), cord care for newborns, and exclusive breastfeeding, and adapting modules for a mobile platform. In collaboration with a Ghanaian developer, Leti Arts, and the National Malaria Control Program, MCSP is developing a malaria game on a mobile app to supplement classroom learning. The game allows the player to use case studies to guide the user through real-life situations in the community or at the facility.
- Other country-level work included a scoping visit to Zambia to develop a formative assessment of opportunities for eHealth in the community health system; the assessment will be carried out in PY2.

Africa Bureau

Maternal and Newborn Health

MCSP's work in the Africa region focused on strengthening the delivery and quality of high-impact antenatal care (ANC) services with an emphasis on regionally relevant infectious diseases, including malaria and HIV/STIs. ANC and postnatal care (PNC) intervention packages and indicators were introduced at the country level. The Africa Bureau supported activities also focused on increasing understanding of and strengthening MPDSR and Perinatal Death Surveillance and Response (PDSR) systems in the region through a planned multi-country assessment and support of implementation of MPDSR systems at the regional and country levels. MCSP initiated the development of a TOR and concept paper to outline regional- and country-level support related to MPDSR including the multi-country assessment. MCSP also initiated discussions with WHO, USAID, and other global and regional partners on MPDSR to coordinate efforts.

Accomplishments

- MCSP introduced high-impact ANC and PNC intervention packages and associated indicators to track implementation progress in several country programs—Ethiopia, Tanzania, Kenya, Rwanda, Nigeria, and Mozambique—to inform program implementation.
- MCSP Maternal Health and Malaria teams worked with representatives of the PMI to develop indicators for appropriate prevention and treatment of MIP.
- MCSP drafted a TOR to guide the design and objectives of the planned MPDSR regional situational review, which will involve four to six African countries (to be confirmed in consultation with USAID).
- MCSP participated in a technical consultation in September 2015 in Montreux to review draft WHO guidelines for implementing perinatal death reviews and recommend next steps for field-testing, finalization, dissemination, and implementation of the guideline. The forthcoming guide (anticipated mid-to-late Year 2) will inform future MCSP MPDSR programming.
- MCSP teams began collaborating with MCSP/Nigeria and SNL on national- and state-level MPDSR efforts in Nigeria. SNL plans to conduct a national review to map, document, and assess the effectiveness of current implementation of MDR and PNDA systems in Nigeria. Findings from this review will be incorporated into the Africa regional situational review as well as inform state-level, field-funded program implementation in the MCSP-supported states: Ebonyi and Kogi.
- MCSP Maternal Health and Newborn teams held discussions with representatives from Uganda's SNL team to discuss opportunities for targeted discreet MCSP TA to national policy-level efforts related to MPDSR in Uganda. MSCP and SNL defined potential activities in Uganda, which may include support to update national

MPDSR guidelines to reflect WHO recommendations, with a focus on strengthening the perinatal components of the national MPDSR guidelines and associated tools.

Child Health

MCSP child health activities were supported by the Africa Regional Bureau to complement core child health funding and to gain greater understanding of opportunities to scale up iCCM programs in sub-Saharan African countries.

Accomplishments

- As noted in the CH section, MCSP has generated six reports detailing lessons learned and recommendations for strengthening partner coordination and developing stronger concept notes for future funding based on key informant interviews and experience providing support to countries (Ghana, Kenya, Nigeria, Uganda, and Zambia) that applied for funding through the NFM. Application of these recommendations will facilitate more equitable access to integrated care for under-5s. These reports are being finalized for dissemination in early PY2. This activity was co-funded by the regional Africa Bureau, PMI and child health Core funds.

Immunization

With Africa Bureau funds, MCSP is able to broaden its reach in immunization, contributing through leadership roles to numerous partner-organized meetings and working groups, and leveraging USAID's priorities in the Africa Region. Collaboration with WHO, UNICEF, Gavi, and other partners was strengthened as MCSP co-sponsored workshops and participated in multi-partner reviews and assessments of national RI programs in the region. By further engaging with partners, MCSP ensured that its own country-level experiences and USAID's priorities were reflected in regional strategies and that the TA provided to strengthen RI was aligned with partner efforts (e.g., WHO/AFRO Mid-Level Managers Modules workshop, East and Southern African Gavi Sub-Regional Working Group, WHO/AFR Immunization Managers Meetings).

Accomplishments

- MCSP collaborated with the WHO/Africa Regional Office and Kenya's MOH to begin design of and introduce a school-based tetanus toxoid vaccination demonstration targeting girls and boys in early primary school in two counties. Discussions had been under way, but efforts ceased due to objections from the Catholic Church to a UNICEF-funded nationwide mass campaign targeting women. In PY2, MCSP will re-approach the Kenyan government and religious authorities in an attempt to launch this activity. MCSP has also participated in African regional and subregional Polio Eradication Initiative (PEI) and measles control/elimination activities in conjunction with its country work.
- MCSP supported cross-learning by mobilizing field-based technical advisors to participate in regional partners meetings. These technical advisors also supported national counterparts in communicating and sharing success stories that improved RI systems performance. They have also served as capacity builders by reviewing and harmonizing the Extended Program on Immunization (EPI) prototype pre-service curricula for medical, nursing, and midwifery training schools in the African region.

Latin America and the Caribbean (LAC) Bureau

MCSP contributed to regional- and country-led efforts to reduce maternal and newborn mortality and morbidity in the LAC region. The MCSP LAC Bureau's strategy is designed to achieve results though the utilization of and participation in regional platforms, including: the Regional Maternal Mortality Reduction Task Force (GTR) and the LAC Neonatal Alliance. In addition, the MCSP LAC Bureau promotes the regional strengthening of midwifery education programming, collaborating with the Caribbean Regional Midwifery Association (CRMA), and supporting a South-to-South Learning exchange between Peru-Paraguay and Peru-Guatemala in order to create competency-based midwifery curriculums in both countries.

Maternal Health

Accomplishments

- MCSP, as a member of the GTR executive steering committee, continued to promote the implementation and scale-up of MNH high-impact interventions and strategies to address the main causes of maternal mortality in the region: hemorrhage, pregnancy-induced hypertension, complications related to unsafe abortion, and sepsis. The GTR serves as the regional mechanism for collaboration, linking efforts among agencies of the UN system, bilateral and multilateral organizations, professional networks, and CSOs, to reduce maternal morbidity and mortality in the region.
- MCSP continued to contribute to the GTR, including providing technical support for the finalization and revision of the Interagency Strategic Consensus for Latin America and the Caribbean (DCEI). Finalization of the DCEI will allow for a standardized regionally agreed-upon framework on preventing and responding to maternal mortality and morbidity in the LAC region. MCSP also contributed to the revision of the "Global Strategy for Women's, Children's and Adolescent's Health" to ensure the incorporation of LAC priorities.
- In the Caribbean region, MCSP continued to support the CRMA in the development and implementation of a cascade training approach for midwives, using blended learning methods; the aim is to build the capacity of midwives in maternal and newborn care. The CRMA also supported a competency-based education workshop for midwifery educators and preceptors in Dominica.
- In PY1, MCSP helped launch the country's first midwifery education program. With MCSP support, the MOH will create a new and important cadre of health workers to provide maternal and newborn care, particularly serving the rural and indigenous populations who have limited access to skilled providers. The MOH approved the Norms and Regulation to Implement the Technical University for Midwifery Career and pledged to initiate the curriculum in January of 2016 for 50 students at the Universidad da Vinci (UDV) located in Huehuetenango. Collaboration among MCSP, MOH, and UDV has led to the development of selection criteria for both faculty and students for the competency-based midwifery curriculum (CBC). In addition, in August 2015, MCSP held a Training of Trainers (TOT) course for 14 health professionals from UDV. Building on the results of the training, MCSP, the MOH, and UDV drafted a three-month plan for the UDV's scale-up of its technical midwifery team, which will lead training at the four health facilities serving as exclusive sites for the midwifery students' clinical practice.
- MCSP concluded its midwifery education work in Paraguay, efforts that culminated in two schools executing the MCSP-developed CBC. Prior to MCSP interventions, there were no standardized midwifery curricula and disparate accreditation processes in Paraguay. The CBC was adopted by the National Higher Education Evaluation Agency as the standard by which all Paraguayan midwifery schools will be evaluated and accredited.

Newborn Health

Accomplishments

- MCSP continued to serve as a member of the LAC Neonatal Alliance steering committee to maximize limited funding available in the region, and promote and scale up regional and global priorities addressing the main causes of newborn mortality: complications of prematurity, sepsis, and asphyxia. The Alliance serves as a key mechanism through which TA and programmatic support are provided to the region. The Alliance's strategic objectives are to: 1) create an enabling environment for the promotion of newborn health; 2) strengthen health systems to improve access to MNCH, with a special focus on most vulnerable populations; 3) promote community-based interventions; and 4) develop and strengthen M&E systems for newborn health. Globally, the Alliance has achieved a "seat at the table" through its participation in ENAP's TAG and other global strategy fora.
- On behalf of the LAC Neonatal Alliance, MCSP supported the formation of a TWG that aims to: 1) provide an overview of the current status of neonatal death surveillance in various countries in the region; 2) generate a regional discussion on the importance of strengthening the surveillance system; and 3) determine the value added, feasibility, and functionality of a standardized regional approach led by a working group. Through TWG consultations and a regional survey completed in collaboration with GTR, it is evident that surveillance systems in LAC experience great variability, and much work remains to support availability and use of high-quality data that are aggregated, analyzed, and linked to an action plan to improve QoC for newborns.

- MCSP, on behalf of the LAC Neonatal Alliance, and in collaboration with the MOH of Colombia and the Colombian Neonatology Association, carried out the first regional training on the AAP ECEB in Bogota in August 2015. Fifty-six health care providers, including physicians (pediatricians and neonatologists), nurses, and midwives from 11 countries in the LAC region participated in the two-day training to strengthen provider skills. Prior to the regional launch of the ECEB, a two-day training for instructors was held for 11 Colombian participants, who then developed a national replication plan. Trainees returned to their home countries with equipment donated by the LAC Neonatal Alliance to facilitate replication of trainings.
- MCSP, in collaboration with the Pan American Health Organization and LAC Neonatal Alliance membership, marked the 10th anniversary of the Alliance with the issuance of quarterly newsletters in English and Spanish. These newsletters are meant to provide intra membership updates and promote knowledge-sharing via dissemination of newborn health resources, ultimately enhancing communication, supporting technical leadership, and strengthening the expanding membership.
- In PY1, the number of national neonatal alliances expanded to include Paraguay. PY1 also marked the 5th anniversary of the national neonatal alliance in El Salvador. Contributions over the five-year period included participation in the design, dissemination, and implementation of the 2011–2014 National Strategic Plan for the Reduction of Maternal, Perinatal, and Neonatal Mortality; support for capacity-building trainings, courses, and forums targeted at health care providers in compliance with the technical guidelines on maternal and neonatal care to improve the QoC in the Network of Ministry of Health Centers; and support for implementation of the birth defects surveillance system in 100% of the maternity wards in the centers.

Asia Bureau

MCSP is supporting Asia Bureau priorities to improve access to and quality of health care in the region and to tackle public health challenges through the development of innovative approaches in partnership with Asian governments, civil society, and the private and nonprofit sectors. More specifically, MCSP support in the Asia Region is being provided over multiple years through the implementation of an MNH program in Laos and focused implementation research and analysis on PNC and estimation of GA, including active sharing of results from both studies to inform programs in multiple countries. As described in the Newborn section, Asia Bureau funds also supported the Asia Regional HBS workshop.

Accomplishments

- Asia Bureau funds are supporting implementation of activities in Laos to strengthen the capacity of the MOH to deliver high-quality, Day of Birth care in two provinces. The program aims to improve QoC by strengthening provider skills, supporting the MOH-led supportive supervision strategy, and capturing program learning through process documentation of the skills-strengthening activities. During PY1, following a program assessment, the country workplan was approved in consultation with the Lao People's Democratic Republic (PDR) MOH. Negotiations are under way for MCSP Laos to implement an MOU with the Government of Lao PDR.
- MCSP and SNL are collaborating with in-country stakeholders to develop a study in India on PNC, which aims to generate evidence to inform PNC-related policy and program design and implementation, and to augment the findings of the SNL-led global, multi-country PNC review. During PY1, MCSP and SNL solidified the methodology for the proposed India PNC study with review and input from the Asia Bureau.
- In Cambodia and India, MCSP is implementing research to evaluate estimation and documentation of GA for clinical decision-making. The identification of optimal strategies to improve GA assessment in low-resource settings is a critical research gap with clinical relevance to maternal health and newborn survival. This study examines the current state of GA estimation, analysis, documentation, and data utilization in antepartum and intrapartum care settings. During PY1, MCSP finalized the study design with feedback from the Every Preemie-SCALE PTB Working Group. Discussions have also been initiated with the local Jhpiego team in India to discuss the budget and understand any potential logistical challenges in the pre-implementation or implementation period for the study.

Global Development Alliances

MAMA

The Mobile Alliance for Maternal Action (MAMA) delivers vital health information via mobile phones to new and expectant mothers living in poverty throughout developing countries. Hosted by the United Nations Foundation, MAMA provides age- and stage-based messages aligned with global best practices, empowering women to make the best decisions for themselves and their families.

Accomplishments

- MAMA Global provided strategic guidance and assistance to MAMA country programs including Bangladesh, South Africa, India, and Nigeria. MAMA Bangladesh continues to have a positive monthly growth rate, with enough funding to ensure sustainability for the next year, and is submitting external evaluation research to journals for publication. MAMA South Africa successfully integrated with the MomConnect program. MAMA India is on track to meet its goal of 200,000 women reached by the end of 2015 and is well-positioned to expand to at least one new urban slum. MAMA Global provided the Nigeria program extensive support, including detailed project management, creation of research frameworks, and management of complex relationships at every level. Together, these programs reached have three million pregnant women and new mothers.
- MAMA Community Members were supported to implement and scale up programs, which resulted in reaching one million users through the Wazazi Nipendeni Program in Tanzania; MAMA facilitated a cross-country learning trip for an Afghan consortium implementing the MAMA messages (FHI360, Jhpiego, and MOH) to learn from the MAMA Bangladesh program.
- MAMA Global cultivated and solidified key partnerships to enable global scale-up and high-level communications—a partnership with Facebook's internet.org initiative reached four million users in 20 countries with our content; a partnership with Jennifer Lopez and the Lopez Family Foundation secured Ms. Lopez as the UN Foundation's first-ever global advocate for women and girls; partnerships with PSI and UNICEF were established to expand MAMA's global reach and integrate with MOHs.
- As part of MAMA's role in fostering evidence and learning from the country programs, MAMA Global worked closely with evaluators in MAMA countries to ensure that: global evidence gaps were addressed in the studies; rigorous outcome-level study designs were implemented; and high scientific standards maintained. As a result of these efforts, outcome-level impacts of the messaging programs in Bangladesh and South Africa are currently being used as the basis for numerous articles targeting high-impact scientific journals. Both countries' studies found statistically significant effects on knowledge and maternal health practices, and both contribute findings on dosage of messages for those effects. In addition, MAMA was invited to participate on a panel at the Global Maternal and Newborn Health Conference and submitted findings from a rigorous external evaluation of MAMA Bangladesh to peer-reviewed journals.

mPowering

mPowering Frontline Health Workers is an innovative public-private partnership designed to accelerate the use of mobile technology to improve the skills and performance of frontline health workers (FLHWs). MCSP hosts mPowering's Secretariat and provides financial management, human resources, communications, and administrative support to mPowering, as well as technical partnership. Sixteen Steering Committee partners represent the public and private sectors: USAID, UNICEF, MSCP, Qualcomm Wireless Reach, Intel, MDG Health Alliance, GlaxoSmithKline, Praekelt Foundation, Frontline Health Workers Coalition, World Vision, Dalberg, Palladium, One Million Community Health Workers Campaign, Accenture Development Partners, UN Foundation, and New England International Donors.

mPowering is a catalyst for creating dynamic partnerships, ideas, and opportunities for collaborations within the mHealth/global health sector. We host/ co-host international conferences, workshops, and webinars based on three key themes informing our work: promoting the use of open source content; advocating for improved CHW training standards; and supporting the effective use of mobile technologies to help improve the performance of FLHWs.

Accomplishments

- The mPowering team launched ORB in June 2015, a new mHealth content platform that connects Ministries, NGOs, training institutions, and health workers to openly licensed mhealth training content, job aids, and toolkits (including for trainers and supervisors). As of the end of PY1, ORB hosts more than 200 resources, with content available in 16 languages, and has been accessed by users in 118 countries.
- mPowering also contributed to the Ebola response by hosting a high-level international event "(Re)Building Health Systems in West Africa" at Wilton Park (part of the UK Foreign and Commonwealth Office). A total of 64 representatives from nine governments, together with NGOs, private sector, and other stakeholders, convened to consider the role of ICT and mobile technologies in the response to the Ebola crisis and the subsequent focus on building resilient health systems. Recommendations from the event were published in the (Re)building Health Systems report, available on the mPowering website; the event has led to new connections to improve coordination in HSS in West Africa.
- mPowering team members continued to actively support mHealth programs in Zambia, Ethiopia, Kenya, India, and Ghana with a focus on improved training and access to information for FLHWs. mPowering developed and launched new mHealth programs in Nigeria and Uganda to improve maternal and newborn care by providing refresher training to health workers in primary health care facilities and demonstrating how ORB content can be integrated with training to improve access to on-demand training for health workers in rural and remote facilities.
- The team developed and disseminated global learning content to share lessons across the mHealth and global health communities, including: webinar series on Ebola Response for Frontline Health Workers (with almost 1,000 registrations from 75 countries); a Global End-to-End Mobile Content Distribution Process for Health Workers white paper; the peer-reviewed publication Evidence on feasibility and effective use of mHealth strategies by frontline health workers in developing countries systematic review; a Multi-stakeholder dialogue for shared solutions in health in Bangladesh manuscript; and two animated videos: Creative Commons for Global Health and Story of Ebola. Together with partners, MCSP and Dalberg facilitated development of USAID's Community Health Framework, which will be finalized in Year 2
- Strategic advocacy was conducted for improved CHW standards in training: submitted statement to World Health Assembly calling for improved guidance on training for CHWs; produced series of interviews and co-hosted online discussion series on the need for improved data on CHWs; and maintained active blog with thought leadership content focused on our core activities (outlined above).

Saving Mothers Giving Life (SMGL)

Driven by the goal of decreasing maternal deaths by 50% in one year in eight pilot districts of Uganda and Zambia, SMGL uses a district-strengthening systems approach to ensure that every woman has access to clean and safe normal delivery services as close to home as is practical, and, in the event of an obstetric complication, emergency care within two hours. The model strengthens the existing health network—both public and private—within each district to help overcome the three delays that often prevent women from receiving lifesaving care during a pregnancy or childbirth emergency. SMGL upgraded specific facilities, trained health care workers, implemented a voucher program in Uganda and upgraded maternity waiting homes in Zambia to help achieve program objectives. MCSP enables the function of the SMGL secretariat; provides management, operations, and administrative support; and offers technical expertise as well as technical oversight on deliverables.

Accomplishments

- The SMGL M&E advisor collaborated with Centers for Disease Control and Prevention (CDC) in-country in Uganda and Zambia to standardize quarterly SMGL M&E tools and finalize SMGL Performance Indicator Reporting Sheets across all SMGL countries.

- The SMGL M&E advisor also supported CDC in-country teams in Uganda and Zambia with M&E activity implementation and managed, with CDC Atlanta, the reporting out of SMGL mid-initiative results across all three SMGL countries.
- Another activity completed during this time period was the HFA Data Management and Analysis Guide to support the Health Facility Assessment (HFA) tool used across all three SMGL countries. In addition, the M&E advisor and M&E team finalized the HFA tracking tool for all SMGL countries to track HFA implementation since Phase 1 of the SMGL initiative.
- The SMGL M&E advisor also worked with M&E teams in-country to finalize the Client Satisfaction Tool.
- The last major activity completed was the Data Quality Assessment (DQA) guidelines, which highlighted frequency of DQA, indicators to use for DQA, and finalization of DQA tools for implementation in Zambia and Uganda.

Survive & Thrive

Survive & Thrive's overall strategy focuses on two primary objectives: 1) supporting and sustaining facility-based MNCH interventions and clinical competencies through training and QI approaches and processes; and 2) mobilizing and equipping members of professional associations to improve the quality of high-impact MNCH interventions in health facilities and to be champions in MNCH.

Accomplishments

Except where indicated, the following accomplishments were supported with core funds:

- In India (September 2014) and Ethiopia (October 2014), technical advisors from AAP, ACOG, and ACNM attended and participated in a Helping 100,000 Babies Survive & Thrive (100KB) Stakeholders Meeting. This meeting included key stakeholders in-country and resulted in core decision-making and collaboration needed to frame and implement a country workplan for the initiative. Enhanced relationships between US and India and US and Ethiopian professional associations also resulted from this activity.
- Myanmar: ACNM and ACOG facilitated a workshop in November 2014 for the Myanmar Nurses and Midwives Association covering KMC, Bleeding after Birth, and RMC; these efforts have contributed to strengthening the midwifery association in Myanmar. Supported by MCSP Myanmar field funds.
- In January 2015, ACOG technical advisors co-led a professional association strengthening (PAS) session for ob/gyns in Malawi and met with residents to discuss needs and assess clinical in-service opportunities; because of this working relationship, a new ob/gyn association has launched in Malawi (Association of Obstetricians and Gynaecologists) and they have become members of the International Federation of Gynecology and Obstetrics and created an outline of their goals, priorities, and activities. In February 2015, ACNM and AAP technical advisors facilitated a Master Training of Trainers (MTOT) of the ECEB course. ACNM and AAP led a multi-disciplinary PAS workshop in May 2015. A second ECEB training for the Association of Malawian Midwives was held in June 2015 (ACNM). Support and follow-on for integration of supportive supervision of HBB and ECEB were also provided.
- Tanzania: ACNM conducted an assessment of the pre-service midwifery education programs in four districts, leading to an improved midwifery training program in Tanzania. Supported by MCSP Tanzania field funds.
- Afghanistan: In October 2014, an ACNM mentor facilitated a MTOT workshop for the Afghan Midwives Association. Support to new trainers was provided as they facilitated the course for 30 provincial midwives.
- The ECEB training module was rolled out in November 2014, and more than 70 participants were trained as North American Mentors. A training in Dhaka, Bangladesh, in April 2015, reached participants in 11 Asian countries that are priority countries for the ENAP. An important development for the HBS modules includes integration of QI techniques. ACNM and ACOG are leading the development of a PAS module with other GDA partner support that is slated to launch in early 2016.
- At the request of USAID, the HBB and the Survive & Thrive GDAs merged into a single GDA to more efficiently support the global ENAP. This GDA now includes more than 20 partners from all sectors of the development community. AAP assumed the role of Secretariat for the Survive & Thrive GDA and has

facilitated and hosted monthly conference calls throughout this project period and in-person partner meetings in November 2014 and June 2015.

Strategic Communications

MCSP continued to build on efforts to embed a robust communications department within the Program—with the execution of a strategic communications workplan that leverages existing platforms within the global health community to communicate the work of the Program, highlight its impact, disseminate resources, collaborate with like-minded organizations, and share knowledge and lessons learned to promote USAID's flagship MCSP to strategically interact with key audiences. MCSP also continued a monthly communications working group, which included representation from each of the implementing partner organizations, to strategically communicate the Program's work and to advocate and promote RMNCH messages. Additionally, MCSP Headquarters communications has mobilized a network of field-based communicators or focal points from each country program in order to have better communication about and alignment of activities globally.

MCSP Communications used dissemination platforms such as:

- E-communications
- Website
- Social media
- Traditional news media
- Events and conferences

Program Website

A dynamic website was created in this reporting period with over 70 pages of content to include multiple navigation tabs with information on the Program, leadership, an interactive and sortable world map with associated country landing pages, 10 intervention pages with 25 sub-pages, and more than 50 pieces of content (blogs and success stories; full listing in Annex D) populated on the news landing page. A great deal of planning has been undertaken, as well, for the development of the soon-to-be-launched resource section, which will house nearly 100 resources developed by the Program thus far.

Communications Capacity-Building, Program Materials, and Collateral

A big focus in PY1 was on properly educating Program staff on branding requirements, which resources are available, as well as building their communications capacity. The MCSP communications toolkit was updated from under MCHIP and provides guidance on dissemination, writing blogs/success stories, multimedia and consent release, planning events, and working with the media. Additionally, capacity-building sessions were held on five topic areas over the course of the year, with the participation of field and Headquarters staff.

Other key informational collateral was developed to include technical team fact sheets (also translated into French), templates for report covers, certificates, office signage, vehicle branding, and the like. Additionally, the technical teams worked with communications on publications support for over 50 technical products (case studies, toolkits, manuals, briefers, etc.), as well as over 20 articles published in peer-reviewed journals (full listing in Annexes F and G). All of these materials, in addition to those produced in Year 1, were disseminated widely at meetings, events, and conferences held globally, regionally, or in-country.

The **MCSP website** (in PY1) has had 70,397 page views and 27,291 sessions (according to Google analytics). Visitors from 24 countries, accessed the site—from the US, Haiti, India, and Rwanda, to South Africa and Bangladesh..

Special Events

Messages and learning from the Program were also widely shared at high-level events and conferences. MCSP hosted or co-hosted 11 events this year including the HBB Regional Workshop, the Maternal Mortality Mapping Meeting, the "Integrating Maternal and Newborn Health" panel at the World Health Assembly, and a panel with the Center for International Studies on "Enhancing U.S. Engagement on Maternal and Child Health." There were over 50 presentations by MCSP staff at global meetings, conferences, and other events. A good deal of effort over the past year was spent on planning for the Global Maternal Newborn Conference, with MCSP serving on the core communications planning committee. A full listing of all events and presentations can be found in Annex E.

Photo Credit: MCSP/Saroare Hossain Bulbul; Helping Babies Survive Asia Regional Workshop 2015 in Dhaka, Bangladesh

Online Engagement

To increase visibility of USAID's work to end preventable child and maternal deaths, MCSP engaged new and existing audiences via social media, digital campaigns, and email communications.

Program Social Media

MCSP social media sites increased in influence over the past year, with 5,077 new followers joining us on Facebook and Twitter. There were 17,100 "interactions" (the number of Twitter mentions, retweets, and Facebook stories) and 20.7M "potential reach" (combines the number of potential users who saw any content associated with the Twitter and Facebook profiles). The counties most reached on Facebook included USA, India, Pakistan, Kenya and South Korea. MCSP regularly participated in partner and donor campaigns on key events such as World Prematurity Day, World Breastfeeding Week, World Immunization Week, and the International Day of the Midwife. The Program also provided live social media coverage for the launch of the President's Malaria Strategy at the White House, launch of mPowering's ORB platform, UN General Assembly side events, and launch of the UN Commission on Status of Women's Every Women Every Child Progress report. We also continue to grow our photo-sharing account on Flickr with seven albums and over 800 photos.

By developing strategic relationships with news outlets, partner blogs, and international media organizations, **MCSP's work was promoted by external sources 165 times**. Outlets included The Huffington Post, Impatient Optimists, and USAID.

Photo Credit: MCSP; APHA 2014

Program e-Communications

The Program distributed five e-newsletters out to nearly 6,000 subscribers, which included an MCSP introduction, launch of key CSHGP resources, and messages to commemorate the New Year and Mother's and Father's Days. All e-blasts had an average 25% open rate (with a peak up to 30%), which is incredibly successful as compared to industry standards. During the month of September alone, our mailing list increased by 500 subscribers, thus indicating not only the keen interest in the Program, but also the success of communication efforts to raise the visibility of MCSP.

Opportunities and Challenges

Aligning Global and Country Priorities

As a global project with multiple global mandates but with a smaller proportion of core funding in relation to field funding, core-funded investments must be designed to align with and complement field investments. As mentioned previously, PY1 represented a year in which 34 field-funded programs in 22 countries were initiated. As the core workplan was finalized in August 2014, assumptions regarding field opportunities and funding had to be made when the workplan was developed. Teams had to actively revisit these assumptions once field programs started, which sometimes resulted in delays or adjustments to planned core activities.

Further adjustments were made in response to other exogenous factors such as emerging global evidence. For example, the findings of the 2014 antenatal corticosteroids trial (ACT) on use of antenatal corticosteroids (ACS) for prevention of newborn complications resulting from PTB prompted MCSP to reevaluate and reconsider programmatic approaches to PTB and led to substantial revisions to the Threatened Preterm Birth Care training module. These findings also led to MCSP prioritizing the development of a research protocol to better understand gestational age estimation.

Cross-cutting areas of work within MCSP led to different levels of interest by USAID field Missions. As a result, staff working on a number of issues—including HSS, community health and civil society engagement, adolescent health, e- and mHealth, WASH, and—must actively seek and create opportunities to address these priority issues in MCSP's global scope. MCSP would benefit from additional efforts to communicate with Missions on how MCSP can support country programs in these areas. Some teams, such as the community team, are working to further strengthen communications by developing tools such as the CSE strategy and brief in order to guide core-funded seed activities in selected countries, and to stimulate mission country interest and support.

MCSP's mandate has some new areas of work including innovations, ehealth, and HSS. Reaching consensus with USAID on a structured approach to achieve Objective 2 took longer than anticipated. Further to the agreement reached in June 2015, MCSP has initiated efforts to document and track work under this objective.

Global Fora

The Global Maternal and Newborn Health Conference and the Global Meeting on Accelerating Access to Postpartum Family Planning provide opportunities for MCSP to demonstrate technical leadership and share learning from multiple country programs and technical priorities. Similarly, global conferences provide a tremendous opportunity to learn from others.

Although these meetings were more intensive than anticipated in terms of preparation and coordination, they did and will provide opportunities to demonstrate leadership and share learning, and allow for focused discussions with multiple MCSP field staff. In Mexico City, supplemental meetings will be held with HQ and field staff to review learning from the conferences and to discuss opportunities, challenges, and best practices of field teams. These conferences and meetings have been valuable opportunities to build a sense of shared purpose and to debate practical strategies and solutions. Kenya, one of the countries supported by MCSP at the Global Meeting on Accelerating Access to PPFP, has revised its policy on PPFP as a direct consequence of attending the conference.

Global Partnerships/Global Development Alliances

- There are opportunities to grow the mPowering partnership and align with country program strategies in West Africa to support community health workforce development at scale; increasingly, mPowering is invited to advise, support, and help secure funding for programs in sub-Saharan Africa and South Asia. Existing relationships will continue to be developed and new ones will be built to foster investment in stronger community health systems using mobile technologies to deliver effective training and provide supportive job aids and supervision tools to health workers. Additional staff to support country programs and develop the ORB platform will be needed to deliver on the strategy approved by the Steering Committee in 2014.

- Communication and collaboration among Survive & Thrive professional associations have, at times, been a challenge, but leadership at all three associations have committed to enhanced transparent communication toward mutual achievement of GDA goals, which has led to increased collaboration and better activity outcomes.
- The Handwashing Study in Kenya continues to experience delays stemming from the partnership with Unilever. Continued delays will have a number of implications including cost and staffing. MCSP wants to remain responsive to and supportive of the global partnership with Unilever; however, we are growing increasingly concerned about the ability to conduct this work as originally designed.

Annex A: Financial Summary

As of the end of Program Year 1 (PY1) (September 2015), MCSP has received core and field obligations totaling [redacted]. This amount represents [redacted] of the MCSP award ceiling of $500M. Cumulative costs to-date, to September 30, 2015 (with accruals), are estimated at [redacted].

MCSP Cumulative Obligations, Costs, and Pipeline at September 30, 2015

	Total obligated funds by element/ sub-element to 30SEPT15	Total cumulative costs to 30SEPT15 (no accruals included)	Balance of pipeline at 30SEPT15 (excluding accruals)
CORE FUNDS			
MCH	$[redacted]	[redacted]	[redacted]
Ebola	[redacted]	[redacted]	[redacted]
FP	[redacted]	[redacted]	[redacted]
HIV/AIDS	$[redacted]	[redacted]	[redacted]
Nutrition	$[redacted]	[redacted]	[redacted]
Malaria	$[redacted]	[redacted]	[redacted]
TOTAL CORE	[redacted]	[redacted]	[redacted]
BUREAU FUNDS			
AFR/SD	$[redacted]	[redacted]	[redacted]
LAC	[redacted]	[redacted]	[redacted]
ASIA/SPO	$[redacted]	[redacted]	[redacted]
TOTAL BUREAU	$[redacted]	[redacted]	[redacted]
FIELD SUPPORT FUNDS			
TOTAL FIELD SUPPORT	$[redacted]	[redacted]	[redacted]
TOTAL MCSP	$[redacted]	[redacted]	[redacted]

Note:

1) **Core funds obligated include newly obligated funds for PY2.**
2) **For some countries Field Support funds obligated also represent multiple years of funding.**

Regarding the Civil Society Organization funding target of [redacted], the estimated rate at the end of PY1 is [redacted] A formal request was sent to the US Agency for International Development (USAID) Agreement Officer on October 6, 2015 to reduce the [redacted] target rate to a more realistic target rate of [redacted]

Annex B: Performance Monitoring Plan

#	Indicator	Definition and Disaggregation	Data Source/ Collection Method	Frequency of Data Collection	FY2014 Data	FY2015 Data
Objective 1: Increase coverage and utilization of evidence-based, sustainable, high-quality RMNCH interventions at the household, community, and health facility levels						
Performance Indicators Collected through Routine Data Sources						
1	Couple years of protection (CYP) in MCSP-supported areas*	CYP is the estimated protection provided by contraceptive methods during a one-year period, based on the volume of all contraceptives sold or distributed free of charge to clients during that period. CYP is calculated by multiplying the quantity of each method distributed to clients by a conversion factor to yield an estimate of the duration of contraceptive protection provided per unit of that method. The CYP for each method is then summed for all methods to obtain a total CYP figure. CYP conversion factors are based on how a method is used, failure rates, wastage, and how many units of the method are typically needed to provide one year of contraceptive protection for a couple. The calculation takes into account that some methods, such as condoms and oral contraceptives, for example, may be used incorrectly and then discarded, or intrauterine contraceptive devices (IUDs) and implants that may be removed before their life span is realized. Disaggregated by country and method	HMIS/service statistics	Quarterly	Haiti: 68,294 Mali: 2,103,176	Total CYP: 862,190 Ethiopia—BEmONC: 2,290 Guinea FP-MCH/GBV: 12,248 Haiti Social Marketing: 105,364 Kenya: 78,352 Mali: 460,613 Mozambique: 201,012 Nigeria: 805 Zambia: 1,504
2	Percent of women delivering in MCSP-supported health facilities who accept a method of family planning prior to discharge	Numerator: Number of women who delivered at MCSP-supported health facilities who accepted a method of FP prior to leaving the facility Denominator: All women who delivered in MCSP-supported facilities (over the reporting period) Disaggregate by country and FP method (IUD, tubal ligation, no-scalpel vasectomy [NSV], lactational amenorrhea (LAM), condoms, progesterone vaginal rings, implants, injectable)	HMIS	Quarterly	Mali: 63%	Ethiopia—BEmONC: 498/11,706 (4%) Guinea FP-MCH/GBV: 3,574/19,759 (18%) Mali: 41,370 (numerator only reported) Zambia: 56/4,028 (3%)

#	Indicator	Definition and Disaggregation	Data Source/ Collection Method	Frequency of Data Collection	FY2014 Data	FY2015 Data
3	Number of countries where MCSP increased access to permanent family planning methods	Countries where MCSP supported introduction/re-introduction (after at least one year of no new acceptors) of new permanent FP methods. Disaggregated by country and methods	Program records	Annually	Mali: 1 (for IUD, LAM, condoms, implants and injectables)	4: Ethiopia—BEmONC, Mozambique, Nigeria, Zambia
4	Number of countries where MCSP support includes training of service providers and/or promotion of permanent methods	Disaggregated by country and type of method(s)	Program records	Annually	None Reported	6: Ethiopia—BEmONC, Madagascar, Mozambique, Nigeria Tanzania, Zambia
5	Number of clients attending essential MNCH services at MCSP-supported facilities who adopted a FP method during that visit	Disaggregated by point of service (ANC, L&D, FP, OPD, other) and age (if possible) and by country Essential MNCH services include ANC, postabortion care, postpartum care, well-baby/immunization services	HMIS/service statistics	Quarterly	None Reported	Total: 291,824 FP Guinea FP-MCH/GBV: 35,225 Mozambique Bridge Project: 291,824 Nigeria—Maternal Newborn Health: 4,825 L&D Ethiopia—BEmONC: 498 Guinea FP-MCH/GBV: 3,574 Other : PAC: Guinea FP-MCH/GBV: 221 Unknown Service delivery point (SDP) Zambia: 394

#	Indicator	Definition and Disaggregation	Data Source/ Collection Method	Frequency of Data Collection	FY2014 Data	FY2015 Data
6	Number of service delivery points that expanded the types of contraceptive methods available with MCSP support	This indicator counts the total number of facilities (public or private), vendors, or other service delivery points that add a method to the contraceptives available for the first time (during the reporting period). Of particular interest is expansion of LARC and permanent methods but all methods should be counted here. Do not count re-stock of a previously available method. Disaggregated by country and contraceptive method: IUD, implant, BTL, vasectomy, injection, pill, condom	HMIS/service statistics	Quarterly	Total: Haiti: 17 IUD, 51 Condoms, 38 Injectables, 38 OCs Mali: 175 SDPs for IUD, LAM, Condoms, Implants, Injectables	Ethiopia—BEmONC: 72
7	Number/ percentage of MCSP-supported facilities that offer delivery services with MgSO4 available in the delivery room	Numerator: Number of facilities that offer delivery services with MgSO4 available in the delivery room Denominator: Total number of facilities that offer delivery services Disaggregated by country	Supervision reports, logistic management information system, health facility survey	Annually	None Reported	Ethiopia—BEmONC: 18/22 (82%) Guinea FP-MCH/GBV: 234/234 (100%) Mozambique Bridge Project: 127/127 (100%) Zambia: 17/91 (19%)
8	Number of women provided with misoprostol in advance of delivery for prevention of postpartum hemorrhage in MCSP-supported areas	Disaggregated by country This pertains to advance distribution of misoprostol to pregnant women for self-administration if having a home birth.	HMIS/service statistics	Quarterly	None Reported	None Reported

#	Indicator	Definition and Disaggregation	Data Source/ Collection Method	Frequency of Data Collection	FY2014 Data	FY2015 Data
9	Percentage of women receiving a uterotonic in the third stage of labor in MCSP-supported areas*	Numerator: Number of women receiving a prophylactic uterotonic in the third stage of labor (immediately after birth) Denominator: Total number of women giving birth Disaggregated by country and facility and home births MCSP will use the new definition in the World Health Organization (WHO) PPH prevention guidelines of 2012.	HMIS/service statistics	Quarterly	Mali: (17,221/ 19,290) 89%	Ethiopia—BEmONC: 3,775/12,761 (30%) Guinea FP-MCH/GBV: 11,954/15,595 (77%) Mozambique: 104,422/118,262 (88%) Nigeria: 1,851/4,424 (42%) Tanzania: 38,146/44,025 (87%) Zambia: 9,881/10,460 (94%)
10	Number of newborns admitted to facility-based KMC at MCSP-supported facilities	Disaggregated by birth weight if possible (<2,000g and/or <2,500g) A rate may be calculated as well. The denominator options would be a rate per 100 live births or per 100 expected births.	HMIS/service statistics or program records	Quarterly	Mali: 1,026	Mozambique: 437
11	Percentage of babies not breathing/crying at birth who were successfully resuscitated in MCSP-supported areas	Numerator: Number of babies not breathing/crying at birth born in MCSP-supported areas that were successfully resuscitated Denominator: Number of babies not breathing/crying at birth born in MCSP-supported areas Disaggregated by community-based and facility-based births and by country This is one of the Helping Babies Breathe indicators.	HMIS/service statistics	Quarterly	Mali: (301/324) 93%	Ethiopia—BEmONC: 13/83 (16%) Guinea FP-MCH/GBV: 355 (numerator only) Mozambique: 128/171 (75%) Zambia: 447/520 (86%)

#	Indicator	Definition and Disaggregation	Data Source/ Collection Method	Frequency of Data Collection	FY2014 Data	FY2015 Data
12	Percentage of newborns with suspected severe bacterial infection who receive appropriate antibiotic therapy	Numerator: Number of newborns with suspected severe bacterial infection (infant reportedly stopped feeding well and/or stopped moving on its own) receiving antibiotics Denominator: Number of newborns with suspected severe bacterial infection. Disaggregated by country	HMIS, supplemental data collection form	Quarterly	None Reported	None Reported
13	Number of countries in which interventions to address the unique RMNCH needs of young, first-time parents are initiated	This includes age and stage sensitive counseling for young mothers, youth-sensitive QI or values sensitization, etc. Disaggregated by country	Program records	Annually	None Reported	Total: 1 (Nigeria)
14	Percentage of children age 2–59 months with fever during the reporting period (three months) for whom advice or treatment was sought from a CCM-trained CHW in MCSP-supported areas	Numerator: Number of children aged 2–59 months with fever during the reporting period (three months) for whom advice or treatment was sought from a CCM-trained CHW in MCSP-supported areas Denominator: Expected number of children aged 2–59 months with fever during the reporting period (3 months) in MCSP-supported areas Denominator will be estimated from best locally available demographic data (e.g., government census data, DHS, or MICS) Disaggregated by country	HMIS, CHW records, community HIS, if available	Quarterly	Mali: (23,713/ 30,530) 78%	None Reported

#	Indicator	Definition and Disaggregation	Data Source/ Collection Method	Frequency of Data Collection	FY2014 Data	FY2015 Data
15	Percentage of children age 2–59 months with fast or difficult breathing during the reporting period (three months) for whom advice or treatment was sought from a CCM-trained CHW in MCSP-supported areas	Numerator: Number of children aged 2–59 months with fast or difficult breathing during the reporting period (three months) for whom advice or treatment was sought from a CCM-trained CHW Denominator: Expected number of children aged 2–59 months with fast or difficult breathing during the reporting period (three months) Denominator will be estimated from best locally available demographic data (e.g., government census data, DHS, or MICS) Disaggregated by country	HMIS, CHW records, community HIS, if available	Quarterly	Mali: (6,235/ 6,235) 100%	None Reported
16	Number of cases of child diarrhea treated in USAID-assisted (MCSP) programs*	Number of cases of child diarrhea treated through MCSP-supported programs with oral rehydration salt (ORS) AND zinc supplements Disaggregated by country, type of health worker (facility-based health worker or community health worker and if CHW is CCM-trained)	HMIS/service statistics, community HIS	Quarterly	Mali: 6,259 by CHW	Kenya: 6,812 Mali: 369
17	Number of cases of child pneumonia treated with antibiotics by trained facility or community health workers in USG (MCSP)-supported programs*	Disaggregated by country, type of health worker (facility-based health worker or community health worker and if CHW is CCM-trained)	HMIS/service statistics, community HIS	Quarterly	Mali: 6,235 by CHW	Kenya: 2,998 Mali: 734

#	Indicator	Definition and Disaggregation	Data Source/ Collection Method	Frequency of Data Collection	FY2014 Data	FY2015 Data
18	Percentage of children aged <12 months who received DPT3/Penta3 vaccine in MCSP-supported areas	Numerator: Number of children aged <12 months receiving three doses of DPT/Penta3 vaccine in MCSP-supported areas Denominator: Total estimated number of children aged <12 months in the in MCSP-supported catchment area Disaggregated by country	HMIS	Quarterly	Malawi: (397,503/ 440,194) 90%	Haiti: 34,051 (numerator only) Kenya: 14,662 (numerator only) Malawi: 591,673/632,977 (93%) Uganda: 86,918/92,431 (94%)
19	Percentage of target health facilities with appropriate handwashing supplies in the delivery room in MCSP-supported areas	Numerator: Number of target health facilities with appropriate handwashing supplies in the delivery room Denominator: total number of targeted health facilities Clinics workers must wash hands before attending to a birth. Supplies include soap and water or hand sanitizer. Disaggregated by country	Health facility survey, program records	Annually	Mali: (175/175) 100%	Guinea FP-MCH/GBV: (74/234) 32%
20	Number of children under 5 reached by USG (MCSP)-supported nutrition programs	Disaggregated by country, sex	Program records	Annually	Mali: 5,879 (2,717 male; 3,162 female)	Kenya: 117,388

#	Indicator	Definition and Disaggregation	Data Source/ Collection Method	Frequency of Data Collection	FY2014 Data	FY2015 Data
21	Number of HIV-positive pregnant women who received antiretrovirals (ARV) to reduce the risk of mother-to-child transmission*	The number of HIV-positive pregnant women who received ARV to reduce the risk of mother-to-child transmission during pregnancy, labor and delivery, or after delivery at the health facility/location/SDP/site. Disaggregate by: 1. Single-dose nevirapine (with or without a tail); 2. Maternal zidovudine (AZT) (prophylaxis component of WHO Option A during pregnancy and delivery); 3. Maternal triple ARV prophylaxis (prophylaxis component of WHO Option B during pregnancy and delivery); 4. 4Life-long antiretroviral therapy (ART) newly initiated on treatment during the current pregnancy (including Option B+), and 5. Life-long ART already on treatment at beginning of pregnancy (including Option B+)	HMIS/service statistics	Quarterly	None Reported	Total: 17,884 Haiti: 546 Mozambique: 16,602 Zambia: 736
22	Number of MCSP-supported countries with pre-service education strengthened to improve RMNCH services with MCSP support	This includes updating curricula and improving the skills of tutors and strengthening/establishing skills labs Disaggregated by type of technical area strengthened and cadre of provider (e.g., midwife, nurse, clinical officer)	Program records	Annually	Malawi: 1 (immunization for doctors, nurses, midwives, CHWs) Uganda: 1 (immunization)	Total: 6 See Tables 1 and 2 for details related to this indicator

#	Indicator	Definition and Disaggregation	Data Source/ Collection Method	Frequency of Data Collection	FY2014 Data	FY2015 Data
23	Number of people trained through USG-supported programs*	Disaggregated by technical or cross-cutting area, training topic, funding (any core funding used or only field support), sex, type of personnel, and country Personnel may include: health care workers (doctors, nurses, midwives); CHWs, community health volunteers, non-health personnel Technical and cross-cutting topics include: child health and nutrition, immunization; FP/reproductive health; malaria; maternal; newborn; HIV/AIDS; WASH; M&E	Training information monitoring system, training participant registers	Quarterly	Haiti: Core funds: 398 (258 FP, 140 WASH) Mali: Core funds:157 CH/Nutrition: 33 Malaria: 94 Newborn: 10 M&E: 20 Cadres: doctors 7, nurse 23, midwives 2, CHW 123, non-health personnel 2, Male: 26, Female: 131	Total: 9,287 See Table 3 for details related to this indicator
24	Number of MCSP-supported health facilities actively implementing a QI approach	Number of MCSP-supported facilities that are actively implementing a QI approach, such as Standards-Based Management and Recognition (SBM-R® or RAPID Disaggregated by country and type of facility (e.g., dispensary/health post, health center, hospital) and type of approach	Quality improvement assessment tool, tracer condition assessment, health facility survey, supervision visit reports	Annually	Mali: 177 (2 hospitals, 175 health centers)	Total: 4,830 See Table 4 for details related to this indicator

#	Indicator	Definition and Disaggregation	Data Source/ Collection Method	Frequency of Data Collection	FY2014 Data	FY2015 Data
25	Percentage of MCSP-supported health facilities that provide RMNCH services with stock-outs of the 13 lifesaving commodities	Numerator: Number of MCSP-supported health facilities that provide RMNCH services with a stock-out of the 13 lifesaving commodities identified by the UN Commission on Life Saving Commodities during the specified reporting period Denominator: Number of MCSP-supported health facilities that provide RMNCH services during the specified reporting period Disaggregate by country and number of commodities (0–3, 4–6, 7–9, 10–13)	Facility survey, supervision reports, LMIS	Every 1–5 years	None Reported	None Reported
26	Number of countries where MCSP has supported the scale-up of high impact RMNCH interventions	Disaggregated by country and intervention.	Program records	Annually	None Reported	Total: 8 (Ethiopia, Guinea, Madagascar, Malawi, Mali, Nigeria, Tanzania, Zambia) See Table 5 for details related to this indicator
Objective 2: Close innovation gaps needed to improve health outcomes among high burden and vulnerable populations through engagement with a broad range of partners						
27	Number of people completing an intervention pertaining to gender norms that meets minimum criteria	This includes adults and children completing an intervention in the reporting period that had: 1. a component that supports participants to understand and question existing gender norms and reflect on the impact of those norms on their lives and communities 2. a clear link between the gender norms being discussed and RMNCH Disaggregated by country, male/female	Program records	Annually	None Reported	None Reported

#	Indicator	Definition and Disaggregation	Data Source/ Collection Method	Frequency of Data Collection	FY2014 Data	FY2015 Data
28	Number of countries where MCSP supported a gender analysis	A gender analysis includes: 1. review of key gender issues and gender-based constraints based on published and grey literature, 2. identification of gaps in information, 3. data collection to fill in targeted information gaps, 4. assessment of the institutional support for gender mainstreaming, at different levels (government, donor, civil society organizations (CSOs), and project management), and 5. recommendations for gender integration strategies, objectives, activities, and indicators. Disaggregated by country,	Program records	Annually	Mali: 1	Total: 2 (Guinea and Nigeria)
29	Number of countries that have integrated GBV screening into ANC services with MCSP support	GBV screening is conducted during ANC when the provider suspects there may be GBV, as well as referral to appropriate treatment services. Disaggregated by country	Program records	Annually	None Reported	Total: 2 (Guinea and Madagascar)

#	Indicator	Definition and Disaggregation	Data Source/ Collection Method	Frequency of Data Collection	FY2014 Data	FY2015 Data
30	Number of countries that have introduced a health service innovation with MCSP support	An innovation is "an idea, practice, or object perceived as new by an individual or other unit of adoption. 1. Introducing a product or drug into a program or service delivery system that is new to that setting (e.g., an improved BP detection device; bCPAP; uterine balloon tamponade, misoprostol for PPH prevention). This may be adapted from another country or setting, 2. Using an existing or known product in a new way or application or by a new user (e.g., ketamine as anesthetic in emergency obstetric care, chlorhexidine for umbilical cord care, using rapid diagnostic tests [RDTs] for intermittent screening and testing [IST] for pregnant women), 3. Implementing a new process aimed at improving coverage, quality, and/or equity for one or more high impact interventions on which MCSP is focusing (e.g., task shifting, such as allowing new cadres of providers to offer injectable contraceptives or PPIUD; new processes for data capture, visualization and/or use), performance-based financing or incentives approaches, etc. 4. Delivering a package of high impact interventions that have not been combined in that setting previously (e.g., integrating TB screening or GBV screening into the ANC platform, MCSP's initiative on the "Day of Birth, or "Whole Market District" approach, application of community action cycle for community mobilization). Disaggregated by country	Program records	Annually	Mali: 1	Total: 1 Prioirty health innovations (list of 7): 2 in progress: Nigeria (Bubble CPAP), and Ethiopia (UBT) Other country-level innovations: Madagascar: Clinical Governance including MNH quality dashboards GBV integrated into MNH training for first time
31	Number of grants awarded to local non-governmental institutions to advance RMNCH services	Non-governmental institutions include professional societies, CSOs, academic or research institutions, faith-based organizations, etc. This may include grants to support service delivery or knowledge generation. Disaggregated by country	Program records	Annually	None Reported	Total: 5 Malawi: 1 Nigeria: 4

#	Indicator	Definition and Disaggregation	Data Source/ Collection Method	Frequency of Data Collection	FY2014 Data	FY2015 Data
32	Number of local partners whose capacity MCSP has built	Capacity-building refers to enhanced ability implement activities following technical support from MCSP. Local partners may include the MOH, non-governmental institutions, including professional societies, CSOs, academic or research institutions, faith-based organizations, etc. Disaggregated by country	Program records	Annually	None Reported	Total: 23 Burma: 1 Ethiopia—BEmONC: 11 Ghana: 3 Madagascar: 3 Malawi: 1 Nigeria: 4

#	Indicator	Definition and Disaggregation	Data Source/ Collection Method	Frequency of Data Collection	FY2014 Data	FY2015 Data
33	Number of countries that have used information and communication technologies to improve the performance of health systems or support service delivery with MCSP support	"Improving the health system" includes addressing deficiencies or poor functioning areas of the health care system and seeking to improve them ICT with a specific focus on enhancing quality, access/equity and/or efficiency. "Support service delivery" includes: laboratory management information systems, commodities tracking systems, or electronic clinical decision trees. Quality: ICT interventions can improve quality of care provided per clinical or other standards, for example, using smart QI using electronic data collection and rapid, iterative feedback to providers and near-real time communication with supervisors. Access/equity: ICT intervention can allow a population access to health information or provide care to remote and vulnerable populations, for example, SMS information systems enabled with a short code allows clients who never interact with the formal health system to subscribe to information about pregnancy and postnatal care. ICT can be used to report and address follow up to GBV (gender). Efficiency: ICT interventions can facilitate efficiency in time, financial resources, or human resources, for example, mobile data collection/aggregation of service delivery statistics reduces data entry costs and time and improves the time that data for decision making takes to reach district, regional, and other central levels. ICT includes: mobile phones, text messages, electronic medical records, LMIS Excludes: radio, television campaigns, routine HMIS Disaggregated by country, equity, gender, incorporation into national or subnational e/mHealth strategy	Program records	Annually	Mali: 1	Total: 4 (Ghana, Guinea, Madagascar and Nigeria)
34	Number of countries that have introduced new vaccines with MCSP support	This means a vaccine that is new to the target country. Disaggregated by country, vaccine type (e.g., rotavirus, pneumococcal)	Program records	Annually	None Reported	Total: 2 Malawi (IPV, Measles) Tanzania (Other)

#	Indicator	Definition and Disaggregation	Data Source/ Collection Method	Frequency of Data Collection	FY2014 Data	FY2015 Data
35	Number of countries where MCSP has used innovative approaches to strengthen referral systems	An innovative approach is "an idea, practice, or object perceived as new by an individual or other unit of adoption. Countries will provide a narrative that explains specific country work with referral systems Disaggregated by country	Program records	Annually	Mali: 1	Total: 1 (Guinea)
36	Percentage of MCSP target districts that have engaged CSOs to develop community health strategies that include institutionalization of CSO involvement	Numerator: number of MCSP target districts that have engaged CSOs to develop community health strategies that include institutionalization of CSO involvement Denominator: total number of MCSP target districts Disaggregated by country	Program records	Annually	Mali: (11/13) 85%	Guinea FP-MCH/GBV: 20/20 (100%), Guinea IPC: 24/24 (100%) Malawi: 2/2 (100%) Mozambique: 7/7 (100%)
Objective 3: Foster effective policy, program learning and accountability for strengthening RMNCH outcomes across the continuum of care						
37	Number of (national) policies drafted with USG (MCSP) support*	This refers to the number of national laws, policies regulations, strategy documents, including national service delivery guidelines and performance standards, developed or revised with MCSP support to improve access to and use of high-impact reproductive health, maternal and newborn health, and child health services. The list of policies will be provided. Disaggregated by country and technical area	Final policy document; program records	Annually	Mali: 1 (community health) Uganda: 1 (immunization)	Total: 9 (Ethiopia, Guinea, Madagascar, Malawi, Mali, Mozambique) See Table 6 for details related to this indicator

#	Indicator	Definition and Disaggregation	Data Source/ Collection Method	Frequency of Data Collection	FY2014 Data	FY2015 Data
38	Number of studies completed	This includes special studies, baseline and feasibility studies and evaluations conducted with both core and field funds. Special studies are analyses undertaken to gather information relevant for a particular program or activity in order to improve knowledge or understanding about the study subject. Special studies examine unique circumstances as opposed to an entire activity or program. A baseline study records the context of the host country working environment at that time. Such studies are generally carried out before program activities begin or during program start-up. A feasibility study examines the context in which an anticipated activity would be implemented as well as the viability and practicality of implementing the particular activity. A study is completed when either the final study report, research brief or manuscript is completed. A list of study names will be provided. Disaggregated by country	Program records	Annually	Malawi: 1	Total: 4 Madagascar: 1 Malawi: 1 Mali: 1 Nigeria: 1 See Table 7 for details related to this indicator
39	Number of articles submitted for publication in peer reviewed journals	This includes all articles submitted for publication in a peer review journal that MCSP project staff have written or contributed to. Disaggregated by country For a list of published articles, refer to Annex G.	Program records	Annually	Malawi: 1	Total: 3 Guinea FP-MCH/GBV (2) Madagascar (1)
40	Number of technical reports/papers, policy/research/ program briefs, and fact sheets produced and disseminated	This refers to any type of technical report, paper, policy brief, research brief, program brief, or fact sheet produced and disseminated about MCSP or written by MCSP staff. Dissemination can be electronic or in a public forum such as a national or international meeting or conference. Disaggregate by country and type of publication	Program records	Annually	Mali: 1 (MSCP fact sheet)	Country: 26 Ghana: 3 Guinea FP-MCH/GBV: 5 Guinea IPC: 10 Madagascar: 2 Mozambique: 1 Nigeria: 3 Uganda: 2 HQ: (Annex H)

#	Indicator	Definition and Disaggregation	Data Source/ Collection Method	Frequency of Data Collection	FY2014 Data	FY2015 Data
41	Number of MCSP-supported countries that have integrated new RMNCH indicators into the national HMIS	To be reported here, indicators must be institutionalized and incorporated into standard national HMIS recording and reporting formats. This includes service use and quality of care indicators related to maternity services, postpartum care, community case management, immunization, etc. Disaggregated by country	Program records	Annually	None Reported	Total: 1 (Mozambique)
42	Number of MCSP-supported countries pilot testing new RMNCH indicators	This includes service use and quality of care indicators related to maternity services, postpartum care, CCM, immunization, etc. To be considered a pilot, the tools must be used for more than a month in at least one facility. Disaggregated by country	Program records	Annually	Mali: 1	None Reported
43	Percentage of MCSP target districts that have a systematic approach to track and display a priority set of RMNCH indicators	Numerator: Number of target districts (or counties/LGAs/woredas) that have a systematic approach to track and display a priority set of RMNCH indicators. This may include district scorecards/dashboards. Denominator: Total number of target districts Disaggregated by country	Program records	Annually	Mali: (13/13) 100%	None Reported

#	Indicator	Definition and Disaggregation	Data Source/ Collection Method	Frequency of Data Collection	FY2014 Data	FY2015 Data
44	Percentage of MCSP target districts with regular feedback mechanisms supported by the program to share information on progress toward RMNCH health targets with community members and/or CSOs	Numerator: Number of target districts with regular feedback mechanisms to share information on progress toward health targets to community members and CSOs Denominator: Total number of target districts Feedback mechanisms may include: regular meetings, data review meetings with communities and CSO members invited, reports/scorecards in community-appropriate language posted at service points, etc. Disaggregated by country	Program records	Annually	Malawi: (0/2) 0% Mali: (13/13) 100%	Mozambique: 7/7 (100%)
45	Percentage of MCSP target districts that conducted a data quality assessment in the past year that included RMNCH indicators	Numerator: Number of target districts with one or more health facilities that conducted a data quality assessment in the past year that included reproductive health, maternal and newborn health, and child health indicators Denominator: Total number of target districts Disaggregated by country Examples of appropriate data quality assessment tools are: routine data quality assessment tool (RDQA), immunization data quality self-assessment (DQS)	Annual HIS review assessments	Annually	Mali: (7/13) 54%	Guinea FP-MCH/GBV: 2/20 (10%) Nigeria: 34/34 (100%) Tanzania: 16/16 (100%)
46	Number of countries implementing a maternal and perinatal death surveillance and response system with MCSP support	This could cover the community and/or facility-based deaths and may include application of WHO's Maternal Death Surveillance and Response approach. Disaggregated by country	Supervision reports, health facility survey, surveillance reports	Annually	Mali: 1	Total: 3 (Guinea, Nigeria, Zambia)

* USAID-required Operational Plan (OP) indicators

Table 1: Details on Indicator 22: Pre-service education strengthened, by cadre

Country	Doctor	Nurse	Midwives	CHWs
Burma			X	
Ghana		X	X	
Guinea	X	X	X	
Madagascar			X	
Malawi	X	X	X	
Tanzania		X	X	X

Table 2: Details on Indicator 22: Pre-service education strengthened, by topic

Country	Maternal Health	Newborn Health	Child Health and Nutrition	Family Planning/ Repro-ductive Health	Immuni-zation	M&E	Malaria	Other
Burma	X	X						
Ghana	X	X					X	X
Guinea	X	X		X			X	
Madagascar	X	X		X	X		X	
Malawi					X			
Tanzania	X			X	X			

Table 3: Details on Indicator 23: People trained

Row Labels	Maternal Health	Newborn Health	Child Health and Nutrition	Family Planning/ Repro-ductive Health	Immuni-zation	M&E	Malaria	Other
Ethiopia—BEmONC	174			38				17
Ethiopia—CNBC		10,472				31		
Ghana								33
Guinea IPC								356
Haiti EPCMD	19							19
Haiti North			325					
Haiti Social Marketing				308				
Kenya	480	480	400	752			3,500	
Madagascar	228	228			228		228	
Malawi					207			
Mali				233			1,042	
Mozambique Bridge	81		41	68				124
Nigeria—MNH	154			62				
Tanzania	881			175				
Uganda					1,271			
Zambia	43	123						310

Row Labels	Maternal Health	Newborn Health	Child Health and Nutrition	Family Planning/ Repro-ductive Health	Immuni-zation	M&E	Malaria	Other
Total	2,060	11,303	766	1,636	1,706	31	4,770	859

Table 4: Details on Indicator 24: Facilities Actively Supporting Quality Improvement Approaches

Country	Hospital	Health Center	Health Post
Ethiopia—BEmONC		22	
Ethiopia—CNBC		730	3594
Guinea FP-MCH/GBV	23	25	
Guinea IPC	16	23	
Madagascar	1	5	
Malawi	2	25	15
Mozambique	48	81	
Tanzania	23	197 (includes Dispensaries)	

Table 5: Details for Indicator 26: High-Impact Interventions (Malaria TBD)*

Indicator	FY2015 Data	Total Countries Covered to Date
High-Impact Maternal Health Interventions		
CEmONC	4: Guinea, Kenya, Mozambique, Tanzania	4
BEmONC	8: Burma, Ethiopia, Haiti, Kenya, Madagascar, Mozambique, Tanzania, Zambia	8
PE/E screening and management	7: Burma, Ethiopia, Guinea, Madagascar, Mozambique, Nigeria, Zambia	7
PPH management	6: Burma, Guinea, Madagascar, Mozambique, Tanzania, Zambia	6
Labor monitoring and management (partograph)	3: Nigeria, Tanzania, Zambia	3
Uterotonic use – Oxytocin for facility deliveries	7: Ethiopia, Guinea, Madagascar, Mozambique, Nigeria, Tanzania, Zambia	7
Uterotonic use – Misoprostol for home deliveries	2: Madagascar, Mozambique	2
High-Impact Newborn Health Intervention		
Chlorhexidine	2: Ethiopia, Mozambique	2
Kangaroo Mother Care (KMC)	5: Burma, Mali, Mozambique, Tanzania, Zambia	5

Indicator	FY2015 Data	Total Countries Covered to Date
Newborn resuscitation through ENC/HBB	7: Burma, Ethiopia, Guinea, Haiti, Madagascar, Mozambique, Zambia	7
Handwashing	3: Guinea, Haiti, Mozambique	3
Antibiotic treatment for PSBI	1: Ethiopia	1
High-Impact Child Health Interventions		
IMCI	2: Guinea, Mozambique	2
ICCM	4: Burma, Kenya, Mozambique, Namibia	4
High-Impact FP Interventions		
Expanding FP method options (LARCs + permanent methods)	8: Ethiopia, India, Kenya, Madagascar, Mozambique, Nigeria, Tanzania, Zambia	8
PPFP (PPIUCD / LAM)	6: Ethiopia, Guinea, Madagascar, Mozambique, Tanzania, Zambia	6
PAC	1: Mali	1
High-Impact Immunization Interventions		
Introduction of new vaccines	3: Malawi, Nigeria, Tanzania	3
Routine Immunization	7: Kenya, Madagascar, Malawi, Nigeria, Tanzania, Uganda, Mozambique	7
High-Impact WASH Interventions		
Point-of-use water treatment and promotion of clean environment	1: Mozambique	1
High-Impact Nutrition Interventions		
Exclusive breastfeeding	2: Mozambique, Tanzania	2
Promotion of proper infant and young child feeding (IYCF)	1: Mozambique	1
High-Impact Malaria Interventions		
MIP Package (IPTp, ITNs, malaria case management)	5: Burma, Kenya, Madagascar, Mozambique, Tanzania	5

*Other high-impact interventions under discussion.

Table 6: Details on Indicator 37: Policies drafted

Country	# of policies	Titles
Ethiopia	2	National RH Strategy 2015–2020 National QI & assessment tool for Health Centers
Guinea	1	National Norms and Directives for RH and FP
Madagascar	2	1. Roadmap for accelerating the reduction of maternal and neonatal mortality; 2. National Malaria In Pregnancy Protocol
Malawi	1	National Immunization Policy

Country	# of policies	Titles
Mali	2	National strategic plan for SEC; National plan for the introduction of Chlorhexidine
Mozambique	1	National Strategy for Quality and Humanization, 2015–2019

Table 7: Details on Indicator 38: Studies Completed

Country	Title
Madagascar	Status of MNH services delivery at public health facilities in 15 regions of Madagascar
Malawi	Baseline coverage survey for priority districts
Mali	Seasonal malaria chemo prevention intervention, introduce chlorexhedine for umblical cord care
Nigeria	Nigeria Maternal and Newborn Health Facility Readiness Assessment

Annex C: MCSP Core Action-Oriented Learning Agenda

MCSP Action-Oriented Learning Agenda Core Learning Questions—September 30, 2015		
Learning Question	**Stage of Implementation (i.e., planning, data collection, analysis, dissemination)**	**Countries in which the learning activity is being implemented**
Child Health		
What are feasible measures for tracking the additional coverage achieved from implementing iCCM? What are feasible measures for improving quality of iCCM programs using routine information systems?	Data Collection	MCSP priority countries
What is the country and global experience in resource mobilization for iCCM scale-up?	Dissemination	Kenya, Uganda, Zambia, Ghana, Nigeria
What is the feasibility of implementing iCCM in Kenya? (Carried over from MCHIP)	Dissemination	Kenya
How can existing QI tools and approaches be adapted to monitor and improve quality of care in child health services? Can a feasible and effective QI system be developed for child health services at the community and facility level?	Planning	Rwanda, potentially Haiti, Liberia, Guinea
Through implementation and management of a systematic scale-up process, can countries accelerate achievement of high, effective coverage and institutionalization of the integrated management of childhood illness at the community level (iCCM) to end preventable deaths of children under five? (Coordinated with MMEL)	Planning	DRC, Namibia
Community Health and Civil Society Engagement		
What are the key components and characteristics (such as policy, incentives, scopes of work and intervention packages) of government CHW programs in the 24 priority countries?	Data Collection	MCSP priority countries
Does policy in the 24 priority countries address health facility committees, village/local development committees, women's groups and other similar types of community structures?	Data Collection	MCSP priority countries

MCSP Action-Oriented Learning Agenda Core Learning Questions—September 30, 2015		
Learning Question	**Stage of Implementation (i.e., planning, data collection, analysis, dissemination)**	**Countries in which the learning activity is being implemented**
How can systems thinking approaches contribute to the successful scale-up of community-based health initiatives such as the Community-based Health Planning and Services (CHPS) Initiative in Ghana?	Data Collection	Ghana
Family Planning		
What are effective mechanisms and models of PPFP implementation for integrating FP with MNCH services including immunization and nutrition? (Carried over from MCHIP)	Analysis	Kenya, India
How does integration of family planning and immunization services affect service provision, utilization and quality in a range of settings MCSP works?	Planning	Tanzania, Malawi, Liberia
How feasible and effective is it to track women through a reproductive continuum, inclusive of all methods in extended postpartum, and their receipt of key health services and uptake of key behaviors?	Planning	Ethiopia
Test age- and stage-specific counseling tools and techniques to improve the quality of services for adolescent girls/young mothers and expand PPFP utilization by this age group. Conduct formative research on individual, family, community and service factors influencing first-time parents' use of SRH services.	Planning	Nigeria, Madagascar
Test new approaches for communicating about the lactational amenorrhea method and transition in context of optimal maternal, infant and young child nutrition practices.	Data Collection	Tanzania
What does a chart review reveal about the incidence of method failure in implant users in relation to specific antiretroviral therapy regimens?	Data Collection	Kenya
Explore male care-seeking patterns and needs to design a model of male services that includes no-scalpel vasectomy alongside other desired services for men.	Planning	Kenya
Assess movement of women across public and private sectors along continuum of care and gaps in PPFP that may result.	Planning	TBD
Health Systems Strengthening and Equity		
What are the lessons learned from the process of field-based adaptation and implementation of the Comprehensive Approach to Health Systems Management?	Data Collection	Tanzania, additional countries TBD

MCSP Action-Oriented Learning Agenda Core Learning Questions—September 30, 2015		
Learning Question	**Stage of Implementation (i.e., planning, data collection, analysis, dissemination)**	**Countries in which the learning activity is being implemented**
What is the feasibility and effectiveness of applying core quality improvement principles in combination with local health systems strengthening activities to improve delivery of an integrated facility-based package of interventions for mothers and newborns on the day of birth? (Coordinated with Maternal Health team).	Planning	Tanzania, Nigeria, Madagascar, Mozambique, Rwanda, additional countries TBD
Immunization		
Which process indicators are appropriate for providing real-time routine immunization system data that are on a pathway to uniformly high routine immunization coverage that is sustainable over time?	Planning	Nigeria
What steps and processes are needed to improve the generation and active use of reliable routine immunization data?	Planning	Nigeria
What approaches are most effective and efficient to build health worker capacity for routine immunization?	Planning	Nigeria
How can the community engage in birth tracking to improve routine immunization and other interventions?	Planning	Malawi, Nigeria
Malaria in Pregnancy		
What is the effect of a community intervention for provision of intermittent preventive treatment of malaria in pregnancy (IPTp) on IPTp coverage and antenatal care (ANC) attendance in three districts of rural Burkina Faso? What are social and cultural factors that influence levels of IPTp uptake and ANC attendance?	Planning	Burkina Faso
Maternal Health		
What are the in-country contextual factors that enable or restrict scale-up of advance distribution of misoprostol for self-administration for prevention of postpartum hemorrhage (PPH) at home birth? (Coordinated with MMEL).	Data Collection	Afghanistan, Mozambique, Haiti

MCSP Action-Oriented Learning Agenda Core Learning Questions—September 30, 2015		
Learning Question	**Stage of Implementation (i.e., planning, data collection, analysis, dissemination)**	**Countries in which the learning activity is being implemented**
Maternal Health Team also coordinating on the following learning questions referenced under other technical and cross-cutting teams in this annex: • What is the feasibility and effectiveness of applying core quality improvement principles in combination with local health systems strengthening activities to improve delivery of an integrated, facility-based package of interventions for mothers and newborns on the day of birth? • Can monitoring stillbirth and very early newborn death provide a valid indicator of quality of intrapartum care, and what is the appropriate scale of application of the indicator? • How feasible and useful is it to integrate the new streamlined labor and delivery observation checklist into routine supervision visits by district health management teams? Examine the current state of gestational age estimation, analysis, documentation and data utilization in antepartum and intrapartum settings.		
Measurement, Monitoring, Evaluation, and Learning		
Through implementation of a systematic method for scaling up, can countries accelerate achievement of high, effective coverage and institutionalization of high-impact MNCH interventions? (Coordinated with Maternal Health, Newborn Health, and Child Health teams).	Data Collection	MCSP priority countries
Can monitoring stillbirth and very early newborn death provide a valid indicator of quality of intrapartum care, and what is the appropriate scale of application of the indicator? (Coordinated with Maternal Health team).	Planning	Tanzania
Which key data elements related to MNCH indicators are present in routine health information systems in the 24 priority countries, and how are they managed?	Data Collection	MCSP priority countries
How feasible and useful is it to integrate the new streamlined labor and delivery observation checklist into routine supervision visits by district health management teams? (Coordinated with Maternal Health team).	Dissemination	Tanzania
What is the health situation at a local level? Does intervention coverage vary across different vulnerable groups? (Knowledge, Practices and Coverage survey).	Planning	Bangladesh, Ethiopia, Kenya, Tanzania

MCSP Action-Oriented Learning Agenda Core Learning Questions—September 30, 2015		
Learning Question	**Stage of Implementation (i.e., planning, data collection, analysis, dissemination)**	**Countries in which the learning activity is being implemented**
Field test indicators from the WHO MNCH QOC indicator list.	Planning	Rwanda, Nigeria, Tanzania, Madagascar, Mozambique, DRC, additional countries TBD
Assess four sets of factors related to RMNCH quality of care: the national policy environment; facility readiness to provide care with respect to infrastructure, supplies, medications and client-friendly services; health provider skills with respect to performance of evidence-based RMNCH and respectful care; and health provider knowledge of evidence-based practices. (RMNCH Quality of Care Assessment).	Data Collection	Nigeria, Mozambique, additional countries TBD
Newborn Health		
What are the key barriers to post-training provider performance of newborn resuscitation and how can those barriers be addressed?	Planning	Rwanda
Do training activities that integrate basic newborn care with basic emergency obstetric care (BEmOC) effectively ensure providers' competencies in basic newborn care in Ethiopia and Zambia?	Planning	Ethiopia, Zambia
Support introduction of a simplified antibiotic regime for the management of serious infections in young infants in settings where referral care is not accessible or acceptable.	Planning	Nigeria, additional countries TBD
MCSP will propose a question related to quality improvement of newborn health services.	Planning	TBD
Through implementation and management of a systematic scale-up process, can countries accelerate achievement of high, effective coverage and institutionalization of resuscitation of asphyxiated newborns in the first minute after birth (the "Golden Minute") using the Helping Babies Breathe protocol at facility level?	Planning	Rwanda, Mozambique
Nutrition		
What innovative approaches are programs taking to address the major barriers to and also factors facilitating/motivating exclusive breastfeeding in the first six months?	Data Collection	MCSP priority countries
To what extent is the consumption of junk food by children younger than five years a nutrition problem in the USAID-MCSP 24 priority countries and what are the factors influencing the feeding of these foods to children?	Data Collection	MCSP priority countries

MCSP Action-Oriented Learning Agenda Core Learning Questions—September 30, 2015		
Learning Question	**Stage of Implementation (i.e., planning, data collection, analysis, dissemination)**	**Countries in which the learning activity is being implemented**
What are the major barriers to adequate food intake during pregnancy and what are programs doing to address the problem in the 24 USAID-MCSP countries?	Analysis	MCSP priority countries
Is community-based distribution of iron-folic acid supplements practiced in the 24 USAID-MCSP priority countries and what are the barriers in moving community-based distribution of iron-folic acid supplementation forward?	Analysis	MCSP priority countries
Water, Sanitation and Hygiene		
Which combination of handwashing with soap interventions (handwashing devices, clinic level messaging, and/or household level messaging) results in improved newborn outcomes in Kenya?	Data Collection	Kenya
Are oral rehydration therapy corners functional in Igembe North and Bondo sub-counties in Kenya, and to what extent do they adhere to the intervention standards outlined in Kenya's National Oral Rehydration Therapy Corner Operational Guidelines?	Analysis	Kenya
Pilot the Clean Clinic Approach.	Planning	DRC
Asia Bureau		
Examine the current state of gestational age estimation, analysis, documentation and data utilization in antepartum and intrapartum settings. (Coordinated with Maternal Health team).	Planning	Cambodia, India
Which are the major program platforms in India to reach mothers and newborns at home in the postnatal period with preventive services, including assessment, counseling and referrals? To what extent have home visits for postnatal care been included and implemented in state-level programs? What aspects of these programs have performed well? What aspects have not performed well? What are the conditions that need to be met to achieve high, effective coverage of postnatal home visits in the typical program setting at scale? Pilot a model postnatal care program.	Planning	India

Annex D: Success Stories, Blogs and Happenings

Bringing Newborn Care Closer to Communities in Ethiopia

Rahmete (left) and Boltena (center) with baby Semredin.

Boltena Kadera, 28, lives with her husband and four children in southwestern Ethiopia. After giving birth to three of her children at home, she took the advice of a Health Extension Worker (HEW) during an antenatal visit and delivered her youngest child, Semredin, at the nearby health center.

The baby appeared fine at first, but in his second week, Semredin began coughing and had shortness of breath. Boltena and her husband were worried, but did not seek care outside of the home, assuming the baby was too little to be treated at a health facility. About a week after first showing signs of illness, Semredin's condition had not changed, and even appeared to worsen.

Boltena and her husband then returned with Semredin to the health center where he was born. However, health workers said the baby was too young to be treated at their facility and referred them to Halaba Hospital. Unfortunately, while Boltena and her husband wanted care for Semredin at the hospital, it was too difficult for them to leave their three small children at home and decided not to take the baby for treatment.

After two days, Boltena and her husband were visited by Rahmete, the local HEW. Rahmete asked to examine the baby, saying she had recently attended a training on treating young children with Possible Serious Bacterial Infections (PSBI).

The training—organized by Save the Children and MCSP—gave Rahmete the confidence to assess Semredin. She noted the baby appeared very sick, and strongly recommended he be taken to the health center for treatment. When Boltena explained that she had already been there and

refused to return, Rahmete gave the baby an injection and a tablet.

She explained that the tablets should be dissolved in breast milk for Semredin to take twice a day, and promised to come to their home daily to check on the baby's progress and to give him the remaining injections. Rahmete also counseled Boltena to breastfeed Semredin as frequently as possible.

Almost immediately, Semredin's condition started to improve. As promised, Rahmete visited Boltena and her husband every day for seven days to give Semredin an injection, and Boltena continued to give him dissolved tablets twice a day. Semredin is now fully-recovered.

Boltena and Semredin, who was treated by an HEW for PSBI, as per the Community-based Newborn Care protocol.

"Although I was initially scared of treating neonates with danger signs indicating PSBI like Semredin," Rahmete said, "the result I observed has boosted my confidence and satisfaction. The Community-based Newborn Care training I was given by MCSP and Save the Children has really enabled me to serve the community better."

Boltena added: "I am very grateful of Rahmete, who saved the life of my baby and returned joy to our family. I am also very happy that such kind of service is being given at the health post. It's really very beneficial and relieving for mothers like me."

Under MCSP, Save the Children implements the Community-based Newborn Care / Newborns in Ethiopia Gaining Attention project in collaboration with Ethiopia's Federal Ministry of Health, Regional Health Bureaus and Zonal Health Departments and woreda (equivalent to district) health offices in 135 woredas. The goal of the project is to reduce newborn and child morbidity and mortality and support the Ethiopian government's efforts to scale up high-impact essential newborn care interventions in communities and primary health care facilities. In the Southern Nations Nationalities and Peoples' Region, the project is implemented in 37 woredas, and has been working in the Halaba Special District since January 2015.

Caribbean Regional Midwifery Association Success with Competency-Based Education Workshops

Filia Macnack-Boschveld, a midwifery educator from Suriname, participated in the 2013 MCHIP-sponsored Competency-based Education (CBE) workshop. Initially worried that her English was not sufficient to participate, Filia persevered and successfully completed the workshop. She then committed to taking the information back to her country, where she and her colleague, Georgetina Ellioth, conducted their own CBE workshop.

Using ModCAL in group discussion sessions, they overcame language barriers and Filia was driven to move away from traditional teaching methods and incorporate CBE methodology in her program. As the only midwifery instructor, she had to creatively design ways for students to work in small groups within a larger class.

To start, she developed and used case studies in the classroom to facilitate critical thinking. These cases were given to small groups of students, who worked through them together, answered questions, and presented their findings and plans to their colleagues. The resulting discussions—about how groups addressed the cases—stimulated student engagement and self-directed learning.

Learning through student-led cases and sharing is a significant departure from the traditional teacher-directed lecture model. Irene dela Torre, a Caribbean Regional Midwifery Association member and educator consultant from Puerto Rico, observed one of Filia's classes. She noted that students worked on pre-eclampsia cases and, with Filia providing facilitation, student participation was high, and they found the critical aspects of the cases.

SUCCESS STORY

MADAGASCAR

Photo: MCSP / Haja Andriamiharisoa

NAME
Marielle Olivia Bezafy

ROLE
Midwife

LOCATION
Tanambe, Madagascar

SUMMARY

During a maternal and newborn health training led by MCSP, Rasazy, the midwife in charge of deliveries at the primary health center in Tanambe, Madagascar, develops important competencies to improve the quality of services administered.

Upon returning to her clinic, she rediscovers a stock of long-ignored resuscitators and penguins, and is soon presented with an opportunity to use them during a delivery. The instruments, which the baby's grandmother deemed "bizarre," are soon praised, along with the newly trained midwife, for saving the life of the baby.

Effective Training and Proper Equipment are Saving Newborns in Madagascar

Midwife Marielle "Rasazy" Bezafy is the provider in charge of the delivery ward at the Centre de Santé de Base II (CSB II, Primary Health Center II) in northeastern Madagascar.

When Rasazy began working at Tanambe's CSB in February 2015, she received a list of job duties from the district's Chief of Medicine along with a cupboard full of new, neatly-arranged and inventoried medical materials. These included a group of resuscitators and penguins which, at the time, Rasazy was unclear how to use. She set them aside and made a mental note to learn more about them in the future.

Just a few months later, Rasazy was selected to participate in a training of maternal and newborn health (MNH) providers organized by MCSP/Madagascar in Ambatondrazaka. Several MNH topics were covered during the training, including prevention of postpartum hemorrhage, newborn essential care, and newborn resuscitation. Rasazy proved to be an enthusiastic participant and avid leaner; by the end of the training, she earned a 100% competency score in the category of newborn resuscitation, which was evaluated with the use of anatomical models.

After multiple demonstrations and practicum sessions using the anatomical models, Rasazy and her fellow participants requested a donation of similar resuscitators. (Until then, they had been using only obstetrical stethoscopes to resuscitate newborns.) The newly trained providers saw the value in the evidence-based methods and protocols taught by MCSP, and were empowered to bring those standards back to their health centers.

Upon completing the five-day training, Rasazy returned to Tanambe and, in her post-training report to her supervisor, asked to review the medical materials stored at her CSB. Her inquiries led her to rediscover the group of resuscitators and penguins which—together with her newly acquired knowledge via the MCSP training—she began to use regularly in her practice.

On August 14, 2015, Felicie Raharinirina, accompanied by her mother-in-law, went to the CSB in Tanambe to deliver her baby. Several hours later, her son, Albert, was born via a natural delivery, but with meconium-stained amniotic fluid, which causes fetal distress and can lead to newborn asphyxia and death if untreated. Rasazy quickly reached for a resuscitator and penguin, at which Felicie's mother-in-law exclaimed, "*Inona ary ity ataon - drasazy mampiasa fitaovana hafahafa ity!* [But what is she doing with these bizarre instruments!]"

"Mahavonjy aina ny mampiasa ilay fitaovana lazan'ny rafonam-bavy ho hafahafa."

[The use of instruments that women may find bizarre can save lives].

- Marielle Bezafy

After performing a few rounds of suction, stimulation and ventilation and cutting the umbilical cord, the baby began to breathe. It was then that Rasazy replied, "*Fa ny aina mahavonjy mampiasa ilay fitaovana* [Using such equipment saves lives.]"

It is through interactive, practice-based MNH trainings that providers like Rasazy are able to learn how to utilize lifesaving equipment and techniques. In the right, trained hands, the resuscitator and penguin, which sat neatly in the health center's cabinet, saved the life of little Albert.

By: Dr. Raoeliarisoa Andriatsarafara, Haja Andriamiharisoa

SUCCESS STORY

MALAWI

Photos: Participants engaged at cold chain management and repair training / John Snow, Inc.

LOCATION

Ntchisi and Dowa Districts, Malawi

SUMMARY

Vaccines are sensitive to heat and freezing and must be kept at the correct temperature from the time they are manufactured until they are used. A constant challenge of managing vaccines is the frequency of refrigerators breaking down, particularly due to use of old refrigerators and the complexity of operating gas and kerosene refrigerators. To address the challenges of managing vaccines and improve refrigerator conditions, MCSP supported two cold chain management and repair trainings in Ntchisi and Dowa districts for 84 HSAs from all health facilities. The two-day practical training provided participants with basic skills and knowledge on how to repair and maintain refrigerators. The HSAs were trained to handle minor repairs and to avoid transferring vaccines and relying heavily on district cold chain technicians, which will improve overall routine immunization in Ntchisi and Dowa.

USAID ensures that cold chain equipment in Malawi is repaired instantly

The USAID-funded MCSP immunization program works in Malawi to assist the Ministry of Health roll-out lifesaving vaccines, including Inactivated Polio Vaccine and Measles Second Dose. MCSP also provides capacity building of managers and service providers at all levels, and provides technical support to strengthen routine immunization.

Use of potent vaccines is critical for the prevention of vaccine-preventable diseases. Vaccines are sensitive to heat and freezing and must be kept at the correct temperature from the time they are manufactured until they are used.

A constant challenge of managing vaccines is the frequency of refrigerators breaking down, particularly due to use of old refrigerators and the complexity of operating gas and kerosene refrigerators. When this happens, the District Cold Chain Technician (DCCT) is notified to come and rectify the problem and vaccines are transferred to the nearest health facility, which can be very far away.

Unfortunately, most DCCTs are not able to respond to these calls immediately, as most do not have reliable transportation. This in turn affects immunization sessions, when Health Surveillance Assistants (HSAs) have difficulty collecting the vaccines on clinic days.

Ironically, many repairs could be handled by an HSA with proper training; however, most HSAs do not have the required skills and are forced to wait for the DCCT.

To address this gap and improve refrigerator conditions, MCSP supported two cold chain management and repair trainings in Ntchisi and Dowa districts for 84 HSAs from all health facilities. The two-day practical trainings provided participants with basic skills and knowledge on how to repair and maintain refrigerators. This training will aid HSAs to handle minor repairs and avoid transferring vaccines and relying heavily on district cold chain technicians.

"I never knew these things are so simple to do; I thought only the district technicians can do it. Even when a new refrigerator comes, especially the gas operated ones, we could not event connect until the DCCT comes. Now I will be able to do it myself."

- *Anonymous participant*



Photos: Participants engaged at cold chain management and repair training / John Snow, Inc.

Participants were very enthusiastic about their new knowledge. As one participant said: "I never knew these things are so simple to do; I thought only the district technicians can do it. Even when a new refrigerator comes, especially the gas operated ones, we could not even connect until the DCCT comes. Now I will be able to do it myself."

by: Hannah Hausi

SUCCESS STORY

MOZAMBIQUE

Photo: Jhpiego

NAME
Rute Ricardo Mbia

ROLE
Mother

LOCATION
Matola Province, Mozambique

SUMMARY
Traditional birth attendants trained by MCHIP are, in collaboration with the Ministry of Health, placed in communities needing assistance related to maternal, newborn and child health, as well as HIV. Their role includes educating pregnant women on preparation of a birth plan, the importance of giving birth in a health facility, and the danger signs of life-threatening complications.

In Mozambique, Strong Community and Facility Linkages Improve Antenatal Care and Delivery Services

Sara Zacarias is a traditional birth attendant (TBA) in Matola Province, Mozambique. She received training in maternal, newborn, and child health issues—including knowledge on HIV—from USAID's predecessor flagship Maternal and Child Health Integrated Program.

"After the training, I learned how to do my work better. I have mapped the pregnant women in my community and now I know where to go and what house to visit," she said. "I love my work because, with what I have learned, I can help women. Some don't know the importance of birth plans, the danger signs during pregnancy, and the importance of having a baby at the health center."

Ana Samuel Mulungo is the mother of Rute Ricardo Mbia, a 20-year-old woman who was recently pregnant with her first child. When Ana was at the market, Mamã Sara approached her to see if her daughter had all of the information that she needed to make the right choices during her first pregnancy. Knowing women who died due to complications during labor, Ana wanted Mamã Sara to explain the importance of getting good prenatal care and having the birth at the health center.

Mamã Sara did just this, going to Ana's and Rute's house to discuss the vital role of prenatal care (including testing for HIV) for both mother and baby, and the benefits of giving birth at the health center. She also helped Rute develop a birth plan, including the steps of attending all appointments at the health center and recognizing the signs of danger during pregnancy.

"I am very thankful to Mamã Sara for the visit," Rute said. "Now I know more things about my baby and me and how I can prepare myself for the day of labor and avoid having problems at the last minute. For me, the most important part was the birth plan and my plan for transportation when I have to go to the hospital."

"I used to hear horrible stories in my community of women who were not well-treated in hospital by nurses. This was not my case – I was very well treated." –Rute Ricardo Mbia, first-time mother

Mamã Sara visited Rute monthly to monitor her health and follow her pregnancy. When Rute started to feel labor pains, her mother ran to Mamã Sara's house for help. Together, they alerted the pre-arranged transport and took Rute to Matola II Health Center. At the hospital, they were received and treated with respect, and Rute had a safe and successful delivery of a healthy baby girl, Tatiana.

Since the birth of her daughter, Rute has been teaching other mothers in her community about the importance of preparing in advance for childbirth. She shares her positive experience at the health center to encourage them to receive prenatal care and deliver at the facility.

With support from both MCHIP and MCSP, more than 10,000 women have given birth safely at Matola II Health Center between April 2011 and September 2015.

by: Zaida Agostinho Macia, Denise Alves, and Matias Anjos

Extended Health Services Vital to Remote Communities in Namibia

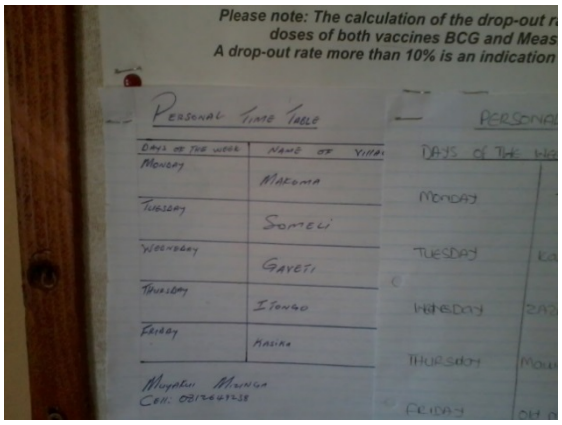
HEWs (seated) meet with the Health Extension Program focal person (standing) during a supervision visit to Impalila Island.
Photo credit: MCSP/Namibia

Impalila Island can only be accessed by boat from the town of Kasane, in Botswana. One must travel more than 85 miles by road and 3 miles by boat—crossing the border four times in the process—to reach the island.

Until recently, the island's 1,091 residents—most of whom make their living by farming and fishing—were cut off from even the most basic health services. Thanks to a national Health Extension Program, however, this is no longer the case.

The Government of Namibia and Ministry of Health and Social Services (MOHSS) assigned two Health Extension Workers (HEWs) to live on the island and provide a package of basic, essential health services. These HEWs represent a major strategic push from the Government of Namibia to expand access to health care services in Namibia's most remote regions. Thus far, more than 1,400 HEWs have finished a six-month training course and been deployed to communities throughout the country.

And while there are challenges to serving communities spread out across Impalila Island, residents have expressed their gratitude to the MOHSS for including them in the program. The two HEWs based on the island* provide services such as first aid, health promotion, and screening for newborn danger signs. Their schedules are posted at the local health clinic and, despite the travel difficulties over rocky, muddy, and often slipper roads, they are not deterred from meeting daily with their clients.



HEWs' work schedules are posted publically at the Impalila Clinic, enabling community members to know when to expect their visit. *Photo credit: MCSP/Namibia*

The HEWs do face other types of challenges in reaching their patients, however. On one occasion, an HEW tried to meet with adolescents to discuss sexual health issues.

He recounted: "I approached the school principal to request permission to give health promotion on certain days of the week to learners, but I was so disappointed when the principal would not allow me, and instead informed me of the lengthy process that we would have to follow. These procedures require the Directorate of Health in the region to write a letter to the Directorate of Education to get permission for me to come to the school to provide health promotion."

Such delays can be frustrating when the demand and need for health information and services is so high, but the HEW did not give up. He travelled to the Namibian Planned Parenthood Association office in Katima Mulilo to collect different types of educational pamphlets with titles such as "It's okay to say no," "Ten good reasons to not be a teenage parent," and "Sexually Transmitted Infections." He gave the pamphlets to the school life skills teacher to distribute to students.

Another challenge related to population movements. Pregnant women typically move to the much larger town of Katima Mulilo to deliver, and only come back to the village when the baby is two or three months old. This makes it difficult for an HEW to provide a full package of health services for both mother and baby at the appropriate intervals. As a result, HEWs provide what support they can, including providing an expectant mother with a proper referral letter to a nearby facility, allowing her to receive prompt and appropriate care during the remainder of her pregnancy and after her delivery.

The work of these HEWs is recognized and greatly appreciated by their communities and by other health workers on Impalila Island. As the nurse in charge of Impalila Clinic said: "HEWs are an important part of the Ministry's strategy to improve our community's quality of health. For us here, we have already seen the impact of their work in the communities: reduced numbers of children defaulting on immunisation; pregnant women starting antenatal care early; and increased numbers of clients referred."

* HEWs did not want their real names used in this story.

Helping Babies Survive & Thrive: Dhaka Workshop and Beyond

Participants simulate breastfeeding using educational mannequins. All photos courtesy of Ripon Rahman/MCSP

This blog was originally published by MCSP.
Written by Lydia Wisner and Esha Dholia.

The first 28 days of life are some of the most important. Nearly three million babies die each year during this newborn phase—almost half within the first 24 hours of life. In all, newborns account for 41% of all child deaths under the age of five.

Fortunately, the three main causes of neonatal death—preterm birth, birth complications, and neonatal infections—are preventable. And the international community is making combating newborn mortality a priority.

Last year, the World Health Organization and UNICEF launched the Every Newborn Action Plan (ENAP) to guide organizations in their work to reduce preventable newborn mortality and stillbirths. This roadmap links the work of key stakeholders and policy makers to encourage change on the national level, and provides specific objectives for organizations to consider while developing strategies and policies.

To support the aims of ENAP, MCSP and its partners—the Bangladesh Ministry of Health and Family Welfare, UNICEF, the American Academy of Pediatrics (AAP), Survive & Thrive Global Development Alliance, Laerdal Global Health Foundation, and USAID's Applying Science to Strengthen and Improve Systems Project—in collaboration with the World Health Organization, formed a core planning team of global partners, who together supported the design of the "Helping Babies Survive" regional workshop in Dhaka, Bangladesh, in April 2015.

Helping Babies Survive (HBS) is a series of competency-based newborn care training modules developed by international neonatologists. The first three days of the workshop were dedicated to skills-based training to introduce Asian ENAP countries to the newest HBS training modules—Essential Care for Small Babies (ECSB)—as well as the previously introduced Essential Care for Every Baby (ECEB). The module tools include visual guidebooks, flipcharts, and posters containing clear, specific instructions for health care providers to follow after the birth of a baby. Attendees, led by global facilitators from AAP and

regional facilitators from India, Bangladesh, and Uganda, were trained on both modules.

Equipment donated by Laerdal Global Health also included the company's MamaBreast, which simulates breastfeeding and breast milk expression, and the educational mannequins NeoNatalie and PreemieNatalie. These inflatable simulators, which mimic the weight and feel of newborn babies, are used for role playing of several scenarios related to essential newborn care following birth, as well as basic neonatal resuscitation.

Two workshop participants using the MamaBreast. Photo: Rijon Rahaman/MCSP

The team of global partners dedicated the remaining two days of the workshop to discussion between participants from the 11 country delegations—Afghanistan, Bangladesh, Cambodia, China, India, Indonesia, Myanmar, Nepal, Pakistan, Philippines, and Vietnam—which focused on health system issues and bottlenecks that stall their respective efforts to improve newborn training methods and reduce newborn mortality rates. The outcome of these discussions was a draft action plan that each country delegation designed in response to the issues identified.

The workshop was not simply a training, but an opportunity to establish a network of international health practitioners, dedicated to the reduction of infant mortality, primed and ready to return home and use the action plans to rally support among stakeholders and keep up the momentum for change. The objective was to emphasize the need to share and learn, and build a community of practice.

As such, workshop participants were encouraged to maintain contact with one another, and a webpage on the Healthy Newborn Network website was set up as a platform for knowledge sharing and discussion on progress, challenges and successes achieved since Dhaka. Furthermore, quarterly meetings continue to be held between the global partners, during which updates from country delegations are shared, requests for technical support are answered, and partnerships continue to burgeon between countries, agencies and individuals, all united in their efforts to deliver lifesaving newborn health care.

Sabita Tuladhar of USAID/Nepal participates in the Essential Care for Every Baby training. Photo: Ripon Rahman/MCSP

SUCCESS STORIES

NIGERIA

NAME
NANNM, SOGON, PAN, NISONM

ROLE
Health Professional Associations

LOCATION
Abuja, Nigeria

SUMMARY
MCSP is supporting four professional associations to help end preventable maternal and child deaths in Nigeria.

Calling Health Associations to Action in Nigeria

To become more impactful in saving and improving the lives of mothers and children, MCSP is supporting midwives, pediatricians and obstetricians in Nigeria through their main professional associations: the National Association of Nigeria Nurses and Midwives (NANNM); Society of Gynaecology & Obstetrics of Nigeria (SOGON); Pediatric Association of Nigeria (PAN); and the Nigeria Society of Neonatal Medicine (NISONM).

The Program is focusing these efforts in Ebonyi and Kogi States, where staff worked joined with GSK PULSE Volunteers to train 60 association members, equipping them with leadership, organizational, project, and financial management skills. As a result, health professionals are beginning to harness their resources and potentials.

Spurred by MCSP, the associations now have a vision whereby each of them, by 2019, will have:

- Established fully-manned project management offices in Abuja;
- Instituted strong financial and project managerial systems;
- Acquired strong business development skills;
- Attracted grants/awards to contribute to health development in Nigeria; and
- Contributed to learning agendas through implementation of multicenter research projects.

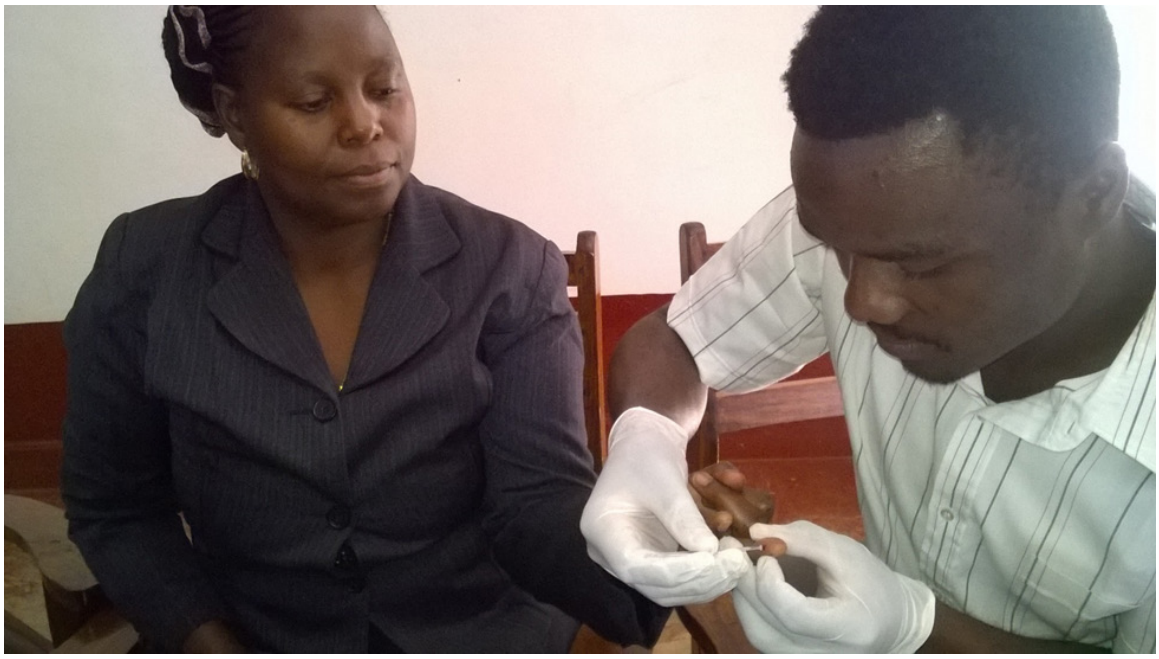
Greater impact of MCSP's efforts will manifest when these associations begin supporting health facilities in Ebonyi and Kogi States, as well.

"After the training, we now appreciate how much more we can do to improve maternal and newborn health in Nigeria. We are more confident and clear of how we can move things forward." – Mrs. Badu Abiodun, NANNM Program Manager

"MCSP's support has been of immense benefit to members of SOGON. It has provided a good platform to improve our organizational capacity. Our improved internal control and structural efficiency has placed us in a better position to be relevant in fulfilling our mandates as leaders in maternal and newborn health service delivery. MCSP has come at a right time." – Dr. Olusegun Adeoye, SOGON Program Manager

"It is rewarding as a trainer to see how the associations not only use the information shared, but build on how to include lessons learned for future projects." – Nikki Samson of GSK PULSE, who facilitated a training on basic project management

Enabling Frontline Health Care Providers to Detect and Prevent Malaria in Pregnancy in Tanzania



Above: Nurse Marwa Saliro draws blood from a fellow participant during MCSP's training on the malaria Rapid Diagnostic Test (mRDT) in Musoma, Tanzania. (Photo: Jasmine Chadewa/MCSP)

In a community hall in northern Tanzania, Marwa Saliro, a nurse from Murangi Health Center, reluctantly but gently pushed the lancet on the fourth finger of his first ever client, a fellow health care provider. He was trying for the first time to test malaria with the low-cost but highly effective malaria rapid diagnostic test (mRDT) approach.

Using a clean stick obtained from the testing kit, he collected a drop of blood and placed it on a small well on the test device. Following procedures from the reference guide, he applied four drops of the malaria test reagent into the square well of the test device. After 15 minutes, Marwa was ready to read the results: it was negative.

Every little step was an eye-opener to Marwa and to the other providers attending MCSP's malaria Rapid Diagnostic Test (mRDT) training for nurses and midwives in the Mara region. With funding from the President's Malaria Initiative through USAID, MCSP is working with the Tanzania Ministry of Health and Social Welfare to strengthen the skills and capacity of maternal and newborn health first responders. As a result, these responders—like Marwa—will be able to promptly diagnose and effectively treat malaria cases and maternal anemia.

The course combines classroom instruction and diagnostic skills, enabling providers who may not be laboratory technicians to get the hands-on experience needed to confidently perform the test for their clients. After the training, health care providers are also better equipped to: provide intermittent preventive treatment with sulfadoxine-pyrimethamine for pregnant women; promote the use of long-lasting insecticide-treated bed nets to their clients; and encourage pregnant women to attend antenatal care clinics at facilities.

"Before the training I thought my performance was fantastic while it was not," he said. "I didn't know if SP prophylaxis could be administered with iron and folic acid supplements to pregnant women. I didn't know that giving 5mg of folic acid couldn't concurrently be given with SP as it counteracts the effectiveness of SP."

Since the program began in 2014, MCSP has equipped more than 360 health care providers from supported facilities in Mara and Kagera regions with malaria in pregnancy skills. These providers, like Marwa, are now providing lifesaving malaria diagnostic and treatment and

malaria prevention services for pregnant women in the two regions.

SUCCESS STORY

Photo: MCSP Rwanda/Kelly Dale

NAME
Nsengiyunva Fabien

ROLE
Father

LOCATION
Gankeke, Rwanda

SUMMARY
A community member from Gankeke district came down with malaria and went to the local health center. Because of the Government of Rwanda's strategy for pre-elimination and MCSP's trainings and activities, the health care workers conducted case investigation, found and treated an entire family suffering from malaria.

In Rwanda, Pre-elimination Activities are Saving Lives from Malaria

Three miles and two mountains away from the Mataba Health Center lives a family whose remoteness proves just how far health care workers in Rwanda will go to find a malaria positive case.

Sitting in the dark on small wooden benches, with a cow mooing in the background and rain pounding on the roof, Nsengiyunva Fabien told the story of how Rwanda's national plan to eliminate malaria reached his isolated village and saved his family. As he spoke, the village community health worker, a nurse from the local health center, and MCSP staff listened attentively, delighted to hear that their work—which may be difficult, tiring, and often without reward—has so positively affected this man and his family.

In August 2015, Nsengiyunva Fabien was feverish, but because he did not have health insurance, he decided to self-medicate with drugs he bought at the pharmacy. His fever persisted. Eventually two of his children (ages 5 and 8), wife and a neighbor were experiencing fevers, as well.

When the neighbor went to the health center and was positively diagnosed with malaria and properly treated, the health center staff jumped into action. They began to track down any related cases and eliminate them.

Fortunately, this health center is located in an MCSP-supported district for malaria activities. To help them reach pre-elimination of malaria by 2017, MCSP is working in two of these epidemic-prone districts in coordination with the Malaria and other Parasitic Diseases Division (Mal&OPDD), the President's Malaria Initiative (PMI), and the Centers for Disease Control and Prevention (CDC).

Work includes implementing active community surveillance, case investigation, and epidemic response. MCSP also trains health center workers on how to actively detect and treat malaria cases, using rapid diagnostic tests (RDTs) for diagnosis when there are no lab technicians.

Nurses at these health centers are trained to conduct case contact follow-up: figuring out where the person with malaria lives; traveling there and meeting those who have come into contact with that person; screening them; and treating positive cases according to the country's guidelines. To date, MCSP has trained 87 health care providers from these districts on active surveillance strategies and the pre-elimination tools (notification form, investigation form, follow-up form, and malaria case surveillance algorithm).

"MCSP arrived at such an important moment. We used to see a lot of cases and, though they have decreased, we know that there are many more people who are sick and not coming. Now we investigate, find those cases, and reduce the morbidity of malaria in Rwanda." – Mataba Health Center Nurse

The trained health care workers from Mataba Health Center estimated that they see up to 20 cases a week. They work tirelessly—climbing mountains, braving rain storms, and navigating twisting rural roads—to find anyone who may have come in contact with a case. After locating Fabien and his family, for instance, the health care worker used RDTs to test them and, upon seeing the positive sign, immediately treated them free of charge.

He realized the essential role of the health center in finding his family and treating them as well as his neighbor. Today, he would not only go to the health center in case of any illness, but has become an advocate of their role in the community. He has enrolled in the district medical insurance and has told others to do the same.

"I was so happy and relieved after the health care worker visited. I felt the government and its partners are truly caring for me. All we really want here is continuous care." – Nsengiyunva Fabien

Rwanda Mal&OPDD is striving for pre-elimination, investing in partners like MCSP to work together to implement these strategies and train health care workers on their role in elimination. However, the goal of elimination will not be met without community buy-in, as demonstrated by Fabien and his neighbor.

By: Angelique Mugirente and Kelly Dale

Ethiopian Midwife Practices Respectful Maternity Care in Rural Health Center

Zerina's mother offers her a drink during labor while Saada observes the patient's status.

Twenty-year-old Zerina Ahmed was pregnant with her first baby when she arrived with labor pains to Karamile Health Center in Oromia Region, Ethiopia. The midwife on duty, Saada Ahmed, assessed her and informed Zerina that she was in active labor, and would deliver her baby in a few minutes.

In the delivery room, Saada asked Zerina if she would like a companion to be with her during the birth and in what position she would like to birth her baby. Accompanied by her mother—who offered her drinks, continuous reassurance, and back massages during labor—Zerina delivered a healthy baby girl.

Karamile Health Center is supported by the Integrated Family Health Program and MSCP, which aims to reduce maternal, child, and newborn morbidity and mortality in USAID intervention sites of Oromia, Amhara, Tigray, and Southern Nations, Nationalities, and Peoples' Region. The Program aims to increase availability and utilization of high-quality maternal and newborn health services.

Saada, 23, has been working at the health center since July 2014, after realizing her childhood dream of becoming a midwife. She is one of 48 midwives in East Hararghe zone who recently received training in Basic Emergency Obstetric and Newborn Care (BEmONC) from MCSP in collaboration with Oromia Regional Health Bureau.

Following the positive management of her labor and birth, Zerina expressed her satisfaction of the services she was provided: "I am very satisfied with the service I received in this facility from the beginning of my first visit. The midwife treated

me politely and allowed my mother to accompany me."

Zerina had decided to deliver at the health center after visiting the facility for the first time to attend her fourth antenatal care (ANC), at the referral of a health extension worker.

"My mother's presence reduced my stress significantly and made me feel comfortable during the labor," she added. "The midwife also called me by name and encouraged me to express my feelings and ask questions." Zerina was also happy with the coffee ceremony held in the health center to celebrate the occasion, a traditional community ritual when a woman gives birth.

Coffee ceremony in the postnatal room of Karamile Health Center.

Before the BEmONC training, Saada recalls caring for a woman whom she had helped have a normal delivery. When she went to check on her in the postnatal room, the woman was convulsing and unconscious.

"Initially, I panicked and I screamed for help," Saada said. "But nobody came and it was in the middle of the night. I thought it was a case of epilepsy at first and was not sure how to manage it. Then I sent the guard to call the health officer in charge and the senior midwife while I assessed the mother's vital signs."

When help arrived, Saada told them what had happened and they immediately started lifesaving management and administered magnesium sulfate (parenteral anticonvulsant) and hydralazine (antihypertensive) drugs to bring down her blood pressure. I realized this was a case of eclampsia. After a few minutes, the mother stopped convulsing and recovered.

However, after the BEmONC training, Saada now handles emergency obstetric and newborn cases alone. "I have gained the knowledge and skills and have developed confidence," she said proudly. "So far, I have successfully conducted three manual removals of placenta, two assisted vaginal deliveries using the vacuum, resuscitated four newborn babies, and administered the parenteral anticonvulsant magnesium sulfate for five mothers with eclampsia."

Midwives who participated in the BEmONC training have saved a number of mothers, said Bikila Bone, the Primary Health Care Unit Director of Karamile Health Center. This includes patients who have had obstetric complications during pregnancy, childbirth, and the postpartum period.

"This result is reflected in a significant drop of client referrals to a higher level facility and increased client satisfaction," Bone said, "and has significantly reduced the health officer's consultation time for obstetric and newborn complications. On top of that, the provision of respectful maternity care after the BEmONC training has increased institutional delivery by 21.45% from April–June 2015 compared to what it was January–March 2015," Bikila says.

SUCCESS STORY

Tanzania

Photo: MCSP/Marty Makinen

NAME
Council Health Management Team Members

ROLE
District Health Managers

LOCATION
Musoma Municipal Council and Butiama District Council, Mara Region, Tanzania

SUMMARY
Members of the council health management teams from Musoma and Butiama Districts in the Mara Region of Tanzania participated in a local health system mapping workshop to gain skills and information necessary to more effectively manage the health system and tailor interventions and solutions to their own health system challenges.

District Managers Empowered to Strengthen Health Systems and Prioritize Local Solutions in Tanzania

Local health system managers often face challenges ranging from data and information use, to commodities and supply chain management, to health care financing. In addition, they are increasingly responsible for coordinating services and resources in an environment where health system planning is often done in a top-down or unsystematic manner. To address these needs, MCSP developed the Comprehensive Approach to Health Systems Management at the global level to increase district managers' capacity to coordinate and orchestrate programs at the local level, identify gaps and bottlenecks, and problem solve using data.

In July 2015, MCSP facilitated a three-day local health systems mapping workshop for 18 members of Council Health Management Teams from Musoma Municipal Council and Butiama District Council in Mara Region, Tanzania. The workshop focused on building the district managers' capacity to choose and implement a comprehensive set of health systems interventions to address their local challenges.

MCSP facilitators guided the managers through an analysis of the strengths, weaknesses, and opportunities related to key health systems "assets." These assets represent a menu of options that district managers can draw on to accelerate and sustain improvements in the quality and coverage of health care for mothers and children.

For each of the categories, MCSP also provided additional information about existing materials and programs that managers could take advantage of to address their local needs. At the end of the discussion, managers from Musoma and Butiama developed tailored lists of opportunities, identifying those initiatives that will allow them to address their highest-priority challenges and maximize the value of national and donor programs.

Through the workshop, the district managers demonstrated greater ability to identify and prioritize local health systems strengthening needs, as well as increased knowledge and capacity to take advantage of existing tools, materials and programs to address their priority challenges. The response to the workshop was enthusiastic, with participants highlighting the value of learning a new approach to health systems management and the practical applications of the mapping and planning tools.

"The whole training was excellent. It gave us a chance to conduct SWOT analysis and plan for district health issues."

"[This information] will be useful for me in my planning activities for the health department."

– District health managers and workshop participants

They also commended the active and participatory nature of the workshop, and expressed enthusiasm about offering a model to other countries and contexts for sustainable, locally led health systems strengthening for reproductive, maternal, newborn, and child health. District managers in Butiama and Musoma are on their way to creating more sustainable health system solutions. They have taken the lead in prioritizing and orchestrating health system strengthening interventions tailored to the challenges they face every day.

by: Cara Sumi and April Williamson

SUCCESS STORY

UGANDA

Photo: Data collection team during training / MCSP

LOCATION

Iganga, Uganda

SUMMARY

Iganga, a rural district in Central Eastern Uganda, has a hard-to-reach population of more than half a million people. The district struggled with a weak routine immunization system evident in the district's high numbers of partially and unimmunized children. MCSP worked with Iganga using the Reaching Every Community/Child – Quality Improvement (REC-QI) approach to achieve a stronger Expanded Program on Immunization system. MCSP worked to build the capacity for health staff at all levels (regional, district, and health facility) through technical support and training. With reoriented focus and renewed effort, Iganga district embraced the REC-QI model, leveraged local resources, proposed innovative solutions, and addressed long-standing systemic challenges to routine immunization in the district.

Rural District of Uganda Makes Strides with Reaching Every Community/Child – Quality Improvement Approach

Iganga, a rural district in Central Eastern Uganda, has a hard-to-reach population of more than half a million people. The district has struggled with a weak routine immunization (RI) system, with a Reaching Every District (RED) category 4: high DPT1-3 drop-out rate, poor access (DPT1 <90%), and high numbers of partially and unimmunized children.

In 2012, Iganga created a partnership with USAID's predecessor flagship Maternal and Child Health Integrated Program (MCHIP) to identify and address RI system challenges. The partnership—which supported and collaborated with the Ministry of Health/UNEPI—worked from the district to the community level through community-driven solutions.

For the next several years, MCHIP and MCSP worked with Iganga District using the Reaching Every Community/Child – Quality Improvement (REC-QI) approach to achieve a stronger Expanded Program on Immunization (EPI) system by following three steps:

1. Orient;
2. Establish and strengthen; and
3. Sustain.

Activities included:

- Capacity building for health staff at all levels (regional, district, and health facility [HF]) through technical support and trainings, including: macro mapping of HF catchment areas; situation analysis; on-the-job and supportive supervision; data quality improvement; and QI techniques.
- Micro planning of RI services: macro and micro mapping of catchment areas.
- Linking services to communities through VHT orientation and regular health facilities quality work improvement team (QWIT) meetings.
- Regular QRMs with the DHT, HSD involving non-traditional stakeholders.

Achievements include:

- Improved district RI performance to Category 1, with DPT1-3 drop-out rate in normal range (0%–10%), improved from 18% in the baseline year.
- District and HFs empowered to micro plan for RI services, with macro and micro mapping of HF catchment areas for target populations as a prerequisite. HF catchment areas and target populations facilitated computation of other health service target populations, such as expected pregnancies per HF catchment area.

"A district empowered to think outside the box"

- Technically empowered district to use locally available resources to purchase 14 stand-by gas cylinders for EPI fridges, an activity described by the project as "a district empowered to think outside the box."
- There is more regular use of local data for action at district, HSD, and HF level, evidenced during quarterly review meetings to discuss data and apply lessons learned. Additionally, all HFs in the district offering RI services established QWIT with at least one non-traditional stakeholder (VHT or leader).
- Iganga team held technical exchange visit to Kabale district, which fostered peer-to-peer learning regarding health service improvement and system strengthening.

The experience in Iganga district proved that mapping of HF catchment areas helps to plan for RI and deepens knowledge and understanding of populations served by each HF, including improved performance of individual health facilities. Through analysis of RI data at the HF district level, it was realized that 33 of the 52 HFs in Iganga had poor access and utilization of RI services (RED category 4), and 19 HFs had good access but poor utilization of RI services (RED category 2).

Through mapping, it became possible to link previously hard-to-reach communities with RI services, and health workers improved relationships with the community. Meager resources were also used more effectively by targeting the HFs most in need—through peer-to-peer learning, and by sharing and leveraging local solutions and lessons learned by HFs in better performing HFs.

During the regular quarterly review meetings, gaps were identified and often bridged by local community leaders. The QI PDSA approach helped Iganga district to identify problems and use local resources as solutions, decreasing dependency on outside resources and empowering the district. With reoriented focus and renewed effort, Iganga district embraced the REC-QI model, evolved from the old RED approach, leveraged local resources, proposed innovative solutions, and addressed long-standing systemic challenges to RI in the district.

Photo: The district vice chairperson giving his remarks during the end of support sharing in Iganga District / MCSP

by: Sophie Dila

Annex Db: List of Success Stories, Blogs and Happenings

	Title	Link	Success Story/ Blog/Happening	Date	Country/ Region	Intervention Area(s)
1	Four Ways Addressing Gender Makes Maternal and Child Health Programs More Effective	http://bit.ly/1Pnskbb	Blog	9/28/2015	Global	Gender
2	Making the Sustainable Development Goals a Reality: Five Things We Need To Know	http://bit.ly/1M4EJgh	Blog	9/24/2015	Global	RMNCH
3	WHO Misoprostol Approval Means Lifesaving Treatment for Women in Low-resource Settings	http://bit.ly/1M4ELEW	Blog	9/8/2015	Global	Maternal Health
4	From launch to saving lives: what does it take to introduce new vaccines?	http://bit.ly/1OCxa4b	Blog	8/27/2015	Global	Immunization
5	In Kenya, Encouraging Breastfeeding at the Community Level is Saving Lives	http://bit.ly/1Irnfsw	Blog	8/4/2015	Kenya	Maternal/Newborn
6	Navigating the Turbulent Waters of Federal Compliance	http://bit.ly/1iSqktd	Blog	7/10/2015	Global	RMNCH
7	We are all in this together: Removing barriers to family planning access	http://bit.ly/1Gc4DIz	Blog	7/10/2015	Global	Family Planning
8	How to measure the quality of facility-based labor and delivery care in sub-Saharan Africa	http://bit.ly/1HGglNQ	Blog	7/6/2015	Global	Maternal Health
9	eLearning Improves Health Training Institutions in Ghana	http://bit.ly/1Y35wPu	Blog	7/1/2015	Ghana	mHealth
10	What women, girls and their partners want	http://bit.ly/1O4Suev	Blog	6/29/2015	Global	Family Planning
11	Top Five Reads and Resources: Maternal and Child Survival Program	http://bit.ly/1HGggd2	Blog	6/12/2015	Global	mHealth

	Title	Link	Success Story/ Blog/Happening	Date	Country/ Region	Intervention Area(s)
12	Advancing a No-Missed-Opportunities Approach Through Integrating Family Planning and Immunization Services	http://bit.ly/1HvTTfJ	Blog	7/10/2015	Liberia	Family Planning
13	Ready for Action: The WHO Expands Postpartum Family Planning, Increasing Chances for Maternal and Child Survival	http://bit.ly/1MJBY1e	Blog	6/2/2015	Global	Family Planning
14	MCSP on USAID blog: "Vaccinating Each Child to Build a Village"	http://bit.ly/1Pny5pe	Blog	4/28/2015	India	Immunization
15	Bringing Communities and Health Workers Together to Expand Immunization Coverage	http://bit.ly/1QgVFUT	Blog	4/23/2015	Global	Immunization
16	Investing in Integrated Health Services to Defeat Malaria	http://bit.ly/1HvTNoo	Blog	4/22/2015	Global	Malaria
17	Why are Junk Foods Considered "Essential Foods" for Egyptian Children?	http://bit.ly/1GVLphR	Blog	4/3/2015	Egypt	Nutrition
18	Addressing Malnutrition to Improve Maternal, Newborn & Child Health Outcomes	http://bit.ly/20L1Zrd	Blog	3/18/2015	Global	Nutrition
19	March 8th: Making the Status of Women and Girls a Priority	http://bit.ly/1OCGhlz	Blog	3/8/2015	Global	Gender
20	A Girl's Big Dreams Lead to a Midwifery Career in Pakistan	http://bit.ly/1PnxZhh	Blog	3/4/2015	Pakistan	Maternal Health
21	USAID Impact blog highlights MCSP work to save lives from Ebola	http://bit.ly/1MJBHvg	Blog	2/20/2015	Guinea	Ebola/IPC
22	MCSP on Global Moms Challenge - "Condoms: a practical history of prevention"	http://bit.ly/1L8Y8cb	Blog	2/13/2015	Global	Family Planning
23	MCSP on Gates: Saving Lives with Better Gestational Age Estimation	http://bit.ly/1NpZAIV	Blog	2/15/2015	Global	Maternal/Child

	Title	Link	Success Story/ Blog/Happening	Date	Country/ Region	Intervention Area(s)
24	USAID Features MCSP blog - "You Can't Save Lives if you Don't Fight Pneumonia"	http://bit.ly/1L8Y787	Blog	11/13/2014	Global	Immunization
25	mMentoring in Ghana: Innovative use of technology improves midwifery care	http://bit.ly/1MJBFUb	Blog	10/28/2014	Ghana	mHealth
26	Brief from the Antenatal Corticosteroids Technical Working Group	http://bit.ly/1QgVjNO	Blog	10/27/2014	Global	Maternal/Newborn
27	MCSP's Olivia Vélez Featured by Johns Hopkins in "Women of Digital Health" Series	http://bit.ly/1NIxv3Z	Success Story	7/27/2015	Global	mHealth
28	We Must Accelerate IPTp Uptake and Anemia Prevention to Save Mothers and Infants	http://bit.ly/1H3qXbi	Success Story	7/29/2015	Global	Malaria/Nutrition
29	Saving Women's Lives Means Involving Men	http://bit.ly/1LnA6iT	Success Story	6/16/2015	Global	Maternal Health
30	Helping Babies Survive & Thrive	http://bit.ly/1O2IMM2	Success Story	4/20/2015	Global	Newborn Health
31	Celebrating Midwives and the Communities They Support in the World's Newest Country	http://bit.ly/1IjoIKN	Success Story	5/6/2015	South Sudan	Maternal Health
32	Improving Facilities to Serve the Women Who Need Them	http://bit.ly/1WQek8Z	Success Story	5/6/2015	Tanzania	Maternal Health
33	File under good news: MCSP in 2015	http://bit.ly/1MmOoN3	Success Story	2/5/2015	Global	RMNCH
34	Introducing the Maternal and Child Survival Program	http://bit.ly/1Y34HWJ	Success Story	9/26/2014	Global	RMNCH
35	Preventing Needless Deaths and the Intergenerational Costs of Inaction	http://bit.ly/1MV7UpC	Success Story	9/27/2014	Global	RMNCH
36	Midwifery and Nursing Tutors in Ghana Schooled on Infection Prevention and Control	http://bit.ly/1Qt5kH8	Success Story	6/12/2015	Ghana	Ebola/IPC

	Title	Link	Success Story/ Blog/Happening	Date	Country/ Region	Intervention Area(s)
37	Thinking Outside the "Family Planning Box" to Ensure No Missed Opportunities	http://bit.ly/1SIDKeg	Success Story	6/12/2015	Global	Family Planning
38	ORB: A Groundbreaking, Online Global Library for Training Frontline Health Workers	http://bit.ly/1WQdVDm	Happening	6/1/2015	Global	mHealth
39	Delivering for Mothers and Newborns: Ending Preventable Maternal and Newborn Deaths	http://bit.ly/1M4KHO4	Happening	5/19/2015	Global	Maternal/Newborn
40	Video: Dr. Koki Agarwal on "Enhancing U.S. Engagement on Maternal and Child Health"	http://bit.ly/1GVKrlP	Happening	5/11/2015	Global	Maternal/Child
41	ENAP Progress Report, Strategies toward EPMM launch at 68th World Health Assembly	http://bit.ly/1M4KJ8F	Happening	5/10/2015	Global	Newborn Health
42	RBM partnership launches Global Call to Action for malaria during pregnancy	http://bit.ly/1Qt59LP	Happening	4/21/2015	Global	Malaria
43	Save the Date! Global Maternal Newborn Health Conference: October 2015	http://bit.ly/1NpZ7qa	Happening	12/20/2014	Global	Maternal/Newborn
44	Innovating for Impact: Acting to End Preventable Child and Maternal Deaths in the Post 2015 Era	http://bit.ly/1MJB3Og	Happening	9/26/2015	Global	Maternal/Child
45	Third Annual Regional Meeting of Priority Interventions for Newborn Health in LAC	http://bit.ly/1iSoZSU	Happening	9/26/2015	LAC	Newborn Health
46	USAID, Kiwanis Work to Eliminate Maternal & Newborn Tetanus	http://bit.ly/1NpZ25I	Happening	7/15/2015	Global	Maternal/Newborn

Annex E: Presentations at International Conferences

#	Month, Year	Name of Conference	Presenter(s)	Presentation or Poster	Technical Area
1	September 2015	2015 Integrated Nutrition Conference	Justine Kavle	Nutrition and Family Planning Integration: Developing programmatic approaches to addressing infant and young child feeding, lactational amenorrhea method, and postpartum family planning in east Africa	Nutrition
3	September 2015	CAFAM's HMO 1st National Primary Health Care conference	Goldy Mazia	HBS strategy and the work of the Alliance	Newborn Health
4	August 2015	Call to Action Summit 2015	Anna Bryant	CCMCentral: One-Stop Shop for Increasing Equitable Access for Child Health Services	Child Health
5	August 2015	Respiratory Therapists and Neonatal Nurses Conference	Goldy Mazia	Helping Babies Survive	Newborn Health
6	August 2015	Respiratory Therapists and Neonatal Nurses Conference	Goldy Mazia	The LAC Neonatal Alliance	Newborn Health
7	June 2015	American College of Nurse-Midwives Annual Meeting	Catherine Carr	Strengthening Midwifery in the Caribbean: Building the Caribbean Regional Midwives Association (note that will include three CRMA presenters)	Maternal Health, Newborn Health
8	June 2015	American College of Nurse-Midwives Annual Meeting	Lindsay Grenier	Helping mothers and babies survive: Threatened preterm birth care	Maternal Health
9	June 2015	Accelerating Access to Postpartum Family Planning – Global Meeting	Anne Pfitzer	Bundle of Love, Part 1: Integration on the Day of Birth (0–48 hours)	Family Planning
10	June 2015	Accelerating Access to Postpartum Family Planning – Global Meeting	Anne Pfitzer	If we do PPFP, let's measure it	Family Planning
11	June 2015	Accelerating Access to Postpartum Family Planning – Global Meeting	Mark Hathaway	Debunking menstruation requirements: Overcoming a critical barrier for PPFP	Family Planning
12	June 2015	Accelerating Access to Postpartum Family Planning – Global Meeting	Chelsea Cooper	The role of community health workers in delivering PPFP	Family Planning
13	June 2015	Accelerating Access to Postpartum Family Planning – Global Meeting	Anne Pfitzer	Monitoring and evaluation: Data, registers, record-keeping, health management information systems, major data sources, clinical governance	Family Planning

#	Month, Year	Name of Conference	Presenter(s)	Presentation or Poster	Technical Area
14	June 2015	Accelerating Access to Postpartum Family Planning – Global Meeting	Rebecca Fields	Do No Harm! Opportunities in Integrating Family Planning and Immunization Services	Immunization, Family Planning
15	June 2015	Accelerating Access to Postpartum Family Planning – Global Meeting	Rae Galloway	Bundling Counseling To Increase Uptake of Maternal, Infant, and Young Child Nutrition and Family Planning	Family Planning, Nutrition
16	June 2015	International Congress of Nursing	Stacie Stender	Infectious diseases: the battle continues	Immunization
17	June 2015	1mCHW Campaign's South-South Workshop	Serge Raharison	C3PO Tool: CHW Coverage and Capacity Planning for Outcomes	Child Health
18	June 2015	Protect, Innovate and Accelerate	Rebecca Fields	Promising Practices in Driving and Sustaining Demand	Immunization
19	May 2015	Family Planning and Immunization Integration Working Group	Rebecca Fields	Reducing Missed Opportunities for Immunization: Experience and Practical Implications	Immunization, Family Planning
20	May 2015	International Summit on Nutrition in Adolescent Girls and Young Women	Rae Galloway	Reaching Girls and Young Women in the Cultural Context	Nutrition
21	May 2015	PTB/LBW Global Technical Working Group	Lisa Noguchi	Planned MCSP operations research on gestational age estimation in Asia	Newborn Health, Maternal Health
22	April 2015	Johns Hopkins University Malaria in Pregnancy Symposium	Jane Coleman	Challenges in Implementing WHO's Updated Policy Recommendation on Use of IPTp	Malaria
23	April 2015	Johns Hopkins University Malaria in Pregnancy Symposium	Elaine Roman	Increasing MIP Coverage: What's Working!	Malaria
24	April 2015	CORE Group Spring Conference	Michael Pacque	Challenges and Successes in Diagnosis and Treatment of Malaria in the iCCM and IMCI Platforms	Child Health
25	April 2015	CORE Group Spring Conference	Jane Coleman, Rae Galloway, Michel Pacque, Lisa Noguchi	Malaria Control: Improving Health Outcomes for Mothers and Children	Malaria, Child Health
26	April 2015	CORE Group Spring Conference	Rae Galloway	Trends in Maternal and Child Anemia and Control	Nutrition
27	April 2015	CORE Group Spring Conference	Laura Raney	mHealth: Tools you can use	mHealth
28	April 2015	CORE Group Spring Conference	Dyness Kasungami	Improving the Quality and Scale of National Integrated Community Case Management (iCCM) Activities through Programmatic Harmonization	Child Health

#	Month, Year	Name of Conference	Presenter(s)	Presentation or Poster	Technical Area
29	April 2015	CORE Group Spring Conference	Emma Sacks	WHO Building Blocks for Health Systems Strengthening: Adding Communities to the Mix and Crosscutting themes in community engagement from USAID's child survival CSHGP FY14 cohort	Community Health/Civil Society Engagement
30	April 2015	CORE Group Spring Conference	David Shanklin, Eric Sarriott, Emma Sachs	WHO Building Blocks Platform for Health Systems Strengthening: Where are Communities?	Community Health/ Civil Society Engagement
31	April 2015	CORE Group Spring Conference	Emma Sachs, Melanie Morrow	Cross-cutting Themes in Community Health/Engagement from the CSHGP FY2014 Cohort	Community Health/Civil Society Engagement
32	April 2015	CORE Group Spring Conference	Lisa Noguchi	Maternal and Child Survival Program	Maternal Health, Newborn Health
33	April 2015	CORE Group Spring Conference	Lisa Noguchi	Prevention of Malaria in Pregnancy: Promoting IPTp-SP Early in the Second Trimester	Malaria, Maternal health
34	April 2015	CORE Group Spring Conference	Carolyn Moore	mPowering Frontline Health Workers Content Platform	mHealth
35	April 2015	CORE Group Spring Conference	Lisa Noguchi	Putting new guidelines into practice: challenges of early ANC attendance and IPTp-SP (Interactive Presentation and Discussion)	Maternal Health
36	April 2015	CORE Group Spring Conference	Jim Ricca	Implementation Research	Program Learning
37	March 2015	Intercountry Support Team for ESA and EPI Managers Meeting	Rebecca Fields	REC-QI Process	Immunization
38	March 2015	A Conversation About the Rising Global Midwifery Movement	Lisa Noguchi	Global Midwifery Initiatives: the Maternal and Child Survival Program	Maternal Health
39	March 2015	Global Health Mini University	Susheela Engelbrecht	Increasing Uptake and Correct Administration of Magnesium Sulfate for Management of Severe Preeclampsia and Eclampsia	Maternal Health, Newborn Health
40	March 2015	Global Health Mini University	Lindsay Grenier	Title: Treating Mom to Save Baby: Integrated Preterm Birth Management	Maternal Health, Newborn Health
41	March 2015	Global Health Mini University	Myra Betron	Gender analysis for maternal health programs	Gender
42	March 2015	Mobile World Congress	Olivia Velez	Design and Implementation of mHealth for LMICs	mHealth
43	February 2015	African Federation of Obstetrics and Gynecology Meeting	Jeffrey Smith	EPMM Strategies, ACS and Clinical Governance	Maternal Health

#	Month, Year	Name of Conference	Presenter(s)	Presentation or Poster	Technical Area
44	February 2015	14th World Congress on Public Health Conference	Rebecca Fields	REC-QI Process	Immunization
45	February 2015	World Federation of Public Health Associations Biannual Conference	Karen LeBan	Innovative approaches to achieve community-based primary health care outcomes	Community Health/ Civil Society Engagement
46	December 2014	mHealth Summit and Global mHealth Forum	Olivia Velez	mHealth ecosystem	mHealth
47	December 2014	Ouagadougou Partnership 4th Annual Meeting	Anne Pfitzer	Postpartum family planning	Family Planning
48	November 2014	WHO SEARO's Regional Meeting on Every Newborn Action Plan and Postnatal Care for mothers and newborns	Neena Khadka	Presentation: Helping Babies Breathe: a Brief Introduction	Newborn Health
49	November 2014	The Network – Toward Unity for Health Annual Conference 2014	Karen LeBan	Creating successful health partnerships between universities, NGOs and communities	Community Health/ Civil Society Engagement
50	November 2014	American Medical Informatics Symposium Annual Conference	Olivia Velez	Global Health Informatics	mHealth
51	November 2014	American Public Health Association Annual Meeting	Melanie Morrow	Collaborating with USAID to End Preventable Maternal and Child Deaths	Community Health/ Civil Society Engagement
52	November 2014	American Public Health Association Annual Meeting	Tanvi Monga	CHWs and Equity	Community Health/ Civil Society Engagement
53	November 2014	10th International Conference on Kangaroo Mother Care	Goldy Mazia	LAC experience and lessons learned regionally; disseminate experiences of the LAC KMC virtual community	Newborn Health
54	November 2014	10th International Conference on Kangaroo Mother Care	Neena Khadka	Key Note Speech Presentation: Kangaroo Mother Care an Epitome of Quality Loving Care	Newborn Health
55	September 2014	8th International Perinatology Meeting	Goldy Mazia	Newborn Health Priorities in Latin American and the Caribbean	Newborn Health

Annex Eb: List of Communications Events

#	Month, Year	Name of Event	Location	MCSP Activity	Co-Sponsors	Hyperlink
2	June 2015	(Re)Building health systems in West Africa: what role for ICT and mobile technologies?	Wilton Park, UK	Communications support (social media, messaging and event support) for *(Re)Building health systems in West Africa: what role for ICT and mobile technologies?*	mPowering	https://www.wiltonpark.org.uk/conference/wp1409/
3	May 2015	Integrating Maternal and Newborn Care: Strengthening the Continuum	Geneva, Switzerland	Communications support (social media, messaging and event support) for *Integrating Maternal and Newborn Care: Strengthening the Continuum*, an event held at the World Health Assembly.	UNFPA, EWEC, UNICEF, A Promise Renewed	http://www.mcsprogram.org/happenings/delivering-mothers-newborns-ending-preventable-maternal-newborn-deaths/
4	May 2015	Enhancing U.S. Engagement on Maternal and Child Health	Washington, DC, USA	Provided messaging and talking points, as well as social media coverage, for Koki Agarwal for her participation in a high-level event on Capitol Hill.	CSIS	http://www.mcsprogram.org/happenings/video-dr-koki-agarwal-enhancing-u-s-engagement-maternal-child-health/
5	May 2015	CORE Group Spring Meeting	Washington, DC, USA	MCSP Communications sponsored a resource table.		http://www.coregroup.org/meeting-reports-n/434-global-health-practitioner-conference-spring-2014-presentations
6	April 2015	Helping Babies Survive Asia Regional Workshop	Dhaka, Bangladesh	Communications support (social media, messaging and event support) for Helping Babies Survive Regional Workshop.	Save the Children Bangladesh	http://www.healthynewbornnetwork.org/event/helping-babies-survive-asia-regional-workshop
7	February 2015	Maternal Mortality Mapping Meeting	Washington, DC, USA	MCSP Communications provided event support, publications support and social media support.		N/A
8	December 2014	mWomen Breakfast at Global mHealth Forum	Washington, DC, USA	MCSP Communications provided event and social media support for mWomen breakfast at the Global mHealth Forum.	mPowering	http://mwomen.splashthat.com/

#	Month, Year	Name of Event	Location	MCSP Activity	Co-Sponsors	Hyperlink
9	November 2014	American Public Health Association Annual Meeting	New Orleans, Louisiana, USA	MCSP Communications co-sponsored a booth with USAID Global Health and provided social media coverage.	USAID Global Health	N/A
10	November 2014	Community Health Worker Forum	Washington, DC, USA	MCSP Communications provided event support, publications support and social media support.		http://www.scribd.com/doc/258651682/Summary-Report-of-the-Community-Health-Worker-Forum#scribd
11	October 2014	CORE Group Fall Meeting	Washington, DC, USA	MCSP Communications sponsored a resource table.	CORE Group	http://www.coregroup.org/meeting-reports-n/465-global-health-practitioner-conference-fall-2014-presentations

Annex F: List of Peer-Reviewed Manuscripts Published

#	Month, Year	Name of Article	Journal Name	Authors	Hyperlink	Technical Area
1	September 2014	Successful Proof of Concept of Family Planning and Immunization Integration in Liberia	Global Health Science and Practice	Cooper, Chelsea M; Fields, Rebecca; Mazzeo, Corinne I; Taylor, Nyapu; Pfitzer, Anne; Momolu, Mary; Jabbeh-Howe, Cuallau	http://1.usa.gov/1Q8OBbT	Immunization; Family Planning
2	December 2014	Monitoring coverage of fully immunized children	Vaccine	Tsega, Asnakew; Daniel, Fussum; Steinglass, Robert	http://www.sciencedirect.com/science/article/pii/S0264410X14014479	Immunization
3	December 2014	The future of routine immunization in the developing world: challenges and opportunities (Commentary)	Global Health Science and Practice	Shen, Angela K; Fields, Rebecca; McQuestion, Mike	http://1.usa.gov/1H3h3Kb	Immunization
4	January 2015	Uterotonic use immediately following birth: using a novel methodology to estimate population coverage in four countries	BMC Health Services Research	Ricca, Jim; Dwivedi, Vikas; Varallo, John; Singh, Gajendra; Pallipamula, Suranjeen Prasad; Amade, Nazir; de Luz Vaz, Maria; Bishanga, Dustan; Plotkin, Marya; Al-Makaleh, Bushra; Suhowatsky, Stephanie; Smith, Jeffrey Michael	http://1.usa.gov/1SmeDHQ	Maternal Health
5	March 2015	Engaging Communities With a Simple Tool to Help Increase Immunization Coverage	Global Health Science and Practice	Jain, Manish; Taneja, Gunjan; Amin, Ruhul; Steinglass, Robert; Favin, Michael	http://www.ghspjournal.org/content/3/1/117.full	Immunization
6	March 2015	The rise in stunting in relation to avian influenza and food consumption patterns in Lower Egypt in comparison to Upper Egypt: results from 2005 and 2008 DHS	BMC Public Health	Kavle, Justine; El-Zanaty, Fatma; Landry, Megan; Galloway, Rae	http://1.usa.gov/1M9Wfxq	Nutrition

#	Month, Year	Name of Article	Journal Name	Authors	Hyperlink	Technical Area
7	March 2015	Missed opportunities for family planning: an analysis of pregnancy risk and contraceptive method use among postpartum women in 21 low- and middle-income countries	Contraception	Moore, Zhuzhi; Pfitzer, Anne; Gubin, Rehana; Charurat, Elaine; Elliott, Leah; Croft, Trevor	http://1.usa.gov/1P7GNbd	Family Planning
8	March 2015	A causal loop analysis of the sustainability of integrated community case management in Rwanda	Social Science and Medicine	Sarriot, Eric; Morrow, Melanie; Langston, Anne; Weiss, Jennifer; Landegger, Justine; Tsuma, Laban	http://www.sciencedirect.com/science/article/pii/S0277795361500150 1	Community Health and Civil Society Engagement
9	March 2015	Neglected Value of Small Population-based Surveys: Comparison with Demographic and Health Survey Data	Journal of Health, Population and Nutrition	Langston, Anne C.; Prosnitz, Debra M.; Sarriot, Eric G.	http://1.usa.gov/1M9Ulge	MMEL
10	May 2015	Respectful maternal and newborn care: building a common agenda (Commentary)	BMC Reproductive Health	Sacks, Emma; Kinney, Mary	http://1.usa.gov/1NoGas6	Maternal Health; Newborn Health
11	June 2015	Institutionalizing early vaccination of newborns delivered at government health facilities: Experiences from India	International Journal of Medical Research and Review	Taneja, Gunjan; Mentey, Vijaya Kiran; Jain, Manish; Sagar, Karan Singh; Tripathi, Bhupendra; Favin, Michael; Steinglass, Robert	http://www.jsi.com/JSIInternet/Resources/publication/display.cfm?txtGeoArea=INTL&id=15755&thisSection=Resources	Immunization
12	June 2015	Development and Validation of an Index to Measure the Quality of Facility-Based Labor and Delivery Care Processes in Sub-Saharan Africa	PLOS ONE	Tripathi, Vandana; Stanton, Cynthia; Strobino, Donna; Bartlett, Linda	http://1.usa.gov/1RUCbm9	Maternal Health; Newborn Health

#	Month, Year	Name of Article	Journal Name	Authors	Hyperlink	Technical Area
13	June 2015	Transition from the Lactational Amenorrhea Method to other modern family planning methods in rural Bangladesh: Barrier analysis and implications for behavior change communication program intervention design	Evaluation and Program Planning	Kouyaté, Robin Anthony; Ahmed, Salahuddin; Haver, Jaime; McKaig, Catharine; Akter, Nargis; Nash-Mercado, Angela; Baqui, Abdullah	http://www.sciencedirect.com/science/article/pii/S0149718914001300X	Family Planning
14	June 2015	A facility birth can be the time to start family planning: Postpartum intrauterine device experiences from six countries	International Journal of Gynecology and Obstetrics	Pfitzer, Anne; Mackenzie, Devon; Blanchard, Holly; Hyjazi, Yolande; Kumar, Somesh; Kassa, Serawit Lisanework; Marinduque, Bernabe; GraceMateo, Marie; Mukarugwiro, Beata; Ngabo, Fidele; Zaeem, Shabana; Zafar, Zonobia; Smith, Jeffrey Michael	http://www.sciencedirect.com/science/article/pii/S0020729215001370X	Family Planning
15	June 2015	Oxytocin in Uniject Disposable Auto-Disable Injection System versus Standard Use for the Prevention of Postpartum Hemorrhage in Latin America and the Caribbean: A Cost-Effectiveness Analysis	PLOS ONE	Pichon-Riviere, Andrés; Glujovsky, Demián; Garay, Osvaldo Ulises; Augustovski, Federico; Ciapponi, Agustin; Serpa, Magdalena; Althabe, Fernando	http://1.usa.gov/1Q3BJ7K	Maternal Health
16	July 2015	Exploring why junk foods are 'essential' foods and how culturally tailored recommendations improved feeding in Egyptian children	Maternal and Child Nutrition	Kavle, Justine A.; Mehanna, Sohair; Saleh, Gulsen; Fouad, Mervat A.; Ramzy, Magda	http://1.usa.gov/1H3mYPw	Nutrition
17	August 2015	Facility-based active management of the third stage of labour: assessment of quality in six countries in sub-Saharan Africa	Bulletin of the World Health Organization	Bartlett, Linda; Cantor, David; Lynam, Pamela; Kaur, Gurpreet; Rawlins, Barbara; Ricca, Jim; Tripathi, Vandana; Rosen, Heather E.	http://1.usa.gov/1GK5WpN	Maternal Health

#	Month, Year	Name of Article	Journal Name	Authors	Hyperlink	Technical Area
18	August 2015	Implementation of the Every Newborn Action Plan: Progress and lessons learned	Seminars in Perinatology	Kinney, MV; Cocoman, O; Dickson, KE; Daelmans, B; Zaka, N; Rhoda, NR; Moxon, SG; Kak, L; Lawn, JE; Khadka, N; Darmstadt, GL	http://www.seminperinat.com/article/S0146-0005(15)00051-8/pdf	Newborn Health
19	September 2015	Count every newborn: a measurement improvement roadmap for coverage data	BMC Pregnancy and Childbirth	Moxon, Sarah G; Ruysen, Harriet; Kerber, Kate J; Amouzou, Agbessi; Fournier, Suzanne; Grove, John; Moran, Allisyn C; Vaz, Lara ME; Blencowe, Hannah; Conroy, Niall; Gülmezoglu, A Metin; Vogel, Joshua P; Rawlins, Barbara; Sayed, Rubayet; Hill, Kathleen; Vivio, Donna; Qazi, Shamim A; Sitrin, Deborah; Seale, Anna C; Wall, Steve; Jacobs, Troy; Peláez, Juan Gabriel Ruiz; Guenther, Tanya; Coffey, Patricia S; Dawson, Penny; Marchant, Tanya; Waiswa, Peter; Deorari, Ashok; Enweronu-Laryea, Christabel; El Arifeen, Shams; Lee, Anne CC; Mathai, Matthews; Lawn, Joy E	http://1.usa.gov/1WwDSgy	Newborn Health
20	September 2015	Kangaroo mother care: a multi-country analysis of health system bottlenecks and potential solutions	BMC Pregnancy and Childbirth	Vesel, Linda; Bergh, Anne-Marie; Kerber, Kate J; Valsangkar, Bina; Mazia, Goldy; Moxon, Sarah G; Blencowe, Hannah; Darmstadt, Gary L; de Graft Johnson, Joseph; Dickson, Kim E; Peláez, Juan Gabriel Ruiz; Ritter von Xylander, Severin; Lawn, Joy E	http://www.biomedcentral.com/content/pdf/1471-2393-15-S2-S5.pdf	Newborn Health
21	September 2015	The Effect of Integrating Family Planning with a Maternal and Newborn Health Program on Postpartum Contraceptive Use and Optimal Birth Spacing in Rural Bangladesh	Studies in Family Planning	Ahmed, Saifuddin; Ahmed, Salahuddin; McKaig, Catharine; Begum, Nazma Mungia, Jaime; Norton, Maureen; Baqui, Abdullah H.	http://onlinelibrary.wiley.com/doi/10.1111/j.1728-4465.2015.00031.x/abstract	Family Planning

#	Month, Year	Name of Article	Journal Name	Authors	Hyperlink	Technical Area
22	September 2015	Factors associated with early growth in Egyptian infants: implications for addressing the dual burden of malnutrition	Maternal and Child Nutrition	Kavle, Justine A.; Flax, Valerie L.; Abdelmegeid, Ali; Salah, Farouk; Hafez, Seham; Ramzy, Magda; Hamed, Doaa; Saleh, Gulsen; Galloway, Rae	http://onlinelibrary.wiley.com/doi/10.1111/mcn.12213/epdf	Nutrition

Annex G: List of Tools and Materials Developed

#	Month, Year	Publication Name	Hyperlink	Country/Region	Technical Area
1	September 2015	Feasibility Study of the Implementation of Integrated Community Case Management (iCCM) in Bondo: Leveraging Existing Systems	http://1.usa.gov/1LOjBLf	Kenya	Child
2	September 2015	WHO Recommendations for Prevention and Treatment of Maternal Peripartum Infections	http://1.usa.gov/1Q3tad0	Global	Maternal
3	September 2015	Strategies to Strengthen Community Maternal, Newborn and Child Health: Findings from a Cohort of Child Survival and Health Grants Ending in 2014	http://1.usa.gov/1NOKMWY	Global	CH/CSE
4	August 2015	WHO Recommendations on Interventions to Improve Preterm Birth Outcomes	http://1.usa.gov/1l6fLo1	Global	Maternal
5	August 2015	WHO recommendations for prevention and treatment of pre-eclampsia and eclampsia	http://1.usa.gov/1KWqp5E	Global	Maternal
6	August 2015	WHO recommendations on prevention and treatment of postpartum haemorrhage	http://1.usa.gov/1Pk7GHq	Global	Maternal
7	August 2015	WHO recommendations on active management of the third stage of labour	http://1.usa.gov/1Sm76c7	Global	Maternal
8	July 2015	Respectful Maternity Care Workshop: Meeting Report	http://1.usa.gov/1P9NFDm	Tanzania	Maternal
9	June 2015	Pathway of Opportunities for Postpartum Women to Adopt Family Planning	http://1.usa.gov/1Ollp1X	Global	Family Planning
10	May 2015	Integrating Maternal, Infant, and Young Child Nutrition and Family Planning Services in Bondo Sub-County, Kenya	http://1.usa.gov/1XMnG7X	Kenya	Nutrition/Family Planning
11	May 2015	Treatment of Uncomplicated Malaria Among Women of Reproductive Age	http://1.usa.gov/1NoXUDR	Global	Malaria
12	May 2015	Global Call to Action to scale-up coverage of intermittent preventive treatment of malaria in pregnancy: seminar report	http://1.usa.gov/1M9BlyH	Global	Malaria
13	May 2015	Global Call to Action: maximize the public health impact of intermittent preventive treatment of malaria in pregnancy in sub-Saharan Africa	http://1.usa.gov/1M9Aj5u	Africa	Malaria

#	Month, Year	Publication Name	Hyperlink	Country/Region	Technical Area
14	April 2015	Postnatal Care for Mothers and Newborns	http://1.usa.gov/1iATBs4	Global	Maternal
15	April 2015	Recommendations for Augmentation of Labour	http://1.usa.gov/1Olyvwa	Global	Maternal
16	April 2015	Helping Babies Breathe Country Case Study: Colombia	http://1.usa.gov/1k82qv9	Colombia	Newborn
17	April 2015	Helping Babies Breathe Country Case Study: Dominican Republic	http://1.usa.gov/1RsFykl	Dominican Republic	Newborn
18	April 2015	Moving Toward Viable, Integrated Community Health Platforms to Institutionalize Community Health in National Strategies to End Preventable Child and Maternal Deaths	http://1.usa.gov/1H3p0iz	Global	CH/CSE
19	April 2015	iCCM Central Postcard	http://1.usa.gov/1Y2NSeG	Global	Child
20	April 2015	Global Health Content for Local Solutions Consultations Synopsis	http://1.usa.gov/1PjvXx6	Global	mPowering
21	March 2015	Using Data Dashboards for Results-Based Management and Accountability	http://1.usa.gov/1KW8M5H	Global	MMEL
22	March 2015	Helping Babies Breathe Country Case Study: Colombia; Successful National Scale-Up Led by the Ministry of Health and Neonatology Association	http://1.usa.gov/1kppq8k	Colombia	Newborn
23	March 2015	Review of Monitoring of Malaria in Pregnancy through National Health Management Information Systems: Results from Six Countries in Sub-Saharan Africa	http://1.usa.gov/1NOP8xe	Africa	MMEL
24	February 2015	Maternal and Child Survival Start Up Report	http://1.usa.gov/1PneXb2	Global	N/A
25	February 2015	Factors Associated with Growth in the First Year of Life in Egyptian Children: Implications for the Double Burden of Malnutrition	http://1.usa.gov/1H3mYPw	Egypt	Nutrition
26	January 2015	Successful Practices to Increase Intermittent Preventive Treatment (IPTp) in Ghana	http://1.usa.gov/1OlqB5Q	Ghana	Malaria
27	December 2014	Case Studies of Large-Scale Community Health Worker Programs	http://1.usa.gov/1NoOBDN	Global	CH/CSE
28	November 2014	Summary Report of the Community Health Worker Forum	http://1.usa.gov/1M9MJul	Global	CH/CSE
29	November 2014	Developing and Strengthening Community Health Worker Programs at Scale	http://1.usa.gov/1Q8FsQB	Global	CH/CSE

#	Month, Year	Publication Name	Hyperlink	Country/Region	Technical Area
30	November 2014	A Review of the Maternal and Newborn Health Content of National Health Management Information Systems in 13 Countries in Sub-Saharan Africa and South Asia	http://1.usa.gov/1M9Qwl4	Africa	MMEL
31	2014	MCSP Technical Team Fact Sheets: Maternal, Newborn, WASH, Malaria, Child, CH/CSE, Nutrition, Reproductive, and Immunization (French and English)	N/A	Global	N/A
32	2014	Postpartum Family Planning Annotated Bibliography: 2008–2014	http://1.usa.gov/1NOStMH	Global	Family Planning

USAID
FROM THE AMERICAN PEOPLE

Maternal and Child Survival Program

MCSP YEAR ONE ANNUAL REPORT ADDENDUM

Reporting Period:
October 1, 2014 – September 30, 2015

Country Summaries and Results

January 2016

www.mcsprogram.org

Table of Contents

Addendum: Country Summaries and Results

This addendum includes a summary of country achievements supported primarily by field funds but also core funds. Country summaries appear alphabetically and are included for programs that were in start-up or full implementation mode during PY1. Country programs with workplans in development or which began at the end of the Program Year or right after are not included. Budget amounts refer to approved PY1 field funded-approved budgets; core funds have not been included, with the exception of Zambia.

- 27 country workplans were in start-up or full implementation mode in PY1 (Burma, Ethiopia BEmONC, Ethiopia CNBC, Ghana, Guinea Ebola 1, Guinea Ebola 2, Guinea MCH, Guinea Restoration, Haiti EPCMD, Haiti-North, Haiti SM, Kenya, Liberia, Madagascar, Malawi, Mali, Mozambique Bridge, Namibia, Nigeria MAMA, Nigeria MNH, Nigeria Polio, Nigeria RI, Rwanda EPCMD, Rwanda Malaria, Tanzania, Uganda, and Zambia).
- 9 new country workplans are in development or began at the end of the PY or right after and do not have country summaries included in this report. (Egypt, Democratic Republic of the Congo [DRC], Guinea Ebola Systems, Ghana IPC, India Family Planning, Laos, Nigeria Child Health, Mozambique EPCMD, South Africa.)

Burma Summary & Results

Kyaw Cho/Jhpiego

Strategic Objectives

- Create an enabling policy environment for the inclusion of maternal and newborn care best practices as part of the MOH National Strategic Plans and guidelines.
- Improve the quality and effectiveness of midwifery education, training, and clinical skills assessment.
- Develop capacity for midwifery strengthening.
- Increase and sustain the capacity of the Myanmar Nurses and Midwives Association (MNMA).
- Collaborate with the MOH to provide national technical assistance for malaria in pregnancy and integrated community case management (iCCM).

Program Dates	October 1, 2014–September 30 2016 (approved June 15, 2015)		
PY1 Approved Budget	[redacted] (*The Burma Workplan is for 2 years for a total budget of* [redacted]*; additional funding will be added in PY2*		
Geographic Focus Area	National (focuses on midwifery education and policy, plus iCCM assessment in PY1)		
Geographic Presence	**No. of states and regions (%)**	**No. of districts (%)**	**No. of facilities and/or communities (%)**
	N/A	N/A	N/A
Technical Interventions	PRIMARY: Child Health; Malaria; Maternal Health; Newborn Health OTHER: Midwifery Education; Policy		

Selected Programmatic Data	
Number of local partners whose capacity MCSP has built	1 (Myanmar Nurse and Midwife Association [MNMA])

Key Accomplishments

MCSP Burma carries forward the work that was accomplished under MCHIP, a 14-month program that provided national technical assistance for maternal and newborn health, with a special focus on strengthening midwifery. As part of MCSP start-up activities, the team met with the Deputy Minister at the Ministry of Health (MOH) to introduce the workplan. The meeting also served as an opportunity to solidify MCSP as a technical assistance partner for the MOH. Additionally, MCSP participated in the MOH-convened Reproductive Maternal and Child Health (RMNCH) Technical Strategic Group and engaged in constructive policy dialogues with the MOH and other partners. These meetings served as a platform for the discussion of MNH priorities and how best to support and complement other program approaches related to midwifery strengthening.

In May 2015, MSCP successfully organized "An International Day of the Midwife" event in collaboration with the Myanmar Nurse and Midwife Association (MNMA) and UNFPA. Hundreds of midwives attended the event and were recognized for their service. This motivational event increased public awareness of the importance of midwifery in MNH service delivery and promoted health-seeking behavior in the communities midwives serve.

An updated Nurse and Midwife Law, passed in the spring of 2015, spurred the interest of the Myanmar Nurse and Midwife Council (MNMC) and the MOH and inspired them to collaborate with MCSP to set up a skills and innovation lab in Rangoon. MNMC is currently drafting the bylaw and procedure law for approval which will determine the institutionalization activities such as competency-based registration and licensure and continuing professional education. The skills lab, which will be housed at MNMC, will be used for skills assessment during the registration and licensure process, and for training. One of the ultimate goals of the registration and licensure initiatives is to allow Burmese women who are trained in midwifery in the border region with Thailand to be licensed in Burma and then return to their home communities to practice.

MCSP worked closely with the Child Health Development Division to support the rollout of Helping Babies Breathe (HBB) in Burma in order to strengthen newborn care provided by midwives and other birth care providers. Multiple partners supported the MOH-led activity, including MCSP, Laerdal Global Health, and UNICEF. MCSP's activities included the facilitation of a HBB Master Training of Trainers (MTOT) in NayPyiTaw in July 2015 and a 2-day training with 150 district-level participants following the MTOT. Participants in the district training also developed their own cascade training plans. Following this activity, MCSP carried out a mapping of the status and coverage of the HBB training rollout. Subsequently, cascade training for HBB was carried out by the MOH/DOH, Community Development Associates, the Three Millennium Goal Development Fund (3MDG), and Save the Children.

Planning for the iCCM assessment began during PY1 and the assessment mission was scheduled for October 2015.

Way Forward

In the coming year, MCSP will draft and submit a revised workplan to incorporate an additional [redacted]. This will include a revision of current activities and proposal to add activities to reflect a shift in focus to a combination of midwifery regulation, in-service training, and continuing professional education. The updated workplan will complement other programs funded by 3MDG that will experience a reduction in funding, and will be shifted to focus on pre-service education. Together, the two workplans will address the spectrum of competency-based midwifery training from pre-service through regulation and into in-service training and continuing professional education. In the first half of PY2, procurement and set-up of the

Rangoon skills lab will be completed. Establishment of this skills lab will allow institutionalization of a competency-based approach to registration and licensure moving forward.

MCSP will also establish a kangaroo mother care (KMC) demonstration site to inform the introduction of KMC nationally. Data entry and analysis of the ANC observation will be completed, recommendations for improving MIP guidelines will be made, and a stakeholder meeting will be held to share study results and build consensus on service improvement recommendations. MCSP will continue to engage in MOH-led MNH policy forums and design and implement an expanded midwifery strengthening program.

Finally, the iCCM assessment will be completed and findings and recommendations shared to influence future USAID and MOH child health programming at the community level. MCSP expects to have a small role in follow-up to the assessment that will be defined as part of the PY2 workplanning process.

Egypt Summary & Results

MCSP

Strategic Objectives

- To identify and assess the strengths, weaknesses, gaps and opportunities of the Raedat Refiat community health worker program through a) strategic review of key documents and b) qualitative evaluation of the RR program
- To provide feasible and concrete recommendations to formulate a comprehensive CHW strategy in Egypt.

Program Dates	Phase I: April 2015 – December 2015 Phase II: January 2016 – April 2018		
PY1 Approved Budget	[redacted] (of [redacted] total to be obligated)		
Geographic Focus Area	National		
Geographic Presence	**No. of provinces (%)**	**No. of districts (%)**	**No. of facilities and/or communities (%)**
	N/A	N/A	N/A
Technical Interventions	 PRIMARY: Child Health; Community Health and Civil Society Engagement; Maternal Health; Newborn Health; Nutrition; Reproductive Health		

Selected Programmatic Data	
MCSP Global PMP Indicator	N/A – program implementation not yet begun.

Key Accomplishments

The following provides a summary of the key accomplishments of the assessment phase – or "Phase I" – of the MCSP Egypt project.

MCSP Assessment of Egypt's National Raedat Refiat / CHW Program

Egypt has made significant progress in the area of Maternal and Child Health (MCH), and is one of only nine countries to meet their Millennium Development Goals (MDGs) related to maternal and child mortality before 2015. However, more efforts are needed to sustain this progress and to protect it from backsliding. In addition, emergent health challenges are expected to have a negative effect on the health of Egyptian women, newborns and children. These include stunting – affecting more than one-fifth of Egyptian children – and obesity and overweight, affecting both children and women of reproductive age, alike.

The Raedat Refiat (RR) – or "village pioneer" – community health worker (CHW) program was established in 1994 under the Ministry of Population (MoP) to address the country's high fertility rate by seeking to increase demand for family planning services and to improve health behaviors among key populations. By 2012, RR represented a workforce of 14,280 permanent Ministry of Health and Population (MoHP) staff. Each RR is responsible for an average of 500 families and expected to conduct 160 home visits per month. The RR workforce is now part of the integrated family health strategy of Egypt, and as such its role has – in principle – expanded to address not only family planning but maternal and child health and nutrition (MCHN) as well.

The MoHP and USAID/Egypt requested MCSP to review and assess Egypt's Raedat Refiat CHW program. MCSP conducted the assessment from April – August 2015, and shared its findings and recommendations in November 2015 to national stakeholders, including Ministry of Health and Population, Ministry of Social Solidarity, World Bank, UNICEF, UNFPA, CSOs, and private sector representatives. Stakeholders engaged in rich discussion and supported all 11 MCSP recommendations to strengthen the RR program.

Assessment Conclusions

The assessment report concludes that RR program is a nationally owned and historic program for promoting preventive and primary care services within the community by expanding the outreach services of the MoHP. The RR are a strong human resource that is now fully integrated as staff of the MoHP. Over the years, the program has forged ties with women of reproductive age (WRA) and families in thousands of communities and primary health care unit (PHCU) catchment areas. This significant capacity and potential is not, however, optimally leveraged nor is it presently able to demonstrate desired results or impact.

Governance of the RR program from central to PHCU level is not aligned with the policy and goals. Coordination between Family Planning (FP) and MCH management is simply 'ad hoc' and quite often non-existent from district to national levels. Direct oversight of the RR does not allow for an integrated preventive health function and has the potential for conflicts. As a consequence, the RR program pays insufficient attention to MCH issues, in particular nutrition; this is observable at implementation level, unit supervision and oversight, district and governorate management and reporting to MoHP central levels.

Goals and objectives of the RR program are insufficiently defined, and most simply represented as a number of home visits to be carried out by day and by quarter, irrespective of the content of those visits, their duration, or effect. The MoHP has fundamentally not resolved how to govern the RR program or make it serve as an integrated family health strategy.

Units and districts have an unequal vision and understanding of what the RR can do for them resulting in their use when special funds and needs emerge. RR are encouraged to continue home visits with a focus on pregnancies and family planning, but they can also be distracted from community work by the pressing needs of facility managers in their units. This has led to public health and behavior change objectives being treated as addressable by a routine home visit. As such, there is no sign of larger thinking regarding determinants of change, use of social structures, involvement of men and community leaders, and/or participatory engagement of community groups.

The RR face decreasing incentives to work in communities, and increasing reasons to spend time in facilities. There is little motivation to expand work in communities beyond the contacts that they have already made or new referrals sent to them by the units. Between 5% and 15% of RR are considered 'inactive', i.e., not performing home visits or field activities. The strain of many years conducting home visits and the monotony of delivering the same messages to the same women likely encourages eschewing long days in the field, at least on occasion. It is likely that the number of women visited by RR, and the number of visits made per quarter do not reach the expected level.

In conclusion, the desired integration of the RR program under a unified family health strategy is for now only an intention and policy statement. Community outreach is an important component of the integrated family health strategy for Egypt. The assessment identified a number of issues concurring to limit the impact of the RR program.

MCSP Recommendations to Strengthen the Raedat Refiat / CHW Program

1. Confirm or reverse the strategic direction of the RR Program toward a full family health strategy.
2. Establish explicit strategic goals, objectives and performance management indicators.
3. Establish clear and recognized operational management and control of the RR program through a management unit at governorate level.
4. Provide practical and operational guidance to RR at governorate level, in order to more strategically balance their activities between home visits and community outreach, and mobilization and support of community groups for health promotion and social change
5. Establish, resource and implement a training strategy adapted to the ambitions of the RR program.
6. Make use of mobile technology in two directions:
   - Improve reporting and data flows in a more efficient and integrated information system upstream to district Hospital Information Systems (HIS) and governorate levels and then on to MoHP sectors allowing information feedback to PHCUs and RR themselves.
   - Support health promotional activities, deliver content, provide electronic job aids and decision guides.
7. Improve the RR and community health promotion information system.
8. Involve communities in setting and achieving health objectives for the RR program through systematic engagement of local leaders and organizations as partners.
9. Start planning for a future with RR career advancement opportunities.
10. Improve the RR motivation and incentive system.
11. Cost these recommendations and options to move the RR program forward in the next five to ten years.

Way Forward

In Phase II of the Egypt project, MCSP will implement activities in support of selected recommendations identified during Phase I. A work plan will be developed in Q2 and activities in country will begin in Q3.

Ethiopia Summary & Results—Community-Based Newborn Care (CBNC)

Sara Bates/Save the Children

Strategic Objectives

- Improved community maternal and newborn health practices and care-seeking behaviors
- Increased provision of high-impact, quality newborn care services in the community
- Strengthened supportive systems for provision of newborn health care

Program Dates	July 2014–September 2015 (approved December 15, 2014)		
PY1 Approved Budget	[redacted]		
Geographic Focus Area	12 zones and 2 special woredas (total 135 woredas) in Amhara, Oromia, the Southern Nations Nationalities and Peoples' Region (SNNPR), and Tigray Regional States		
Geographic Presence	**No. of provinces (regions)**	**No. of districts (woredas)**	**No. of facilities and/or communities**
	4 of 11 regions (36%) (Total population of covered regions: 63,732,046)	135 of 973 woredas (14%) (Total population of covered districts: 17,088,101)	730 health centers, 3594 health posts
Technical Interventions	PRIMARY: Newborn Health, Community Health OTHER: Maternal Health, Child Health		

Selected Programmatic Data	
Number of people trained through MCSP (field funding)	Newborn Health: 7,261 (1,379 nurses, 5,882 health extension workers) M&E (routine data collection and DHIS2 orientation): 22
Number of MCSP-supported health facilities actively implementing a quality improvement approach, by type of facility	3,594 health posts 730 health centers
Number of target districts with regular feedback mechanisms to share information on progress toward health targets to community members and CSOs	135

Key Accomplishments

The goal of the MCSP Ethiopia Community-Based Newborn Care program—known locally as "Newborns in Ethiopia Gaining Attention," or NEGA[1]—is to contribute to the reduction of neonatal morbidity and mortality in Ethiopia through capacity-building to provide high-impact services both at the community and PHCU levels in four regions. MCSP NEGA's activities support the Federal Ministry of Health's (FMOH's) efforts to scale up these services through demand creation, universal provision of high-quality, high-impact services, and strengthened support systems. In Year 1, MCSP NEGA focused on introducing management of possible serious bacterial infections (PSBI) at the health post/community level when referral is not possible or acceptable to families. The majority of activities were thus focused on training and supporting health workers within the health system to initiate PSBI management. Alongside service delivery activities, Year I also focused on initiating interventions to improve communities' knowledge of newborn danger signs and to encourage early care-seeking. MCSP NEGA also conducted a baseline survey at community level in all project regions. In addition to service coverage, the survey assessed existing perceptions and practices of the communities where the project will work.

Initiated Community Based Newborn Care (CBNC) in all project woredas

In Year 1, MCSP NEGA successfully rolled out CBNC in all 12 project zones and 135 woredas. This was done through 310 sessions, which included training:

- 477 health workers (representing 111% of the target) selected from zones, woredas, and health centers as trainers (trained in intensive cascade/TOT sessions). MCSP trained significantly more trainers in Tigray than planned due to the regional health bureau's priority placed on training a trainer from each of the health centers in the target zones. It is envisioned that this investment will contribute to improved knowledge transfer and ongoing support from TOT-trained supervisors to health center staff.
- 1,440 health workers from health centers (72% of the target)
- 5,882 Health Extension Workers (HEWs) from health posts (87% of the target)[2]

The trainings were based on the national CBNC training materials and were aligned with the national CBNC implementation plan. In all sessions, MCSP NEGA assured training quality by maintaining a minimum trainer-to-trainee ratio of 1:5, providing individualized support to trainees, and ensuring practical attachment to health facilities. Based on drug stock-out and refill experiences learned from CBNC Phase I implementation sites, MCSP NEGA successfully integrated a half-day training on Integrated Pharmaceutical and Logistics System (IPLS) in all of the CBNC training sessions. At the end of each session, HEWs were given essential CBNC supplies in the form of a "starter kit," adequate to cover their needs for at least 6 months. As part of the training, post-training follow-up (PTFU) visits were done to 1,790 health posts (61% of eligible health posts) within an average of 8 weeks after the training, to provide on-the-job support to HEWs and build their confidence to manage neonatal health. As a result of the training and PTFUs, a total of 3,332 health posts (92% of the target) initiated CBNC, including the management of PSBI as per the national protocol.

Integrated demand creation and SBCC into national training for health workers and HEWs

[1] *Nega* is also an Amharic word meaning "It turned into dawn." The program has been named as such to signify that newborn health, which some feel has been overlooked in the process of addressing overall child mortality in Ethiopia, is receiving increased attention at the moment.

[2] The remaining HEWs were not trained due to their not being available at their posts (because of maternity leave, school attendance, or because they had left the post), or the few woredas in 1 of the zones with ongoing training at the moment.

Given the need to develop a simple and scalable SBCC strategy to address the deep-rooted cultural and traditional barriers around seclusion of newborns in the early weeks and months of life, MCSP NEGA adapted a demand creation (DC) strategy that was developed by the Saving Newborn Lives project in collaboration with the FMOH. MCSP NEGA successfully introduced the DC training to health workers and HEWs as part of the national CBNC training. MCSP developed the content for an initial training session and supported the translation of the strategy into local languages to facilitate understanding at the primary health care unit (PHCU) level. Subsequently, the project trained 372 health workers as trainers and 5,882 HEWs in DC/SBCC across all of the project's target zones and woredas. The trained health workers and HEWs have since started rolling out elements of the DC strategy: as an initial step, they facilitated orientation sessions with woreda cabinet members (2,191 individuals were reached, of whom 500 were women) to familiarize members with the DC strategy and gain their buy-in and support. Rollout at the kebele level is based on a simplified Community Action Cycle (CAC) model, which aims to help communities identify behaviors and practices that negatively impact MNH outcomes and design local plans to address them. Because demand creation has not previously been a focus of health interventions, let alone at scale, checklists and tools are being developed to facilitate ongoing mentoring of health workers and effective activity monitoring.

Developed a learning agenda

CBNC is a new, high-impact intervention for Ethiopia implemented at scale, and has been designed to allow adjustments along the way, based on lessons learned from implementation. To contribute to this national effort, MCSP NEGA developed a learning agenda in consultation with key partners, including the FMOH and the Ethiopian Public Health Institute (the organization that is mandated to guide and coordinate health research in the country). In addition to ongoing systematic documentation, MCSP NEGA identified key implementation research topics for the project period:

- Barriers to and facilitators of early pregnancy identification, birth notification, ANC, PNC;
- Assessment of community-based care for low birth weight/premature newborns; and
- Assessment of caretakers' compliance with referrals for newborns with PSBI.

The findings from these studies are expected to fill knowledge gaps in Ethiopia and to support the continuous improvement of CBNC by revising the national CBNC Implementation Plan.

Way Forward

In Year 2, MCSP NEGA will continue to support the institutionalization of CBNC within the national health system, focusing on both the supply and demand sides. This will entail:

- Ongoing capacity-building for health managers through joint facility supportive supervision and gap-filling trainings, as well as strengthening of use of data for decision-making;
- Mentoring trained health workers and HEWs through structured supportive supervision visits and review meetings;
- Creating a pool of trainers at zonal level, within regional health science colleges and technical vocational training centers, to ensure that new health workers and HEWs are trained in CBNC before deployment; and
- Rolling out the DC/SBCC activities to kebele level using the existing government structure (Kebele Command Posts).

Finally, given the large number of low birth weight and premature babies born at health centers in the project area, MCSP NEGA will also focus on strengthening health centers' capacity to properly manage newborn asphyxia and low birth weight/premature babies as per the national protocol.

Ethiopia Summary & Results—Strengthening BEmONC

MCSP

Strategic Objectives

- Improved capacity of health facilities and skilled birth attendants to provide high-quality MNH services
- Improved Primary Health Care Unit (PHCU) linkages and community-level MNH practices
- Increased access to postpartum family planning (PPFP) and strengthened service provision
- Enhanced capacity to develop national operations research and program learning agenda for MNH, and MCSP-specific operations research designed and conducted

Dates	September 1, 2014–September 30 2015 (approved March 18, 2015)		
PY1 Approved Budget	[redacted]		
Geographic Focus Area	National-level: FMOH; Regional-level: Addis Ababa, Amhara, Oromia, SNNPR, and Tigray Regions; District-level: 56 districts		
Geographic Presence	**No. of regions (%)**	**No. of zones (%)**	**No. of facilities (%)**
	5/11(45%)	56/971 (6%)	136 (18 hospitals and 118 health centers) 4%
Technical Interventions	PRIMARY: Maternal Health; Newborn Health; Reproductive Health		

Selected Programmatic Data	
Number of MCSP-supported health facilities actively implementing a quality improvement approach by type of approach	22 health centers
Women who delivered at MCSP-supported health facilities who accepted a method of FP prior to discharge (PPIUCD)	498 (13%)
Service delivery points that expanded the types of contraceptive methods available with MCSP support (PPIUCD)	18
Number of women receiving a prophylactic uterotonic in the third stage of labor (immediately after birth)	3,100 (81% from total number of women giving birth)
Number of babies not breathing/crying at birth born in MCSP-supported areas who were successfully resuscitated	72
Number of people trained with MCSP support	229 (174 BEmONC, 38 PPIUCD, and 17 IP)

Key Accomplishments

MCSP continues work that started under MCHIP to improve the quality of care for mothers and newborns in Ethiopia's health facilities. Under the guidance of USAID, MCSP's BEmONC and Community-Based Newborn Care (CBNC) programs signed a terms of reference with USAID's Integrated Family Health Program (IFHP) to facilitate coordination and smooth implementation of project activities in collaborative geographic sites. The BEmONC project also jointly introduced the collaborative activities to the Amhara, Oromia, SNNP, and Tigray Regional Health Bureaus. This support was welcomed by government counterparts.

In PY1, MCSP provided BEmONC trainings for 158 health care workers from IFHP-supported sites in Amhara, Oromia, and SNNP regions. This training helped providers improve the quality of MNH services in 136 IFHP-supported health centers. MCSP also provided onsite supportive supervision visits for trained providers to strengthen the implementation of BEmONC and transferred over the support of those facilities to respective woredas and IFHP after 3 months of post-training follow-up.

MCSP also worked to improve MNH services in 22 health facilities in Amhara, Oromia, and SNNP with comprehensive MNH support, which included BEmONC and quality improvement (QI). MCSP introduced the newly adapted National MNH Quality Improvement Assessment Tool to these health centers to improve provider performance and facility preparedness for quality maternal and newborn care. The new assessment tool has been adapted for the PHCU level from the hospital-level tool; development of the tool was led by the FMOH, supported by partners including MCSP. From these 22 facilities, MCSP also trained 15 health care providers on BEmONC skills based on the gaps identified. During the subsequent supportive supervision, it was noted that the number of facilities that are now providing all 7 of the BEmONC signal functions increased by 27% compared to the baseline assessment findings. Overall, in the past 6 months, there was a marked improvement in these facilities in the provision of parenteral uterotonics to women as part of active management of the third stage of labor, administration of parenteral antibiotic, assisted vaginal delivery (with a vacuum extractor), and parenteral anticonvulsant to manage PE/E (MgSO4).

The project also strengthened PPIUD service delivery in 18 facilities (support that was initiated under MCHIP), through training and supportive supervision. For this effort, an additional 17 health care providers were trained on PPFP counseling and PPIUCD insertion to strengthen existing services. PPIUCD program orientation was conducted at the facility level for service providers and facility managers to ensure that they retain their skills to deliver quality PPFP-PPIUCD services and that health facility management is providing the full range of support. Overall, a total of 3,582 mothers were counseled on all methods of FP at ANC clinics and during the latent phase of labor; of these women, 498 were provided with PPIUCD insertion and 8 accepted the lactational amenorrhea method (LAM) as a short-term FP method. Among the women provided with PPIUCD, 70 came for first follow-up and 1 expulsion was reported.

In support of the GoE's effort to institutionalize and scale up PPIUCD services, MCSP provided technical and financial support to train 22 service providers through a PPIUCD TOT course. MCSP also supported the standardization of the national PPIUCD training package.

At the national level, MCSP continued to support FMOH efforts to improve the MNH, FP, and QI initiatives. MCSP provided technical support to the FMOH in the development of the National Reproductive Health Strategy for the period 2016–2020. As noted above, MCSP has been working closely with the FMOH to support national QI initiatives. Upon request of the State Minster of Health, MCSP hired a Senior QI Advisor, to be seconded to the Medical Services Directorate (MSD), to support the National QI Strategy and the development of various QI tools. The project actively participated in the review and finalization of the National Hospital MNH QI

Assessment Tool and adapted the tool to PHCU (health center)-level MNH services. This tool is now being piloted in 22 MCSP-supported health centers.

Using MCSP core funds, the project discussed with the FMOH and FP partners the design and testing of a comprehensive PPFP model in Ethiopia that will help reduce missed opportunities to initiate a method of contraception before fertility returns. The comprehensive PPFP program will help promote healthy timing and spacing of pregnancies and contraceptive options for women across the continuum of care and levels of the health system and foster the integration of FP at all service outlets and levels of maternal, newborn, and child health (MNCH) services.

The project continued supporting the FMOH's leadership of the MNH research agenda at different levels, including recruitment of a Research Advisor to assist the FMOH, and the Ethiopian Public Health Institute to formulate and develop a National MNH Research Agenda.

MCSP's own program learning agenda focuses on testing MNH innovations introduced by the project. The project has submitted research protocols to USAID and Johns Hopkins University (JHU) for testing the effectiveness of a blended approach for BEmONC training, acceptability of uterine balloon tamponade (UBT), active audit and feedback for the management of severe PE/E, prevalence of RMC, and feasibility of a continuum and integrated FP in the 2-year postpartum period. As part of its implementation research plan, MCSP conducted a training workshop for 20 MNCH technical staff and a UBT training for BEmONC trainers. New evidence on use of antenatal corticosteroids and subsequent WHO recommendations were presented to the Safe Motherhood Technical Working Group (TWG) at the FMOH.

Way Forward

In PY2, MCSP will scale up the facility-level support initiated in PY1 to 22 additional facilities for MNH and FP. This includes ensuring improved quality of care, scaling up high-impact interventions such as BEmONC, increasing promotion of facility-based births through support to the PHCU referrals and linkages, and increasing PPIUCD access. The project will continue to introduce high-impact MNH interventions, such as UBT, in selected facilities and evaluate feasibility and effectiveness in the Ethiopian context. At the national level, MCSP will continue to play a key role in providing guidance and advice to the FMOH, particularly in the national quality improvement efforts in MNH, and assist the FMOH to advance a national priority research agenda on MNH. MCSP will also support the FMOH to ensure enhanced access to PPFP and contraceptive options, including revising the policy and training guidelines for FP as per the new WHO-recommended Medical Eligibility Criteria (MEC).

Ghana Summary & Results

Karen Kasmauski/MCSP

Strategic Objectives

- There is a better prepared midwifery and nursing workforce that is equipped with the knowledge and skills to effectively provide HIV, malaria, nutrition, family planning, and maternal, newborn, and child health services.
- The national Community-based Health Planning and Services (CHPS) strategy, guidelines, training materials, tools, and monitoring systems are standardized and approved.
- USAID/MCSP-supported regions and districts have strengthened management and support systems to implement CHPS according to updated and harmonized policy and guidelines and provide high-quality HIV, malaria, family planning, nutrition, and maternal, newborn, and child health services.

Program Dates	August 1, 2014–September 30, 2015 (approved February 18, 2015)		
PY1 Approved Budget	[redacted]		
Geographic Focus Area	National and Regional Objective 1 (pre-service education): Upper East, Upper West, Ashanti, Brong Ahafo, and Eastern, Volta, Western, Greater Accra, Northern, and Central Objective 2 (CHPS): Upper East, Upper West, Ashanti, Brong Ahafo, and Eastern		
Geographic Presence	**No. of regions (%)**	**No. of districts (%)**	**No. of facilities and/or communities (%)**
	10/10 for pre-service education (100%) 5/10 for CHPS (50%)	Pre-service education: 12/107 (11%) CHPS Zones: 107/107 (100%)	CHPS: 2,119 CHPS zones (52% of all CHPS in Ghana)
Technical Interventions	PRIMARY: Child Health; Community Health and Civil Society Engagement; Malaria; Maternal Health; Newborn Health; Nutrition; Reproductive Health; Water, Sanitation, and Hygiene OTHER: HIV; eLearning; Health Systems Strengthening		

Selected Programmatic Data	
MCSP Global PMP Indicator	Data not available at the close of PY1

Key Accomplishments

MCSP continues the pre-service nursing and midwifery education effort started under MCHIP and in PY1 has added strengthening and rollout of the new national CHPS policy to its work. In PY1, MCSP supported improvement of pre-service education (PSE) and Ghana's CHPS program. For PSE, MCSP conducted an eLearning readiness and skills lab assessment at 11 community health nursing (CHN) schools. Based on the results from this assessment and the midwifery school assessments undertaken under MCHIP, MCSP and the MOH selected the 10 midwifery and 2 CHN schools for Year 1 and equipped their skills labs. In addition, MCSP developed 4 eLearning modules (exclusive breastfeeding, cord care, prevention of mother to child transmission of HIV [PMTCT], and gender-based violence), and is working to establish an electronic malaria game (Android application). MCSP also developed an electronic supervision checklist for the National Midwifery Council and reviewed and provided input into the revision of the midwifery and CHN curricula. MCSP also received proposals from 6 pilot midwifery schools to enhance preceptorship.

For CHPS, MCSP convened the CHPS National Best Practices Seminar, which brought together 136 participants from all regions to discuss implementation realities and challenges as well as share regional differences in implementing CHPS across the country. The seminar resulted in the decision to develop the national CHPS technical working group, which is scheduled to hold its first meeting in Quarter 1 of Year 2.

MCSP also finalized the regional data collection for the CHPS costing exercise methodology. Findings based on the data will inform the CHPS costing tool and dashboard. A preliminary draft of the tool will be available in Year 2, Q1. In addition, MCSP supported Ghana Health Services (GHS) Policy, Planning, Monitoring & Evaluation to develop a draft CHPS webpage and content and drafted the CHPS costing tool to be used during data collection and analysis. MCSP, under guidance from GHS, is supporting the GHS national and regional integrated planning meetings with a strong focus on CHPS implementation. Three of the 5 regions (Eastern, Upper East, and Upper West) were finished in Year 1.

Way Forward

For PSE, MCSP will continue to scale up implementation of the skills labs at 10 midwifery and 5 CHN schools and the eLearning module content development and dissemination. Fixed amount awards (FAAs) to 6 pilot midwifery schools will be implemented to improve preceptorship practices. MCSP is also conducting a task analysis of CHNs, which will then inform their scope of practice, PSE curriculum, and in-service training priorities.

For CHPS, MCSP is finalizing the costing of the CHPS services, and will develop a performance table to track targets. In addition, MCSP, at the request of GHS Policy, Planning, Monitoring & Evaluation, is supporting the regions' internal planning process and will provide FAAs coupled with MCSP technical assistance to each of the regions to implement best practices, and MCSP will hold another annual national best practices seminar to share lessons learned.

Guinea Summary & Results—Ebola IPC 1

Jacqueline Aribot/MCSP

Strategic Objectives

- **Prevention at facilities:** Support health care workers and facilities to offer safe and high-quality health services by strengthening infection prevention and control (IPC) practices through training, supportive supervision, and complementary monitoring and evaluation.
- **Prevention within communities:** Support communities and their local leaders to combat disease transmission through improved contact tracing and intensified social mobilization.

Program Dates	November 17, 2014–August 16, 2015 (approved December 15, 2014)		
PY1 Approved Budget	[redacted]		
Geographic Focus Area	5 communes of Conakry and 3 rural prefectures—Beyla, Kissidougou, and Forekariah		
Geographic Presence	**No. of regions (%)**	**No. of prefectures (%)**	**No. of facilities and/or communities (%)**
	4/8 (50%)	8/38 (21%)	55/461 (12)
Technical Interventions	PRIMARY: Community Health and Civil Society Engagement; OTHER: Ebola Response – Infection Prevention and Control		

Selected Programmatic Data	
Number/percentage of staff in health facility who receive IPC training	2,985 (100%)
Number/proportion of health facilities that have appropriate (and sufficient quantity of) personal protective equipment (PPE) for at least 1 month	Availability of PPE improved from 35% (Q2) to 48% to 57% (Q4) among the 52 facilities (excluding university hospitals) Availability of PPE improved from 23% (Q1), 25% (Q2) to 62% (Q4) among the 67 services within the three university hospitals,

Selected Programmatic Data	
Number/proportion of health facilities that have access to disinfecting agents (and sufficient quantity for at least 1 month)	Availability of disinfecting agents at 52 health facilities (excluding the three university hospitals) improved from 47% (Q2) to 52% (Q3) to 63% (Q4) Availability of disinfecting agents fluctuated at three university hospitals from 57%(Q2) to 90% (Q3) to 23% (Q4).

Note: MCSP was requested to monitor the indicators on availability of supplies for IPC, but was not directly involved in their provision beyond an initial stock provided to focus facilities following training.

Key Accomplishments

2014 was marked by the arrival and rapid advance of the Ebola Virus Disease (EVD) in Guinea and in neighboring Liberia and Sierra Leone. The Ebola-affected countries were already strained by the high prevalence of diseases such as malaria, cholera, pneumonia, and HIV/AIDS, and further burdened by human resources shortages, inadequate health care facilities, and stock-outs of essential commodities. These countries were struggling to manage the Ebola outbreak, including retaining focus on the critical IPC interventions necessary to limit transmission and manage the exponentially growing patient loads, and also maintain access to routine health care services such as delivery care, management of sick children, and treatment of malaria. To support the Ebola response in Guinea, MCSP was requested to focus on IPC, building on the USAID investment under MCHIP which reinforced IPC as part of all reproductive, maternal, newborn, and child health services and developed a pool of national trainers.

To initiate large-scale training of health care workers, MCSP started the project with an IPC update for 27 trainers who were previously trained as trainers under MCHIP (2010–2014). In February 2015, 23 new candidate trainers were selected from among providers who had completed the IPC training and demonstrated initiative in improving IPC. This group was trained in Clinical Training Skills, resulting in a total of 50 qualified IPC trainers to support the MOH and the National Ebola Response Coordination's response to EVD. These trainers were then able to provide training to 2,985 providers in 121 5-day training sessions from December 2014 to March 2015, targeting all health care personnel working in 55 health facilities located in some of the areas hardest hit by the EVD epidemic. Within a month of training, consultant trainers conducted post-training follow-up visits to review implementation of IPC practices and assist staff to address challenges. In each prefecture, 6 to 8 coaches were identified among well-performing providers so that they could further support the implementation of high-quality IPC practices, and strengthen hygiene and safety committees in the targeted health facilities.

Three sets of performance evaluations were completed in December 2014, April 2015, and August 2015 at each of the 55 health facilities to monitor the implementation of IPC performance standards. At the national hospitals of Donka, Ignace Deen, and Sino-Guinéen, 66 services were evaluated and the median performance score rose from 24% (baseline) to 50% (second evaluation) to 68% (third evaluation). At 7 Community Management Committees (CMCs) in Conakry and Beyla and 3 prefectural hospitals in Beyla, Forecariah, and Kissidougou, the median performance score rose from 20% to 50% to 62%. At the remaining 42 health centers supported by the project, the median performance score rose from 19% to 42% to 67%.

Behavior change communication activities (including theatre performance, a soccer match, group talks, and radio programs) are estimated to have reached at least 91,000 people in 3 prefectures. Orientations were also provided to 367 civil society and women's groups to support community engagement in prevention and case identification.

MCSP supported 100 Community Surveillance Committees to carry out contact tracing. Training was also provided to 1,463 pharmacists, health care workers, and traditional healers who work outside of the public health system to support surveillance and improve infection prevention and referral.

MCSP was very engaged with the National Ebola Response Coordination and the IPC committee in particular. The IPC curriculum adapted and used by MCSP was adopted by the MOH as the model for IPC training of health care workers. The IPC curriculum used by MCSP was adapted from Jhpiego materials and updated with specific procedures for Ebola in partnership with JHU and was adopted by the MOH as the model for IPC training of health care workers.

Way Forward

The scope of work for this project was completed and the project closed in August 2015. Similar facility-level activities are continuing through the "MCSP Guinea IPC 2 Workplan" (with Office of Foreign Disaster Assistance funds), which provides IPC training in 5 additional prefectures (reported separately). Ongoing support for maintaining IPC performance also is continuing under the Pillar 2 Ebola Response and Recovery Workplans.

Guinea Summary & Results—Ebola IPC 2

Strategic Objectives

- Support health care workers and facilities to continue to offer high-quality health services in a safe environment by strengthening infection prevention and control (IPC) practices through training, supportive supervision, and complementary monitoring and evaluation.

Program Dates	June 2, 2015–November 15, 2015 (approved July 9, 2015; extension approved to February 28, 2016)		
PY1 Approved Budget	[redacted]		
Geographic Focus Area	The 5 prefectures of Boke, Faranah, Mandiana, Dabola, and Dinguiraye		
Geographic Presence	**No. of regions (%)**	**No. of prefectures (%)**	**No. of facilities and/or communities (%)**
	3/8 (38%)	5/38 (13%)	59/461 (13%)
Technical Interventions	OTHER: Ebola Response- Infection Prevention and Control		

Selected Programmatic Data	
Number/percentage of staff in health facility who receive IPC training	615 (45%)
Number/proportion of health facilities that have appropriate (and sufficient quantity of) PPE for at least 1 month	78% (7/8)
Percentage of health facilities achieving/ compliant with at least 75% of performance standards of IPC	9% (1/11 at second assessment); none of facilities met this indicator at baseline Among services at the regional hospital in Boke, 18% (2/11) met the indicator at second assessment and none at baseline
Percentage of trained staff who receive post-training follow-up supervision	56%

Key Accomplishments

MCSP was pleased to develop a program with funding from the Office of Foreign Disaster Assistance (OFDA)'s Ebola Response to extend IPC training to additional prefectures in Guinea. This builds on the IPC1 project reported above. Just as this project was approved in June 2015, the first cases of Ebola Virus Disease (EVD) were reported in Boké prefecture in the far west of Guinea. At the request of USAID and OFDA's Disaster Assistance Response Team, MCSP quickly modified the project targets to provide support for reinforcing IPC in the facilities and among the health care workers in Boké prefecture. Two hospitals were initially incorporated into the intervention planning and eventually all of the health centers (n=11) and health posts (n=27), as well as private facilities (n=29), were included in the training in Boké.[3]

Baseline assessment of IPC practices was conducted in each service of the 2 hospitals. At Boké Regional Hospital, scores ranged from 0% performance of standards in Pediatrics to 52% in Ophthalmology, with an average of 20% correct performance of IPC standards (Maternity scored 35% with 8 of 23 standards met). At ANAIM Hospital (public-private facility with support from the mining industry), performance ranged from 24% in Internal Medicine to 60% in the Dental service, with an average of 44% (Maternity 58%, Pediatrics 33%). Among the 11 health centers, scores ranged between 0% at Sansalé health center and 31% at Koulifanya health center, with an average of 18.5%. Lack of materials to maintain IPC practices as well as inconsistent performance of tasks that must be done routinely to maintain IPC were key reasons for the low performance scores.

As part of the goal to reach all health care workers in Boké, 576 health care providers completed the 5-day training course led by teams of national trainers supported by MCSP. The course covered standard precautions in IPC as well as additional steps required for EVD and other highly infectious diseases. During post-training follow-up visits to each facility, 127 support staff were also oriented to IPC practice in local languages. Supportive supervision and coaching visits are ongoing.

A total of 62 providers also benefited from a 3-day training specifically on setting up and managing triage of patients seeking care at health facilities. Triage is an important aspect of containing the EVD epidemic; steering suspect cases to the right testing and care, and maintaining the safety of routine health care services in order to protect health care workers and restore community confidence in health care services.

Some activities in the other 4 target prefectures of this project were delayed due to scheduling conflicts and competing activities in the prefectures. The baseline IPC assessments were completed and training schedule set to finish the IPC training. Procurement of incinerators and autoclaves for selected facilities is in process to further support maintenance of IPC practices.

Way Forward

Activities will continue past the anticipate end-date of November 2015, due to scheduling conflicts with MOH with regard to the trainings. All remaining training is planned to take place in November 2015 in 4 prefectures for over 1,000 providers. Coaching and supervision visits are planned for the next 3 months as well as the second evaluation of health facility performance for IPC that will take place at the end of these coaching visits.

[3] Three health centers in the prefecture are not included in this count because funding to provide IPC training and support was received by Jhpiego from the Alcoa Foundation.

Guinea Summary & Results—RMNCH & GBV

MCSP Guinea

Strategic Objectives

- Improve and sustain the quality of RMNCH services in supported health care facilities.
- Improve the quality of pre-service midwifery education at the National Public Health School in Kindia and the medical education at the Faculty of Medicine in Conakry.
- Integrate activities and services for the prevention and management of gender-based violence within RMNCH services at the facility and community levels in Conakry.

Program Dates	January 1, 2015–September 30, 2016 (approved February 13, 2015)		
PY1 Approved Budget	[redacted]		
Geographic Focus Area	Regions and prefectures/communes of Conakry, Faranah, and Kankan		
Geographic Presence	**No. of regions (%)**	**No. of prefectures (%)**	**No. of facilities and/or communities (%)**
	3/8 (37.5%)	14/38 (37%)	150/461 facilities (32.5%)
Technical Interventions	 PRIMARY: Child Health; Community Health; Maternal Health; Newborn Health; Reproductive Health; OTHER: Gender-Based Violence; Quality Improvement		

Selected Programmatic Data	
Number of new acceptors of modern contraceptive methods as a result of USG assistance	63,697
Couple years of protection (CYP)	39,528
Number of women receiving active management of the third stage of labor (AMTSL)	13,459
Number of women delivering with assistance of a skilled birth attendant	16,835

Key Accomplishments

This project was designed as a bridge to sustain MCHIP's accomplishments. Activities focus on supporting the facilities and communities where interventions to improve RMNCH had taken place between 2010 and 2014, with a focus on supportive supervision and continuation of the quality improvement methodology, Standards-Based Management and Recognition (SBM-R®), which has been adopted by the Guinea MOH as the preferred quality assurance mechanism. This project also continues the work initiated under MCHIP to support improvements in the prevention and management of gender-based violence in urban Conakry.

Implementation to date has been hindered by the surge in the Ebola Virus Disease (EVD) epidemic, as priority was given to activities to respond to EVD. The geographic coverage of the project also shifted as the epidemic calmed down in the N'zérékoré region, previously supported under MCHIP, which was then in need of support to ensure that routine health services are resuming and that community confidence to seek health care from these facilities is restored.

Nevertheless, several key accomplishments include the completion of supervisory visits to 189 health facilities across 4 regions (N'zérékoré was added back into workplan once EVD had subsided in the region). These visits provided an opportunity for trainers and supervisors to reinforce correct infection prevention practices as well as the provision of key RMNCH services. Support to regional and district health managers to conduct supervision could not be realized due to scheduling conflicts and will be rescheduled in Year 2. A total of 119 community health workers (CHWs) received supervision (79% of target for year), along with another 40 CHWs based in hair salons in urban Conakry. The 5 hair salons were also provided with audiovisual materials to support their health education activities.

Review of performance against the SBM-R standards was completed in 5 facilities implementing SBM-R, while another 5 completed the final module for full implementation of this quality improvement methodology. Most facilities have been maintaining high levels of performance. A few were put on alert for declines in performance that need to be remedied; otherwise, the facilities risk losing previously earned recognition. One urban health center and 1 regional hospital received validation visits from the national SBM-R committee for a first and second star, respectively.

MCSP Guinea provided support to several policy and data management issues in collaboration with the MOH. A supervision visit was conducted in Kankan region with representatives of the national HMIS to review use of data for decision-making as well as continued use of the Routine Data Quality Assessment methodology, which was initiated under MCHIP. At the policy level, MCSP has been advocating with the MOH and partners to incorporate misoprostol for PPH prevention in home births into RMNCH and community health strategies, as well as to add misoprostol to birth kits distributed at health centers and dispensaries. MCSP also continued its advocacy with local mobile phone providers to support the network of phones held by health care providers to facilitate referral coordination, and epidemiological surveillance.

Related to pre-service education, MCSP completed an orientation with staff and instructors on the new midwifery training curriculum and also supported the development of educational tools to support implementation of the midwifery program. These activities were particularly valuable at a time when midwifery students were prohibited from visiting nearby health facilities for practical learning as a result of EVD; thus, use of the skills lab and other learning tools became even more valuable for learning. At the Faculty of Medicine, a performance evaluation using SBM-R standards for pre-service education was conducted and action plans were developed by faculty to address gaps identified in this process.

For the gender-based violence (GBV) initiative, MCSP completed the dissemination of the baseline assessment findings to key stakeholders in Conakry, including more than 400 community members from the 5 communes. The terms of reference for an intra-ministerial committee were drafted for approval by the participating ministries. The curricula for community and providers training were drafted for review by stakeholders. Forty-two providers at the 7 focus facilities were identified for participation in the GBV training, and interviews were completed to select 125 community educators, including peer educators at secondary and tertiary schools, for upcoming training.

Way Forward

Now that the EVD epidemic is nearing an end, and only sporadic cases are being reported, MCSP is better placed to complete activities from its workplan. Supervision and ongoing monitoring using SBM-R are all the more important now that providers and health managers are working to recover from the impact of the EVD epidemic and restore functioning of essential health services to end preventable maternal and child deaths. GBV activities will also continue to be scaled up to ensure that these important objectives are met.

Guinea Summary & Results—Restoration of Health Services

Strategic Objectives

- Restoration of Health Services (RHS) with a focus on quality improvement in maternal, newborn, and child health services through:
  1. Strengthening service delivery,
  2. Creating a favorable health care environment,
  3. Creating demand, and
  4. Facilitating community engagement.

Program Dates	July 14 , 2015–December 2016 (approved September 11, 2015)		
PY1 Approved Budget	[redacted] (Ebola Response and Recovery Supplemental Funding)		
Geographic Focus Area	Regions of Conakry, Boké, Forécariah, N'zérékoré (plus Kissidougou prefecture), and Kindia		
Geographic Presence	**No. of regions (%)**	**No. of prefectures (%)**	**No. of facilities and/or communities (%)**
	5/8 (62.5%)	20/38 (52.6%)	221/461 (48%)
Technical Interventions	 PRIMARY: Child Health; Community Health; Maternal Health; Newborn Health; Reproductive Health; OTHER: Gender-Based Violence; Ebola Response – Infection Prevention and Control		

Selected Programmatic Data	
MCSP Global PMP Indicator	Data not available at the close of PY1

Key Accomplishments

The MCSP Guinea Restoration of Health Services workplan received full approval in early September 2015 and builds on the achievements of MCHIP and the Infection Prevention and Control activities funded through MCSP in PY1. The funding is part of the US Government's Ebola Response and Preparedness Initiative which went into effect on December 17th, 2014. The funding for Guinea is part of Pillar 2 of the overall response which focuses on mitigating the second order impacts of Ebola in the 3 countries most affected by the epidemic and further focuses specifically on restoring critical non-Ebola health services. MCSP interventions focus on: the development of local training capacity among health care providers in Guinea; competency-based training methods that work to improve both knowledge and skills; previous work specifically on infection prevention practices in health care facilities; and a commitment to quality improvement and supportive mentoring and supervision to assist health care providers to translate new skills into ongoing service delivery at their worksites.

To date, the project has completed a situation analysis of focus facilities in order to guide specific interventions. The analysis included existing information on facilities supported by MCSP under other projects and data collection in new intervention facilities. As part of the focus on providing onsite training and mentoring in RMNCH services, the training package for postpartum family planning and postpartum IUD insertion (PPFP/PPIUD) was adapted for onsite training by experienced trainers. An orientation on the modified training package was provided to 20 trainers working at 10 facilities, and use of the modules has been initiated. Feedback from this initial experience will help to refine the materials prior to the next training of trainers. Additionally, MCSP is working closely with Expertise France and WHO on guidance for Hygiene and Safety Committees that MCSP will eventually use to reinforce the functioning of these committees. Procurement of materials to support service strengthening was also initiated.

Way Forward

The project plans to support national and regional trainers to conduct coaching visits to facilities, and orient Hygiene and Safety Committees to support internal supervision, stock management, and action planning. Other activities include the procurement and distribution of autoclaves to selected facilities, joint quarterly visits with the District Health Office to supervise SBM-R implementation, and introduction of additional performance-based standards. The planned trainings include a session on key components of integrated services: EmONC+PPFP, focused ANC, PNC, and onsite training and mentoring by MOH trainers. Workshops will be conducted to introduce IMNCI performance standards and mentorship skills for supervising CHWs. There will also be refresher training of CHWs on RMNCH health messages and community services.

Haiti Summary & Results—EPCMD

Strategic Objectives

- Provide national technical assistance to the Ministry of Public Health and Population (MSPP) to create an enabling national policy and coordination environment for improved reproductive, maternal, newborn, and child health (RMNCH) in Haiti.
- Finalize and pilot the guidelines and technical standards for the structure and operation of three model referral networks (MRNs)—Ouanaminthe, Matheux, St. Michel De L'Attalaye—and support the SSQH projects' initial implementation of the MRN guidelines.
- Increase the capacity of the national RMNCH training and education system, specifically at three National Training Centers and one midwifery pre-service education (PSE) institution, to support the development of a health provider work force that is equipped with the knowledge and skills to effectively provide high impact priority RMNCH services.
- Promote learning, knowledge sharing, and coordination to foster the scale-up of evidence-based community health strategies.

Program Dates	August 2014–September 2017		
PY1 Approved Budget	[redacted]		
Geographic Focus Area	National level TA, Model Referral Networks: Ouanaminth, St. Michel de L'Attalaye, and Matheux; National Training Centers s: Fond-des-Blancs (South), Milot (North), Mirebalais (Centre)		
Geographic Presence	**No. of provinces (%) (departments)**	**No. of districts (%) (arrondissements)**	**No. of facilities and/or communities (%)**
	6 departments (60%)	6/42 Arrondissements (15%)	55/966 facilities (5%)
Technical Interventions	PRIMARY: Child Health; Community Health and Civil Society Engagement; Maternal Health; Newborn Health; Nutrition; Reproductive Health; Water, Sanitation, and Hygiene		

Selected Programmatic Data

Selected Programmatic Data	
Number of people trained through USG-supported programs	19
Number of technical working group (TWG: Maternal Health, Child Health, Nutrition) meetings held	3
Number of organizations that are implementing RMNCH key evidence-based practices	3
Number of national training hospitals with clinical trainers and training coordinators in place	3

Key Accomplishments

The MCSP Ending Preventable Child and Maternal Deaths (EPCMD) project began in Haiti in August 2014 and joined the pre-existing Social Marketing (SM) project (closed October 2015). In August 2015, MCSP began implementation of the Services de Santé de Qualité pour Haiti-Nord (SSQH-North) project focused in the four northern departments of Haiti. Through these programs, MCSP improves maternal, neonatal, and child health outcomes in Haiti by 1) training health providers, advocating for high-level policy change, and contributing to the revision of national programs, strategies and protocols (ECPMD); 2) direct service provision through support to health facilities across USAID sites and engagement of communities in the northern part of Haiti (SSQH-North); and, 3) social marketing and behavior change at the community level (SM).

Provide National TA to the Ministry of Health (MSPP): During PY1, MCSP EPCMD worked with MSPP to identify key areas of national policy that required updating. Groundwork was conducted in which gaps in best practice RMNCH interventions at the national level were identified, and two Advisors—seconded to MSPP—worked to re/launch Technical Working Groups through which to begin to revise and update necessary guidelines and update the Essential Package of Services to ensure these guidelines are in line with the new structure of the Haitian health system. These include maternal health norms, national newborn care guidelines, pediatric consultation protocols, cervical cancer prevention guidelines, and postpartum family planning guidelines. Additionally, advocacy workshops spearheaded by MCSP led to MSPP approval for piloting two community health interventions: the use of misoprostol in preventing postpartum hemorrhage, and the use of chlorhexidine for cord care to prevent newborn sepsis. Finally, MCSP actively participated on the MDSR Steering Committee, including joining MSPP, UN, and USG agencies to Indonesia to gain insight and lessons learned on implementing a national MDSR model. MCSP worked with this committee to conduct a regional workshop and move forward piloting an MDSR system in Haiti in order to better track maternal deaths across the country.

Establish protocols to operationalize three Model Referral Networks: MCSP EPCMD worked with the *Direction d'Organisation des Services de la Santé* (DOSS) of the MSPP and MSH/LMG to pilot the referral and counter-referral form in the Model Referral Network of Matheux. Secondly, technical assistance was provided to MSPP in recommending updates to the Manual on the National Referral and Counter Referral System, as well as in drafting a MRN Operational Plan to be validated by the Ministry. Communication and transportation protocols were also developed in PY1, and their pathways mapped out in a visual tool provided to the facilities in the Ouanaminthe Model Referral Network (the other two will be finalized in PY2). This tool is specific for each facility, showing the lines of clinical referral to other facilities in the network, and communication and transportation options available to those needing referral, especially in obstetric or newborn/child emergencies. Finally, MCSP completed an evaluation of the MRN M&E system as well as an evaluation on WASH services at 21 select facilities across Haiti. The

outcomes of the WASH assessments are feeding into SSQH programming focused on improving WASH at health facilities.

National Training Centers: In order to support the strengthening of a qualified health provider workforce, MCSP established 3 National Training Centers (NTCs) through signed subawards with Mirebalais, St. Boniface, and Milot-Sacre Coeur and provided ongoing assistance in the establishment of a training management system—including hiring a training coordinator, development of action plans, and preparing each NTC to conduct a training needs assessment at key peripheral sites to inform the training calendar. The Training Advisor also conducted SBM-R Institutional Capacity Assessments for all three Hospitals to identify gaps requiring technical support. MCSP trained 19 trainers from the 3 NTCs in RMNCH skills standardization (including most elements of BEmONC) and Clinical Training Skills (resulting in Qualified Trainers in key RMNCH interventions). These 19 trainers are now qualified to conduct most basic RMNCH clinical skills updates to health providers at the peripheral sites and will begin doing so in PY2. Additionally, MCSP procured the materials and equipment to set up training skills labs at all three NTCs and the National Midwifery School.

Community/Civil Society: MCSP completed CSO mapping for 36 organizations and 3 coalitions across Haiti.

Way Forward

The project's major priorities for PY2 will focus on further development of the MRNs and the NTCs. In the MRNs, MCSP will pilot communications and transport referral and counter-referral protocols to contribute towards the operationalization of the MRN system, as well as finalize the clinical referral protocol for submission to the Ministry. MCSP will also finalize the mapping for all 3 MRNs, providing the facilities in each of these MRRNs with the visual tool to understand the protocol referral pathways. Regarding the NTCs, MCSP will continue skills training and supportive supervision of the 19 trainers at the 3 NTCs to provide trainings to peripheral sites on the following topics: focused ANC/PNC, Essential Care for Every Baby, KMC, PPFP and PPIUD, WASH, IMCI, and Emergency Triage Assessment and Treatment. National training calendars will be developed, both for the trainings that MCSP will provide to the NTC trainers and the trainings that the NTC trainers will begin providing to the SSQH and MSPP peripheral sites. Further, MCSP will work to integrate community work done in PY1 into work with the MRNs and NTCs, specifically to bring CSOs working around the NTCs together to share best practices in community RMNCH. Additionally, MCSP will focus on supporting the MSPP in the revision of norms and policies, including those related to the Newborn Health Action Plan, cervical cancer prevention, PPFP, WASH for health facilities, and moving to a full pilot of the MDSR work, among others. The program will also continue to advocate with the MSPP for the adoption of evidence-based policies on the community-based treatment of pneumonia by trained CHWs.

Haiti Summary & Results—Social Marketing

Strategic Objectives

- Improve health behaviors through behavior change communications.
- Expand access to quality WASH, MCH, and FP products.

Program Dates	April 2014–September 2015 (approved June 30, 2014; extension approved to October 30, 2015)		
PY1 Approved Budget	[redacted]		
Geographic Focus Area	National		
Geographic Presence	**No. of departments (%)**	**No. of districts (%)**	**No. of facilities and/or communities (%)**
	10/10 (100%)	N/A	N/A
Technical Interventions	PRIMARY: Child Health; Community Health and Civil Society Engagement; Maternal Health; Newborn Health; Nutrition; Reproductive Health; Water, Sanitation, and Hygiene		

Selected Programmatic Data	
Number of people reached through FP outreach activities	105,557
Number of people reached through hotline	32,609
Couple years of protection (CYP) provided through contraceptive sales	158,672
Number of branded clean water product units sold	2,772,000
Number of branded ORS product units sold	642,240

Key Accomplishments

MCSP/Haiti SM aimed to motivate people to adopt healthier behaviors in FP; MCH; and water, sanitation, and hygiene (WASH). To achieve this objective, the project conducted a range of sensitization activities on radio, in print and social media, and through one-on-one outreach within communities. Key accomplishments for activities implemented between April 2014 through September 2015 include:

BCC activities: The team carried out 11,016 activities and 4,977 household visits, resulting in 249,669 persons reached through interpersonal communication in FP, MCH, and WASH.

FP, WASH, MCH community-based support groups: Twenty trained support groups conducted 4,296 interpersonal communication sessions on FP and reached 92,874 people. Additionally, model couples conducted 426 outreach sessions on FP reaching 12,683 persons in a number of settings, including health centers, churches, and women's associations. Together, model couples and support groups reached 105,557 people with FP outreach activities. A total of 24,479 brochures were also distributed during these activities. 30 supervisory visits were conducted over the course of the project, where FP IPC activities were monitored for quality purposes. Supervisory visit reports showed that messages transmitted during these sessions were very clear and well-received by the participants. The supervisions also highlighted that participants asked many questions about modern FP methods. Hospitals and health centers were grateful for the sessions, especially as they lack the staff and capacity to conduct these activities on their own. At the end of each session, the support groups always provided referral information for FP services.

The project also undertook WASH activities called *Lakay Timoun*. The WASH support groups conducted a total of 3,509 interpersonal communication activities and 8,586 home visits, reaching 90,092 people—28,789 men, 53,056 women and 8,247 children. The themes discussed during the sessions included handwashing, hygiene, water treatment, use of latrines, and the preparation of ORS. IPC activities took place in health centers, schools, women's associations, and water collection points across the country. In addition, 19,725 brochures on hygiene were distributed.

Following the success of the *Lakay Timoun* activity, the project decided to conduct the same type of activity for MCH, focusing on delivering key messages on child nutrition and immunization, pregnancy follow-up, and in-facility delivery. IPC sessions and home visits for MCH started in June 2014, 3,211 outreach activities, and 7,906 household visits reaching a total of 66,703 people, including 19,756 men and 46,841 women. The model couples conducted 318 outreach sessions reaching 9,258 persons on MCH

POZ hotline and radio stations: The project contract with POZ came to term in March 2015, but within just 1 quarter of being under contract, the hotline was running successfully. The hotline received over 32,609 calls, principally by young women between the ages of 15 to 25. Similarly, contracts came to term with radio stations by June 2015, before which 133,587 spots were aired, including 90,901 (68%) product-specific radio promotions, and 41,178 (39%) generic health radio spots.

Cine mobile and special events: A total of 87 cine mobile and special events were organized and conducted across 10 departments presenting and delivering key FP, WASH, and MCH messages to an estimated 44,600 persons. Moreover, the team organized a number of successful promotional and sensitization events during Carnival festivities in February, and reached over 100,000 people.

Trained nurses in IPC: As additional support to the MOH, the project provided training to nursing school students in communication skills and interpersonal communication counseling.

In 2014, 174 student nurses from public nursing schools were trained on IPC communication techniques on subjects such FP, cholera, and MCH. In 2015, 132 were trained in the first quarter, totaling 306 student nurses trained over the course of this project.

Expanded access to quality WASH, MCH, and FP products: MCSP conducted 945 promotional activities, including sound truck announcements and market place presentations, reaching an estimated 508,866 persons. The team sold over 1.45 million FP units, including injectables, OCs, and IUDs helping to avert in that time 44,687 disability-adjusted life years in reproductive health, providing an estimated 158,672 CYPs. Moreover, MCSP sold over 2.7 million water treatment tablets and 642,240 oral rehydration salts, helping to avert 7,630 disability-adjusted life years. The project also concluded a number of national research studies in 2015, providing donors and partners alike with insight into the level of knowledge and use of FP, WASH, and MCH products in Haiti.

Way Forward

The project closed October 30, 2015. An End-of Project report will be submitted to USAID and posted to the DEC early in PY2.

Haiti Summary & Results—SSQH-N

Jess Thimm/MCSP

Strategic Objectives

- Increase utilization of the *Ministère de la Santé Publique et de la Population*'s (MSPP's) integrated package of services at the primary care and community levels (particularly in rural or isolated areas).
- Improve the functionality of the USG-supported health referral networks.
- Facilitate sustainable delivery of quality health services through the institutionalization of key management practices at both the facility and community levels.
- Strengthen departmental health authorities' capacity to manage and monitor service delivery.

Program Dates	August 1, 2015–September 30, 2016 (Workplan approval pending)		
PY1 Approved Budget	[redacted]		
Geographic Focus Area	Department level (4): North, North-East, North-West, and Artibonite		
Geographic Presence	**No. of departments (%)**	**No. of districts (%)**	**No. of facilities and communities (%)**
	4/10 (40%)	32/42 arrondissement (76%)	84/497[4] (17%)
Technical Interventions	PRIMARY: Child Health; Community Health and Civil Society Engagement; Immunization; Maternal Health; Newborn Health; Nutrition; Reproductive Health; Water, Sanitation, and Hygiene OTHER: HIV; Gender-Based Violence; Child Protection		

Selected Programmatic Data	
MCSP Global PMP Indicator	Data not available at the close of PY1

[4] Estimated number of health facilities in the combined 4 departments. http://www.mspp.gouv.ht/cartographie/index.php

Key Accomplishments

The MCSP SSQH-North project, starting in August 2015, joined two other programs in Haiti: the Ending Preventable Child and Maternal Deaths (EPCMD) and Social Marketing projects (closed October 2015). During the first 3 months of the SSQH-North project and pending final workplan approval, the project accomplished the following results:

Government support: SSQH-North has addressed gaps in staffing across the 4 departments by temporarily contracting with 940 health care providers. In addition, SSQH-North has directly subcontracted with 8 NGOs providing oversight and implementation to 21 of the 84 SSQH-North facilities. This timely assistance has ensured the continuation of services across the 4 departments at a critical time.

HIV/TB: As HIV/AIDS is the largest technical component of the SSQH-North project, initial project activities have focused on this area. The HIV team conducted 24 integrated supervisory visits with the Departmental Health Directorates (DDS) at all 21 HIV sites and conducted training and coaching of personnel on HIV/TB, HIV testing and counseling (HTC), PMTCT, palliative care, antiretrovirals, orphans and vulnerable children, and GBV. During supervisory visits, the M&E team verified data quality and validated data submitted into the national data collection system. A key challenge for the DDS has been how to address the high numbers of HIV-positive patients who have been lost to follow-up. The HIV team began addressing this issue by ensuring that all HIV sites had HIV client registers to improve client tracking, and developed and distributed visitor registration forms (HIV visitor form, enrollment form, lost to follow-up [LTFU] report form) to streamline and improve data collection of client visits. At the request of USAID/Haiti, SSQH-North also conducted an evaluation of infrastructure, staff materials, and equipment in Baie de Henne (which will be the 22nd HIV site) for activation of services and antiretroviral distribution. These efforts are contributing to improved service delivery for HIV/TB and show promise for improving patient compliance and continuation of treatment.

mHealth: SSQH-North has partnered with Dimagi to scale up the use of the mSanté application, which will benefit CHWs and their supervisors, and improve data collection through smartphones, for the MSPP. Thus far, the mHealth team has trained 47 CHWs and their supervisors in mSanté modules (FP, maternal health [pregnancy], child health [vaccines and nutrition], and referrals/counter-referrals). The team has also provided supportive supervision and mentorship to 37 CHWs and 13 supervisors on improving data collection at rally posts and home visits using the mSanté modules. The project is on its way to scaling up the use of the mSanté application among the 700 CHWs and supervisors in the project catchment areas; once achieved, the scale-up will allow for timely, more efficient and high-quality data from CHWs to be used for improved decision-making at all levels.

GBV/child protection: The GBV/child protection team has been working closely with the DDS and has finalized a GBV and Child Protection action plan and data collection tool for the DDS-North. An orientation to the plan and tools is programmed for the following month for social workers and CHW supervisors. This plan and the rollout of the approach will be a ground-breaking response at the community and facility levels to a growing need for improved care of vulnerable women and children.

Way Forward

SSQH-North will expand collaboration with the DDS to conduct monthly supportive supervision visits at the 84 sites supported by the project (community and facility) to ensure quality service delivery of HIV/TB, FP, MNCH, immunization, WASH, nutrition, GBV, and child protection.

During these supervision visits, Facility Services Officers and Communality Mobilization Officers will collect data on services, assess capacity-building needs and commodities and supply chain related issues, and report them back to the DDS and the SSQH-North technical team for immediate action where needed. Improved data management systems and processes will be in place and optimized at the facility and DDS levels for improved decision-making. SSQH-North will also work through the DDS to forge stronger links between health facilities and communities and to encourage community care-seeking and healthy behaviors. Additionally, SSQH-North will provide timely technical support to the DDS to provide distinct refresher trainings and updates according to priority needs identified during supportive supervision, ranging across the health technical areas in departments, facilities, and among CHWs. The Reaching Every District/Community (RED/REC) approach will also be introduced and a plan developed with the SSQH-North team and DDS to implement it as one of the program's equity-focused approaches to reaching populations that are not being reached with immunization and other evidence-based RMNCH and HIV/TB services.

Kenya Summary & Results

Strategic Objectives

- **Objective 1:** Strengthen the core capacities of county governments and health teams to increase coverage and utilization of evidence-based, sustainable, high-impact RMNCH, nutrition, and WASH interventions
- **Objective 2:** Foster an enabling environment and promote program learning documentation and dissemination for improved RMNCH, nutrition, and WASH outcomes.

Program Dates	September 1, 2014 – TBD		
PY1 Approved Budget	[redacted]		
Geographic Focus Area	Migori County, Kisumu County, East Pokot sub-County, Igembe North sub-County, Igembe Central sub-County, National level		
Geographic Presence	**No. of counties (%)**	**No. of sub-counties (%)**	**No. of facilities**
	4/47 (8.5%)	7/290 (2.4%)	177 facilities
Technical Interventions	PRIMARY: Child Health; Community Health and Civil Society Engagement; Immunization; Malaria; Maternal Health; Newborn Health; Nutrition; Reproductive Health; Water, Sanitation, and Hygiene; OTHER: HIV		

Selected Programmatic Data	
Couple years of protection (CYP) in MCSP-supported areas	78,352 couple years of protection
Number of cases of child diarrhea treated in USAID-assisted (MCSP) programs	6,811 cases of child diarrhea treated with ORS and Zinc supplements
Number of cases of child pneumonia treated with antibiotics by trained facility or community health workers in USG (MCSP)-supported programs	2,998 cases of child pneumonia treated with antibiotics by trained facility or community health workers in MCSP supported program
Number of children aged <12 months who received DPT3/Penta3 vaccine in MCSP-supported areas	14,662 children aged <12 months receiving 3 doses of DPT/Penta3 vaccine
Number of children under 5 reached by USG (MCSP)-supported nutrition programs	117,388 children under 5 reached by nutrition programs
Number of people trained through USG- supported programs: Technical and Cross-Cutting	399 people trained in child health and nutrition, 752 in family planning/reproductive health, 3500 in malaria, 480 in maternal and newborn health
Number of people trained through USG- supported programs: Personnel	605 community health workers trained

Key Accomplishments

MCSP in Kenya is building on the 5-year MCHIP program, which began in 2009 and focused on providing national-level technical assistance and demonstrating practical innovations for maternal and child health. To support the devolution of decision-making authority to county and sub-county governments. The scope of the MCSP work has evolved to reflect a changing global reproductive, maternal, newborn and child health (RMNCH) landscape, local devolution as well as changes in USAID's priorities.

Focusing on hard-to-reach populations who are most in need, MCSP began working in Migori and Kisumu counties in PY1—two of the counties with the worst RMNCH indicators and continued working in the sub-counties of East Pokot, Igembe North, and Igembe Central, which had also received support under MCHIP. At county and sub-county level, MCSP is working with managers to: plan and advocate for RMNCH interventions; coordinate and leverage supplementary resources; build supervision and mentorship skills; and enable managers to capture and use quality data for decision-making. In the sub-counties, MCSP is taking a holistic approach to implementation by integrating technical interventions for efficiencies and strengthening linkages along the continuum of care (community to facility to county) in order to increase coverage, improve quality, and foster ownership of health services. In the first year of the Kenya MSCP program, numerous accomplishments were achieved across MCSP technical areas as described below.

Maternal and Newborn Health: MCSP support to county governments resulted in expanded access to and quality of obstetric and perinatal care in our target sub-counties. In PY1, MCSP supported the development of 30 clinical trainers (100% of the target) on routine delivery care and Emergency Obstetric and Newborn Care (EmONC) followed by intensive mentorship and supportive supervision. In the reporting period, the project recorded a 12% increase in the number of women completing at least 4 ANC visits and 5% increase in the number of women delivering with a skilled birth attendant.

MCSP partnered with the Heshima 2 project (Population Council) to roll out respectful maternity care (RMC) in Suna West and Kuria West sub-counties of Migori County. A total of 33 TOTs were trained and then supported to scale up RMC to 15 facilities and their surrounding communities. As a result of the RMC initiative, activities such as maternity open days (communities were invited to witness the maternity services being provided at their local facilities) and whole-site orientation of staff and community leaders on RMC were implemented.

Malaria in Pregnancy: MCSP worked to increase intermittent preventive treatment of malaria in pregnancy (IPTp) uptake in 4 lake-region, malaria-endemic counties of Bungoma, Homa Bay, Kisumu, and Migori. MCSP developed 36 clinical mentors from sub-county health management teams (SCHMTs) who mentored 928 health care workers followed by 2 to 3 supportive supervision and mentorship visits In addition, MCSP trained 248 community health extension workers (CHEWs), who in turn, oriented 3,017 CHVs on community MIP interventions and messaging. The CHVs reached 11,656 pregnant women with MIP messages. In PY1, the proportion of pregnant women beginning ANC earlier than 20 weeks increased from 23% to 32% in Bungoma South sub-counties. Early start of ANC visits resulted in increased number of doses taken by pregnant women and translated to a reduction in missed opportunities for taking SP from 39% to 25% in Migori and from 23% to 19% in Bungoma.

Advocacy also played a role in improving MIP services. To address the challenge of pending SP stock-outs, MCSP worked with county governments to follow the directive of the Chief Secretary of the Ministry of Health to budget and procure SP to avert the stock out. MCSP was successful in supporting Bungoma and Migori counties to budget for and procure SP.

Immunization: In 2014/15, MCSP provided technical input to the Unit of Vaccination Services (UVIS) to strengthen its guidance to counties toward improved immunization planning and implementation. At the national level, MCSP strengthened the coordination among immunization partners around key national priorities such as the country multiyear planning, new immunization policy, and orientation of health personnel, as well as Gavi joint annual reviews. For example, in support of the introduction of the Inactivated Polio Vaccine (IPV) into the routine immunization schedule in 2016, in conjunction with other partners, MCSP provided technical support for the development of the introduction guide; IEC materials; and training slides. MCSP harmonized materials and information from the working groups to ensure consistency and relevance to the target audience. MCSP continues to support Kenya in its work with surrounding countries in the Horn of Africa to prevent the reintroduction of wild polio virus and improve oral polio vaccine (OPV) coverage with Core Polio funds. This global priority required experience and technical assistance at national and regional levels.

To strengthen routine immunization system and enhance the capacity of UVIS to deliver services sustainably, MCSP oriented health workers in all immunizing health facilities on the REC approach, including development of micro plans to address challenges affecting immunization services. In addition, health workers were sensitized on the new national immunization policy, the second dose of the measles vaccine, the newly introduced rotavirus vaccine, cold chain and vaccine management, use of data to manage immunization services, building community support for immunization services, and the use of the freeze tag to monitor cold chain temperature.

In order to reach disadvantaged populations, selected facilities were supported to conduct outreach visits focusing mainly on areas with high numbers of unreached children. The implementation of the above activities contributed to an improvement of administratively reported immunization (FIC coverage) from 70.7% to 77.2% (Kuria West sub-county), 73.4% to 82.2% (Nyakach sub-county), and 75.3% to 78.3% (Seme sub-county) over the last year. In addition, it is important to note the improvement in Penta 3 coverage levels from 78.7% to 81% (Kuria west), 77.1% to 78.6% (Nyakach sub county), and 78.0% to 79% (Seme sub county).[5]

Child Health: Findings from the midline Bondo iCCM study—largely completed under MCHIP—were shared at the national iCCM technical working group. The end-line assessment was conducted in July/August 2015. The text box provides key findings from the overall study.

Key Findings

- Proportion of caregivers seeking treatment for fever from CHVs increased from 3% at baseline to 32% at end line in intervention CUs and similarly from 1% to 10% in comparison CUs ($p<0.001$).
- Correct treatment of sick children with diarrhoea using ORS and Zinc increased from 8% to 53% in intervention CUs and also from 43% to 63% in comparison CUs ($p<0.001$).
- CHVs ability to follow correctly the iCCM algorithm improved: at end line, correct assessment of danger signs increased to 93% compared to 32% at baseline ($p<0.001$).

Using the experience and lessons learned from the iCCM study, MCSP facilitated the development of county iCCM implementation plans in Migori and Kisumu and advocated for more financing for community health services including adequate medicines and commodities, supportive supervision and CHV incentives.

Also in PY1, MCSP implemented a mentorship approach using adapted WHO IMCI tools to improve health care worker capacity to manage sick children. MCSP mentored 68 (16%) out of 429 health care workers in Kisumu and Migori. Furthermore, working with facility in charges,

[5] Source: Kenya DHIS 2014–15.

MCSP provided technical support to set up functional ORT corners in 18 out of 39 high-volume health facilities in Migori.

Nutrition: MCSP provided technical leadership on the baby-friendly community initiative (BFCI) for the Government of Kenya and supported the Ministry of Health, Nutrition Unit and UNICEF to develop the BFCI guidelines and implementation package, comprised of the BFCI assessment and monitoring tools. In PY1, MCSP oriented 38 CHMT and SCHMT members as well as 60 health care workers on BFCI. In support of World Breastfeeding Week, more than 200 people were reached through educational sessions in East Pokot, Migori, and Kisumu counties with messages on breastfeeding and male involvement for infant and young child nutrition.

At community level, a total of 154 CHVs were trained and supported to form mothers' support groups to address maternal anemia and micronutrient supplementation, especially with iron folic acid (IFA). A total of 54 health workers were also trained on micronutrients and child health and nutrition information system (CHANIS). Working closely with the malaria team, MCSP disseminated the IFA policy to 1,213 health workers in malaria-endemic counties, namely Bungoma, Migori, and Kisumu.

MCSP Kenya also supported health facilities in the 7 PY1 targeted sub-counties to build capacity in implementation of nutrition interventions including integrated management of acute malnutrition (IMAM). Facilities in all sub-counties were assessed to establish their capacity to manage IMAM. On-the-job training was conducted to improve data capture and reporting on wasting, followed by supportive supervision. In East Pokot, documentation tools (CHANIS) were also distributed to health facilities.

Reproductive Health and Family Planning: Kenya is in the process of transitioning from Implanon classic to Implanon NXT, creating challenges in providing this method by health care workers who are unfamiliar with Implanon NXTIn PY1, MCSP trained 52 LARC trainers nationwide, 100 service providers on Implanon NXT, and mentored 150 health care workers on LARC. After the trainings, mentorship and supportive supervision were conducted to ensure quality and monitor implementation. Also, MCSP trained 30 county health management teams (CHMTs), SCHMTs, and service providers in RH commodity management practices; printed and disseminated RH standard operating procedures and job aids; and coordinated closely with the Kenya Medical Supplies Authority and other partners to ensure commodity security. No service delivery points reported stock-outs in the January to August period of 2015. MCSP also strengthened reporting into DHIS-2 to ensure service data are accurately captured and that data for accurate quantification were available. RH/FP reporting rates increased from 52% in April to August 2014 to 64% in the same period in 2015.

Reproductive Health – HIV Integration: MCSP participated in the development of a toolkit to guide S/CHMTs, facility and departmental in-charges, health workers, and other stakeholders on the steps required to integrate RH and HIV services; MCSP is providing support to the National AIDS and STI Control Program (NASCOP) and RMHSU to conduct a review of the status of RH-HIV integration efforts. A Preliminary landscape analysis by the Kenyan Medical Research Institute indicated the need for guidance on how integration can be implemented in a sustainable manner in different health system levels. The toolkit aims to fill this gap.

WASH: Preparations advanced for the study with Unilever of the effectiveness of several approaches to increase the frequency and effectiveness of handwashing by caregivers before handling a baby during the neonatal period (0–28 days). The study will compare the effects of 3 progressively intensive approaches to perinatal handwashing promotion with standard practices in handwashing behavior of mothers of newborns and handwashing behavior of other caregivers

and family members of newborns. Study protocols were submitted and approved by Institutional Review Boards (IRBs) in the US and Kenya. A local research firm and dedicated field staff have been identified to lead implementation in-country testing of the communication materials was completed..

Way Forward

Key interventions expected to be carried in PY2 include:

Maternal and newborn health: MCSP will continue to support integrated medical outreach visits initiated in the previous year covering the identified sites. To improve on coordination, the program will support facility in-charges' meetings, as well as mentorship on data capture and support for timely and routine reporting for hard to reach facilities. The program will support training of health workers on EmONC and procurement of infection prevention, maternity, and newborn equipment for sites. Furthermore, in PY2, the model for RMC from Migori will be replicated in Kisumu.

Malaria in pregnancy: MCSP will expand coverage of MIP activities from 2 counties (Homa Bay, Bungoma) in Year 1 to 5 counties in Year 2 (Homa Bay, Bungoma, Kisumu, Migori and Kakamega). To increase IPTp coverage in these counties, 5,500 CHVs will be oriented on MIP guidelines and will be expected to reach 50,000 pregnant women with MIP messages on ANC attendance. A learning activity will be undertaken in Bungoma County and will involve intensified activities in tracking pregnant women to change their behavior to start attending ANC earlier in pregnancy.

Immunization: To improve on the immunization coverage in East Pokot specifically, MCSP will procure more solar powered EPI fridges to further increase the number of immunizing facilities. Training on cold chain/microplanning and immunization updates for the sub-county's service providers is scheduled for PY2.

Child health: MCSP will intensify mentorship on IMCI, supporting mentors to offer high-level technical and independent gap assessment, collect and consolidate performance data, and analyze data for sharing. Support for data quality assurance (DQA) of child health will be provided to "close the data quality gaps" noted in supervision and mentorships. MCSP will also apply lessons learned from the Bondo iCCM implementation to facilitate training of community and facility health workers on iCCM in one sub-county of Migori. Additionally, MCSP will focus on scaling up of ORT corners—targeting 80% of health facilities in Y2.

Nutrition: The MCSP nutrition team will continue to lead efforts to develop national BFCI guidelines, continue attendance at the quarterly MIYCN technical working group, and continue to strengthen nutrition related reporting and data use. Finally, training for health workers on micronutrients will be expanded to additional sub-counties and MCSP will also support efforts to map early childhood development centers and engage them in vitamin A supplementation for young children.

Reproductive health and family planning: To improve reproductive health and uptake of FP services, MCSP will develop youth-friendly health services, specifically at Chemolingot Sub County Hospital in East Pokot. Training for CHEWs and CHVs in community FP is also scheduled for Year 2. The program will additionally conduct data quality audits as well as supportive supervision on FP. MCSP will also pilot test the RH/HIV intergration toolkit in Migori and Kisumu.

WASH: The newborn handwashing study is expected to commence in the first quarter of PY2, pending the finalization of the intervention's communication materials. Study implementation will be through close coordination and collaboration with the field-supported MCSP Kenya program.

Learning Activities: Concept notes and the plans for the streamlined learning agenda questions will be prepared for relevant approvals (USAID and IRBs) and obtained prior to commencement of the activities.

Liberia Summary & Results

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Strategic Objectives

- **Prevention at facilities**: IPC practices at 61 health facilities are strengthened through training, intensive supportive supervision, triage, improvement of waste management, and planning and management of essential IPC commodities and supplies.
- **Increase MCH service demand and utilization through restored service delivery**: Demand is generated and delivery of quality primary health care services is restored through the implementation of RMNCH as part of the Essential Package of Health Services (EPHS) in 61 facilities.

Program Dates	August 1, 2015–December 17, 2016 (approved September 17, 2015)		
PY1 Approved Budget	[redacted] (for 2 years)		
Geographic Focus Area	Grand Bassa, Lofa, and Nimba counties		
Geographic Presence	**No. of counties (%)**	**No. of districts (%)**	**No. of facilities and/or communities (%)**
	3 (20%)	16 (17%)	61 facilities (8%)
Technical Interventions	PRIMARY: Child Health; Community Health and Civil Society Engagement; Immunization; Malaria; Maternal Health; Newborn Health; Reproductive Health; Water, Sanitation, and Hygiene; OTHER: Adolescent Sexual and Reproductive Health; Infection Prevention and Control		

Selected Programmatic Data	
MCSP Global PMP Indicator	Data not available at the close of PY1

Key Accomplishments

In light of the Ebola Crisis, USAID/Liberia requested MCSP support in restoring service delivery at primary health care facilities and rolling out the nationwide infection prevention and control (IPC) training and protocols. The funding is part of the US Government's Ebola Response and Preparedness Initiative; Pillar 2 of the overall response focuses on mitigating the second order impacts of Ebola in the three countries most affected by the epidemic and further focuses specifically on restoring critical non-Ebola health services.

In collaboration with the Government of Liberia (GOL) and the USAID/Liberia mission and its many bilateral and OFDA-funded partners, MCSP is working to renew confidence in the Liberian health system by improving access to quality reproductive, maternal, newborn, and child health (RMNCH) services. In early June 2015, MCSP Liberia conducted an assessment in order to help inform the development of the MCSP Liberia workplan. Data was collected from 60 out of 61 target health facilities and gaps related to staffing, IPC, isolation units and dedicated latrines, water sources, and incinerators were identified.

MCSP Liberia began preparations for the baseline assessments of 61 target health facilities by training data collectors and field-testing the assessment tool in Montserrado County. By the end of the program year, 50 health facilities had been assessed (19 in Grand Bassa, 16 in Lofa, and 15 in Nimba). The remaining facilities will be assessed as soon as possible after the rainy season, likely by the end of November 2015. Data collection and analysis is ongoing.

The team also conducted coordination meetings with a variety of partners, including other USAID implementing partners and Ministry of Health teams in order to ensure that all gaps were filled, facilities reached, and efforts were not duplicated.

Way Forward

Over the next year, MCSP aims to reach the overarching goal of restoring confidence in the health care system by upgrading IPC practices critical for fighting Ebola and other infectious diseases and ensuring restoration of MCH services in target facilities. MCSP will strengthen essential health services in 61 facilities across Grand Bassa, Nimba, and Lofa Counties. In these facilities, MCSP will ensure adherence to updated IPC protocols and minimum standards as part of the new Safe Quality Services training package, while ensuring adequate stocks of IPC-related supplies. Adherence to IPC practices will help to build the providers' confidence, as well as the community's confidence in the providers and health facilities. MCSP will also ensure that the 61 target facilities are able to address RMNCH within the Essential Package of Health Services (EPHS) areas, with specific attention to essential RMNCH services across the continuum of care.

Key activities also include: developing detailed implementation plans for each county; conducting Safe Quality Services training of trainers; undertaking supportive supervision visits; and ensuring appropriate screening, triage, disease surveillance, and reporting, especially for Ebola Virus Disease.

MCSP Liberia will host a central-level launch event in Monrovia in November 2015; invitees include the U.S. Ambassador, USAID Mission Director and staff, Minister of Health, leaders of relevant technical departments at the MOH, and representatives from a variety of health partner organizations. Following the central level launch, MCSP Liberia will host county-level launches and will invite the County Health Team and Officers in Charge from the 61 target health facilities, representatives from the community, and partner organizations. These launches will give participants the opportunity to review the workplan and provide feedback on areas for coordination, missed opportunities, and timeline suggestions. This activity will help to not only inform detailed implementation plans but also help the counties take ownership of the program and its success.

Madagascar Summary & Results

Clarc Hervé Rasoanaivo/MCSP

Strategic Objectives

- Provide support and technical leadership in maternal and newborn health, immunization, and family planning at the national level to the government/MOH
- Increase access to and improve quality of maternal and newborn health and immunization services in 15 USG priority regions
- Increase access to post-partum, long-acting family planning methods in 15 USG priority regions
- Improve prevention and treatment of MIP in the context of focused antenatal care
- Strengthen the capacity of pre-service training institutions to educate midwives according to ICM standards and competencies

Program Dates	July 2014 – September 2015		
PY1 Approved Budget	[redacted]		
Geographic Focus Area	Alaotra Mangoro, Menabe, Melaky, Sofia regions and the districts of Soalala and Mitsinjo in Boeny region (will expand to all 15 USG-supported regions in PY2)		
Geographic Presence	**No. of provinces (regions) (%)**	**No. of districts (%)**	**No. of facilities (%)**
	5/22 (22.7%)	24/124 (19.5%)	180/1,790 (10%)
Technical Interventions	 PRIMARY: Immunization; Malaria; Maternal Health; Newborn Health; Nutrition; Reproductive Health; OTHER: Adolescent Sexual and Reproductive Health		

Selected Programmatic Data	
Number of people trained through USG-supported programs	228 providers including 36 physicians, 69 nurses, and 123 midwives.
Number of technical reports/papers, policy/research/program briefs, and fact sheets produced and disseminated	2: *Status of Maternal, Newborn and Family Planning Service Delivery at Health Facilities in 15 Regions of Madagascar* and Malaria briefer

Selected Programmatic Data	
National policies drafted with USG (MCSP) support	3 policies: • Supported the drafting and validation of Madagascar's national strategy, *Reduction of Maternal Mortality Roadmap 2015 to 2019* • FP/RH policies: Family Planning Law, FP 2020 commitment, Plan de Development Sectoriel-Santé (PDSS) • Malaria in pregnancy protocol: Revision of Malaria national strategic plan, MOH Technical Note on IPTp
Number of MCSP-supported health facilities actively implementing a quality improvement approach by type of facility	9 facilities (5 basic health center CSB-Dashboard pilot sites in Alaotra Mangoro and 4 regional referral hospitals CHRR for Clinical Governance)

Key Accomplishments

Baseline assessment: As a part of its national advocacy efforts, MCSP Madagascar began the programmatic year with the implementation of a baseline assessment entitled the "Status of Maternal, Newborn and Family Planning Service Delivery at Health Facilities in 15 Regions of Madagascar," which was then approved by the Ministry of Health (MOH) and disseminated to key strategic partners. The assessment results have provided the evidence needed to garner support and momentum for addressing key gaps in service delivery identified by the survey within the 15 USAID priority regions.

MCSP support to the MOH-DSFa (Division of Family Health) and key RMNCH stakeholders: MCSP participated in several national technical working groups (TWGs), including the misoprostol and chlorhexidine TWG, national FP committee and subcommittees, Immunization TWGs, malaria in pregnancy (MIP) TWG. MCSP also provided technical and financial support during the development of Madagascar's *Reduction of Maternal Mortality Roadmap 2015 to 2019*, following Madagascar's commitment to the FP2020 initiative. The establishment of this Roadmap sets the priority for high-impact interventions at the national level.

To improve the prevention and treatment MIP, MCSP participated in national MOH-led TWGs reviewing the national policy to ensure that the IPTp protocol was updated to follow the WHO guidelines of at least three doses of sulfadoxine-pyrimethamine (SP) during pregnancy; with provision of the first dose as early as possible in the second trimester. MCSP also worked closely with the National Malaria Program to integrate an MIP session into the national MNH training curriculum and to develop corresponding job aids. These interventions have brought MIP issues to the forefront as a national priority, have catalyzed the roll-out of MIP protocols at the regional and district levels, and ensured that providers apply the new guidelines in their settings.

MCSP immunization staff participated in the national Immunization Coordination Committee, several TWGs (for polio, surveillance, routine immunization strengthening, and new vaccine introduction), and the polio "emergency team", and also partnered with the MOH's EPI Manager to develop job aids for use by immunization officers and community agents. The MCSP team assessed 12 regions for routine immunization and polio eradication strengthening needs (including community linkages). This structural support for immunization and participation in the polio "emergency team" has been crucial towards increasing national coverage with the polio vaccine (to prevent further circulating vaccine developed polio virus and raise routine OPV coverage) as well as to determine routine immunization gaps and needs at regional and district levels to develop strategies for reaching un/under-vaccinated children.

MCSP strengthening of public health facilities to improve RCMNH service delivery: Under the objective of increasing access to and improving the quality of MNH services in program regions, MCSP developed an MNH "Day of Birth" learning resource package, which is currently being reviewed by the MOH and harmonized with the national MNH training curriculum. This package, though focused on high-impact interventions during labor and birth, also includes crucial elements built on the platform of focused antenatal care such as prevention and treatment of MIP according to the most recent WHO guidelines; counseling on long-acting methods of family planning available immediately postpartum; and the importance of immunization of newborns and infants. The package promises large returns; once integrated into the national training curriculum, service providers will be trained nationwide to follow these guidelines and implement vital MNH high-impact interventions. MCSP also trained 19 national trainers and 54 regional trainers in MNH and training skills as part of a high-quality, competency-based cascade training approach, which will ensure high-quality MNH services implemented at the facility level in the 5 regions targeted in Year 1 (Alaotra Mangoro, Boeny, Melaky, Menabe, and Sofia). Through this strategic approach, 228 health providers from 180 health facilities in Year 1 regions received MNH training, 66 providers received training on prevention of neonatal infection and postpartum hemorrhage within Mahefa intervention sites in Sava and Menabe, and 8 health facilities serving as clinical training sites received assessments and technical updates prior to the training sessions. These interventions ensure higher quality MNCH services in priority regions, and link with the USAID bilateral project community activities. MCSP also partnered with the MOH to implement an assessment of routine immunization and polio eradication at the community level and linkages with service delivery at primary health centers (CSBs) within the Mikolo- and Mahefa-supported regions. Based on the results of the immunization assessment, MCSP provided technical support which allowed the MOH to implement supplementary immunization activities at the national, regional, and district levels.

In an effort to support quality assurance in health service delivery, MCSP developed an MNH quality dashboard/data visualization tool for health centers in the form of a reusable wall chart with charts for key indicators, which was piloted in 5 CSBs in Alaotra Mangoro region in August 2015. This has been paired with a web-based platform for data collection via SMS. MCSP plans to introduce the MNH quality dashboard in all 175 CSBs supported by MCSP during Q1 of PY2. At MCSP, the web platform allows for the real-time electronic visualization of data across all intervention facilities and facility-specific. This initiative is not only a technological advance from paper reporting, but will allow for solid decision making and facility management through simple data visualizations that present quality data in real-time. Moving forward, the next step with the MNH dashboards will be to work with focal points at the facility and district levels to help staff use this data for decision-making and to improve the value of their indicators. MCSP Madagascar also prepared the framework document and the terms of reference for national and regional workshops to launch the Clinical Governance/Quality Assurance (CG/QA) initiative in Madagascar, which will be piloted in 4 regional hospitals in Ambatondrazaka, Morondava, Maintirano, and Antsohihy.

Under the objective of increasing access to long-term family planning methods, MCSP has been an active member of the national MOH-led family planning and reproductive health TWGs, and successfully advocated for the introduction of postpartum family planning (PPFP) methods—including PPIUD and implants—into national policy documents, as well as an update to the national FP training curriculum. The inclusion of these PPFP methods will be paradigm-shifting; providers will now be trained and encouraged at the institutional level to provide these services. MCSP was also tasked with leading the development of a national PPFP training curriculum and trained 22 national trainers and 54 regional trainers in PPFP and training skills, including the introduction of Implanon NXT, which has only recently been adopted by the MOH. These national and regional trainers in PPFP include the national and regional trainers in

MNH and constitute the pool of trainers that support the MCSP's trainings. These efforts have kick-started the momentum for expanding the delivery of PPFP services.

MCSP initiation of planning for the First Time Parents Assessment: Madagascar has one of the highest adolescent fertility rates in the world at 163 adolescent births per 1,000 (MDG, 2013). In the interest of addressing the need for adolescent-friendly services and counseling, MCSP began the process to launch a formative First Time Parents Assessment. The study protocol will be submitted for approval to the Mission, the ethical committee of MOH Madagascar, and the institutional review board of Johns Hopkins University in Q1 PY2. This study promises to identify key gaps and priority areas to address and will help refine components of First-time/Young parents' intervention. This intervention aims to contribute to improved quality and service delivery for adolescents and first-time/young parents, as well as increased access to and demand for services by adolescents and First-time/young parents.

MCSP strengthening of capacity of pre-service training institutions to educate midwives according to ICM standards and competencies: To strengthen the capacity of pre-service training institutions, MCSP worked closely with representatives from the MOH, the 6 faculties of medicine, the midwifery training institutions, the professional associations, UNFPA, and additional partners to revise the midwifery pre-service (PSE) curriculum to ensure adherence to the standards of the WHO and the International Confederation of Midwives (ICM). The Faculty of Antananarivo is leading the finalization of the document and its dissemination within the other faculties is slated for 2016. MCSP also trained 28 teachers and preceptors from 3 out of the 6 national public midwifery institutions and 1 university hospital (out of 9) in MNH, PPFP, and effective teaching skills. Reinforcement and continual updating of the PSE curriculum ensures adherence with globally accepted standards; MCSP has ensured that this process of updating continues as well as reinforcing the skills and techniques of the teachers and preceptors.

Way Forward

During PY2, MCSP will continue to provide technical assistance and support to the MOH to develop and disseminate RH and MNH policies and strategy documents. Key strategic documents to be updated include the RH Norms and Procedures and the FP strategic plans. MCSP will continue to champion high-impact interventions within these national policy documents to ensure national prioritization and institutionalization. The organization of a national FP conference in 2016 will aim to capitalize on best practices to orient the strategies in FP including consolidation of long-acting family planning methods availability post-partum.

MCSP will continue collaboration with the MOH/DSFa and the regional health authorities to strengthen the capacities of facilities to provide quality services in MNH and immunization. The program will expand into 5 new regions in the first semester and an additional 5 regions in the second semester, to cover all 15 USG priority regions by the end of PY2. This expansion represents an important scale-up of strengthened service delivery, with coverage nearing 70% of the entire country. The scale-up includes the following targets, among others:

- 900 providers in 15 regions will be trained in MNH best practices and PPFP counseling (at least one provider trained per CSB2 and at least 2 per CHD/CHRR).
- 460 health providers working in labor and delivery and immediate postnatal care in 15 regions will attain competencies in PPIUD and Implants insertion (one provider per CSB2 among those with high volume of deliveries).
- 700 health facilities in 15 regions will be strengthened with provision of clinical supplies/equipment (facilities with at least 1 provider trained).

- Regions supported by the USAID-funded MAHEFA and Mikolo Projects with high numbers of un/under-vaccinated will have defined strategies (e.g., REC) for strengthening routine immunization services and coverage.

MCSP will introduce clinical governance in 3 additional regional hospitals, along with the MNH quality dashboards adapted for use at this level of facility and in line with the quality improvement objectives identified at each regional hospital. The orientations, coupled with ongoing supervision, will equip the targeted hospitals with the ability to analyze data from the dashboard, identify successes and gaps, and develop and implement solutions to address those gaps.

MCSP will also complete the First Time Parents assessment, as well as a smaller field-testing of gestational tools in areas with high rates of second trimester antenatal care visits. Targeted providers will receive training on the tools as well as monitoring through structured calls and on-site visits with the aim of improving ANC, maternal health, PNC, PPFP, and ENC services among adolescent parents (young mothers and mothers-to-be).

Community approaches/interventions will be strengthened within the MOH/SV (Immunization Department) and partner annual immunization plan (including SV support to regions/districts) to reduce drop-out and contribute to immunization coverage improvement, including for polio. Immunization job aids will be updated and disseminated (in collaboration with SV and partners). Technical assistance will be provided to the two USAID bilateral awards to update CSB staff and community agents in defaulter tracking and routine immunization strengthening.

Malawi Summary & Results

Kate Holt/Jhpiego

Strategic Objectives

- **New Vaccine Introductions:** Successfully introduce Measles Second Dose (MSD) and Inactivated Polio Vaccine (IPV) and support Ministry of Health/Expanded Program on Immunization (EPI) to implement pre-introduction, introduction and post-introduction activities.
- **Capacity-Building:** Improve the capacity of managers and service providers at all levels to manage and provide quality immunization services.
- **Strengthening Routine Immunization:** Strengthen routine immunization system by improving planning, monitoring, and vaccine and cold chain management at the national, zonal, district, and health facility levels.

Program Dates	July 1, 2014–September 30, 2015 (approved December 19, 2014)		
PY1 Approved Budget	[redacted] of MCH/immunization funds		
Geographic Focus Area	National, as well as zonal and district-specific support for new vaccine introduction and capacity building, as well as intensive work and learning activities in two districts (Dowa and Ntchisi)		
Geographic Presence	**No. of regions (%)**	**No. of districts (%)**	**No. of facilities (%)**
	1/5 (20%)	2/29 (6.8%)	42/780 (5%)
Technical Interventions	Immunization		

Selected Programmatic Data	
Percentage of children aged <12 months who received DPT3/Penta3 vaccine in MCSP-supported areas	93.5%
Number of people trained through USG- supported programs*	249
Number of (national) policies drafted with USG (MCSP) support*	National Immunization Policy updated and pending MOH approval

** identifies an Investing in People/Operational Plan indicator*

Key Accomplishments

A successor to MCHIP, MCSP continues support to the Government of Malawi and its national EPI program to roll out new vaccines and ensure high-quality delivery of routine immunization services. In PY 1, from July 2014–September 2015, MCSP completed start-up and launched activities in support of the Government of Malawi's recommitment to improving the health of Malawian children by introducing new vaccines, building capacity of managers and service providers, and strengthening routine immunization systems at national, zonal, district, and health facility levels.

New vaccine introductions

In alignment with the Global Vaccine Action Plan (GVAP) to "achieve a world free of poliomyelitis" and increase immunization coverage, the Malawi has been working to introduce the Inactivated Polio Vaccine (IPV). MCSP provided technical assistance to pre-introduction activities for IPV, including development of training materials and assistance to conduct trainings of trainers (TOTs). Additionally, MCSP supported the MOH and its partners to launch Measles Second Dose (MSD) vaccine for children at 15 months of age. MCSP will continue to monitor coverage of MSD, and eventually IPV, and will provide post-introduction support to priority districts during regular review meetings and supportive supervision.

Capacity-building for health workers

To improve the capacity of managers and service providers at all levels and provide quality immunization services, MCSP supported numerous trainings for health workers, some nationwide and some in the 2 priority districts. The Mid-Level Managers (MLM) training was new to Malawi; as such, most district EPI coordinators had not been formerly trained in these modules. MCSP provided technical assistance to lead the training and build capacity of 25 managers across several districts within the country. MCSP also supported training of 40 EPI supervisors from all 29 districts in effective supportive supervision, also known as Regular Appraisal of Program Implementation in District (RAPID)—a method that has been used in other countries to improve the quality of immunization delivery, a major challenge in Malawi. MCSP facilitated 2 TOTs for Fridge Tag 2 introduction for 42 trainers from 7 districts. MCSP also provided technical assistance for *Immunization in Practice (IIP)* trainings in the priority districts, training 62 district and facility staff and volunteers. Also, in the 2 priority districts, MCSP supported training in minor repair of cold chain equipment for some Health Surveillance Assistants (HSAs). Often, refrigerators sit non-functional due to minor faults, which can be repaired by vaccinators themselves. These HSAs are now able to manage these repairs on their own and need to call the district support only when there is a major fault.

Additionally, MCSP, in collaboration with the EPI and PHC Units and tutors from the HSA training centers, revised the National HSA Curriculum to include new vaccines: Pneumococcal conjugate vaccine (PCV), Rotavirus vaccine, and other new strategies such as Reaching Every Community (REC). The current HSA immunization curriculum had not been revised since 2009 and, as such, new HSAs were being provided very outdated information. The updated curriculum has been printed and will be used for HSA pre-service training beginning in January 2016.

REC to strengthen routine immunization

Reaching Every District (RED) is a proven strategy to increase access to immunization and other services; the newest iteration of RED is Reaching Every Community/Child (REC). RED/REC strengthen district and health facility planning, as well as the organization, supervision, and monitoring of services and linkages between health facilities and communities. It is also equity focused, in that it encourages districts and health facility managers to use their limited resources to reach communities and populations with the largest number of individuals who are not currently being reached by services. At the MOH's request, MCSP began supporting two low-

performing districts (Ntchisi and Dowa) to implement REC in 2015. These districts were selected based on their low immunization coverage rates and high numbers of unvaccinated children. Before implementing the REC strategy, MCSP conducted a baseline household coverage survey to set a foundation for measuring progress in REC implementation and to identify factors impacting the utilization of vaccination service and systemic challenges affecting service delivery.

MCSP provided technical support for micro-planning workshops in the priority districts and has continued to support quarterly review meetings and supportive supervision. Initially, planning proved difficult because many facilities lacked the data for a situation analysis and most had difficulty defining their target populations. With MCSP's support, a system for data improvement was instituted in most facilities and head count exercises were conducted to provide target populations. With persistent supervision and quarterly review meetings involving the health facility staff, most facilities completed their micro-plans and will continue using them for implementation of planned activities. MCSP's support for REC aims to improve immunization coverage and reach underserved children in hard-to-reach areas. The MOH plans to build on experience with REC in the first two MCSP-supported districts to expand the approach.

Way Forward

In PY2, MCSP will continue its national support for new vaccine introduction—in 2015/16, Malawi is planning to introduce Measles Rubella vaccine (MR), continue its introduction of Inactivated Polio vaccine (IPV), and make the switch along with the rest of the world from trivalent (tOPV) to bivalent (bOPV) oral polio vaccine. REC implementation in the 2 districts will be strengthened to include all 5 components: 1) effective planning and management of resources, 2) reaching all target populations, 3) supportive supervision, 4) monitoring for action, and 5) linking services with communities. A civil society organization (CSO) has been identified and contracted to work with village heads and volunteers to register and mobilize all eligible children and track their immunization status using the My Village My Home (MVMH) tool. MVMH has been found useful in other countries for newborn tracking and for engaging communities in monitoring their own immunization status. MCSP also will continue its capacity-building activities for service providers in the 2 districts by training additional health workers in IIP. Nationally, MCSP will train additional district health management teams in MLM courses.

At USAID/Malawi's request, MCSP will add the integration of family planning and immunization and nutrition promotion (primarily related to breastfeeding and the Baby Friendly Hospital Initiative) to its list of supported interventions.

Mali Summary & Results

Michael Bisceglie/Save the Children

Strategic Objectives

- Contribute to improved national health strategies, policies, and programs that increase the population's access to an affordable, integrated package of high-impact MNCH/FP, malaria nutrition, and WASH interventions (MNCH/FP-Mal-Nut-WASH);
- Improve access to and quality and efficiency of MNCH/FP-Mal-Nut-WASH services at the community level in project areas including the Essential Community Package (SEC) and social marketing products; and
- Improve access to high-quality, integrated MNCH/FP services in public health facilities, private clinics and ProFam sites in project areas.

Program Dates	May 1, 2014–June 30, 2015 (approved September 18, 2014)		
PY1 Approved Budget	[redacted]		
Geographic Focus Area	2 Regions: Sikasso, Kayes, and the district of Bamako 13 Districts and 6 Communes of Bamako 571 Community Health Worker Sites		
Geographic Presence	**No. of regions (%)**	**No. of districts (%)**	**No. of facilities and/or communities (%)**
	2/8 (25%)	13/49 (26.5%) Kayes: 8/8 (100%) Sikasso: 5/7 (71%)	571
Technical Interventions	PRIMARY: Child Health; Community Health and Civil Society Engagement; Malaria; Maternal Health; Newborn Health; Nutrition; Reproductive Health; Water, Sanitation, and Hygiene OTHER: HIV		

Selected Programmatic Data	
Indicator	**Result**
Number of (national) policies drafted with MCSP program support	Three: the national strategic plan for SEC, the national plan for family planning, and the national plan for the introduction of chlorhexidine (using the formative research of newborn cord care and the associated evaluation report)
Number of District Technical Coordinators (DTC) Community Health Workers (ASCs), and relais trained on the SEC package and seasonal malaria chemoprevention (SMC) in MCSP-supported districts	1,042 (127% of target)
Percentage of sick children with pneumonia receiving appropriate treatment by ASCs in MCSP-supported districts	734 out of 773 (93%)
Number of new family planning acceptors through ASCs in MCSP-supported districts	13,282 (86%)
Number of newborns in MCSP supported districts who received a postnatal care visit by an ASC within 48 hours of birth	14,755 (93%)
Proportion of supportive supervision visits with reports that include key issues that need to be addressed and a follow-up mechanism /timeline for addressing these	77%
Number of health workers trained in MNCH/FP and malaria services at MCSP-supported facilities	223 (98%)
Number of new family planning acceptors in MCSP-supported facilities	28,088 (88%)

Key Accomplishments

MCSP was initiated in Mali in April of 2014 to scale up the achievements of MCHIP and address the major challenges identified in the end line evaluation. With this mandate, MCSP worked to introduce and support these interventions in Mali with a focus on ensuring women, newborns, and children equitable access to quality, life-saving health care services. MCSP worked with the government of Mali, civil society, the private sector, health care providers, and communities to increase access to an affordable, integrated package of high impact MNCH/FP, malaria, nutrition, and WASH interventions (MNCH/FP-Mal-Nut-WASH) in public health facilities, private clinics, ProFam[6] sites, and at community level through in 13 districts and also worked at national level to improve health strategies, policies, and programs.

At the national policy level, MCSP supported the MOH to finalize and validate the National Strategic Plan for Essential Community Care (SEC), which enabled the development of regional action plans for SEC, which were with the Cabinet of the MOH for approval at the close of the project. This strategy addressed key issues identified in an assessment of SEC under MCHIP to improve the quality and access to SEC and to position the USAID bilateral for scaling up the approach. MCSP also strengthened supportive supervision, monitoring, equipment, supplies, training, and incentive payments to 571 community health workers (ASCs) to address some of the key issues identified in the MCHIP qualitative study. In line with the National Strategic Plan, MCSP enabled the MOH to scale up the SEC approach from 5 districts in Sikasso and 3 in Kayes to 5 additional districts in Kayes, providing the comprehensive community package in 13 districts in total. MCSP provided technical and financial support to the National Program

[6] ProFam is a social franchise approach used with private health clinics in Mali that was created and is led by PSI/Mali.

against Malaria and the national technical working group for MIP as well as to the national technical working group for the integrated management of childhood illness to align Mali's national reproductive health policies with the WHO guidelines for the prevention and treatment of malaria during pregnancy and in children under 5 years old, and to harmonize the national malaria policy with the national IMCI protocol, and protocol for the integrated management of malnutrition. MCSP successfully advocated to the National Department of Health and supported the Division of Newborn Health to establish a national sub-committee, perform formative research, and develop a strategic plan to introduce chlorhexidine for newborn umbilical cord care.

MCSP supported the MOH to successfully launch a National Handwashing Campaign for which the program developed and disseminated communication messages using local radio and community groups. Awareness-raising tools were developed, used, and monitored by ASCs in the community. This intervention was particularly timely and relevant in face of the Ebola crisis that emerged during the same period. MCSP supported the Government of Mali at the national and district levels to protect a target of 103,296 children in the district of Kita from malaria by implementing a seasonal malaria chemoprevention (SMC) intervention at scale through the existing health system. The intervention achieved 100% protection for 54% of its target. A household study was also supported by MCSP that demonstrated SMC distribution and adherence could attain a sufficient level of efficacy using the existing health system and reduce incidence of malaria and anemia among infants 3–59 months.

MCSP exceeded targets for multiple socially marketed product sales. Aquatabs, ORS/zinc, and oral contraceptive sales targets were particularly exceeded. A total of 667 promotional days for integrated family planning and vaccination ("Jour N'Terini") were organized by MCSP to strengthen the delivery of postpartum services in the community health centers (urban CSCOM) in Bamako, Sikasso, and Kayes; 70,171 women received family planning services, and of those women, 30,451 chose long-acting methods. A total of 7,073 women benefited from cancer screening services using the visual inspection with acetic acid (VIA)/visual inspection with Lugol's iodine (VILI); all 139 VIA/VILI-positive cases were referred for treatment in public and private health centers supported by MCSP and also during cervical cancer screening campaigns.

Health systems strengthening, including strengthening services to vulnerable populations and youth, was a key achievement under the program. MCSP funded and provided technical supervision to 32 women's groups in 6 health districts in Kayes (Diéma and Kita) and to 26 in Sikasso (Bougouni, Kolondièba, Sélingué, and Yanfolila) to support the process of strengthening social mobilization activities and communication for behavior change in favor of maternal, neonatal, and infant health. The program also scaled up and supported the Integrated Package, a sub-set of high-impact interventions implemented under MCHIP in 7 districts: 2 in Kayes and 5 in Sikasso, and reinforced the capacity of targeted facilities to implement the Integrated Package, including training/follow-up, supervision, materials, and supplies.

Over the life of the project, there was an increase in the number of women attending ANC visits (74% up to 80%) and those giving birth in a health facility (47% up to 50%). MCSP developed an innovative, 10-day course that integrated competencies for post abortion care (PAC) and long-acting and reversible contraceptives (LARCs) and minimized providers' absences from their facilities. MCSP strengthened the capacity of service providers and improved the quality of PAC/LARC services in national and regional hospitals and Referral Health Centers (CSREFs) in the regions of Kayes and Sikasso and the district of Bamako. This was accomplished through training and equipment provision, improving the quality of PAC services including access to family planning in 4 facilities in these regions. KMC training and follow up was supported in facilities in Bougouni and Kita. Providers in these sites demonstrated a strong capacity to teach mothers the KMC approach and support them. The successful implementation of the approach was documented as a case study for MCSP (Annex III). Following 826 mobile visits to Sikasso, Koutiala, Bamako, Kayes, Ségou, and Gao, 24,881 people received voluntary HIV counseling and

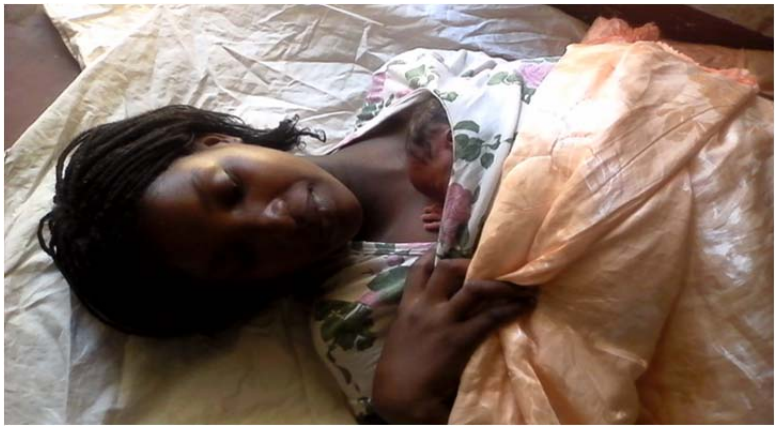
testing services, including 335 who tested positive (a rate of 1.34% and above the national average of 1.1%). Among those tested, 65.6% were female. More than half of the people who tested positive were screened for TB. Building on the youth platform under the MCHIP project, the PSI youth volunteer team organized 15 youth groups, known as "GRINS," in the vicinity of 15 supported private clinics in order to offer youth-friendly reproductive health services in Bamako.

Way Forward

Though MCSP successfully maintained the momentum of the SEC, the backbone of the health system, there remain challenges that should be addressed to ensure full functionality of the program and quality of care. There is a need to strengthen community outreach through supervision of SEC and Integrated Package activities and monthly supervision of the CHWs. In addition, mechanisms should be reinforced that ensure functionality of SEC coordination committees in the health districts to effectively analyze and use data to aid decision-making. Finally, SEC data should be integrated into health districts' Quarterly Activity Reports to ensure monitoring and follow-up on issues.

At the health district, all CHWs need training/retraining on SEC implementation, to include the SEC integrated package. District supervisors need to observe the supervisory visit schedule: identify alternatives in the absence of focal points for the supervision of SEC and IP activities, and ensure the delivery of funds on time. They also need to conduct supervision and proper monitoring of inputs to community health centers, respecting the normal standards of drug management.

Mozambique Summary & Results—Bridge Program



Zaida Macie/MCSP

Strategic Objectives

- Objective 1: Increase coverage of high-impact RMNCH interventions and respectful care at both the community and health facility-levels to contribute to ending preventable child and maternal deaths (EPCMD)
- Objective 2: Strengthen health systems to deliver quality RMNCH services, with an emphasis on data and human resources management, and linkages between community and facility services
- Objective 3: Improve the environment for the delivery of high-impact RMNCH interventions and respectful care through technical leadership and coordination
- Objective 4: Strengthen child health in facilities implementing the MMI through in-service training and Integrated Management of Childhood Illnesses (IMCI) management

Program Dates	MCSP Bridge: April 30, 2015–September 30, 2015		
PY1 Budget	MCSP Bridge: [redacted]		
Geographic Focus Area	National		
Geographic Presence	**No. of provinces (%)**	**No. of districts (%)**	**No. of facilities and/or communities (%)**
	11 (100%)	99/150 (66%)	CECAP: 141/250 = 56.4% Model Maternity Initiative: 125/179 (69.8%)
Technical Interventions	PRIMARY: Child Health; Community Health and Civil Society Engagement; Immunization; Maternal Health; Newborn Health; Nutrition; Reproductive Health (including CECAP) OTHER: Quality Improvement, Health Information Systems		

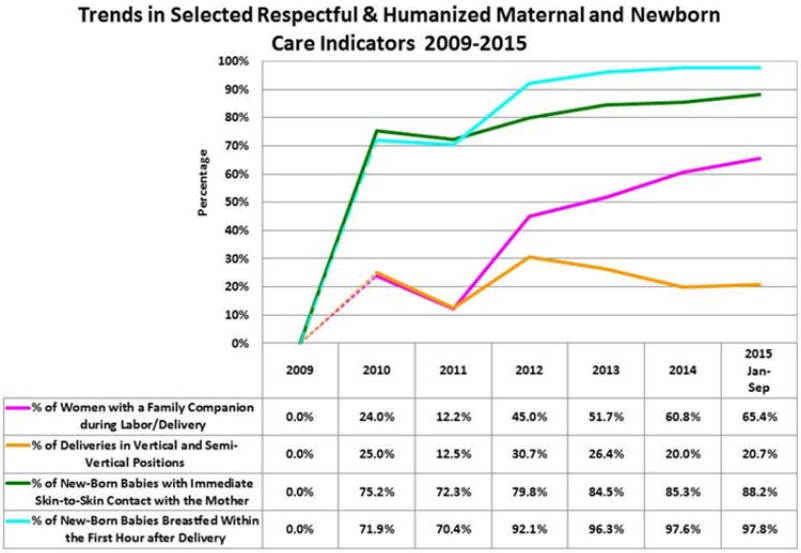
Selected Programmatic Data	
Percent of women receiving a uterotonic in the third stage of labor in MCSP supported areas	88.3%
Number of newborns admitted to facility-based KMC at MCSP supported facilities	437

Selected Programmatic Data	
Percent of babies not breathing/crying at birth who were successfully resuscitated in MCSP supported areas	74.9%
National policies drafted with USG (MCSP) support	1 (National Strategy for Quality and Humanization, 2015–2019)
Number of MCSP-supported health facilities actively implementing a quality improvement approach	127
Percentage of MCSP target districts with regular feedback mechanisms supported by the program to share information on progress toward RMNCH health targets with community members and/or CSOs	100%

Key Accomplishments

The MCSP Bridge Award began on April 30, 2015 and ended on September 30, 2015. The five-month bridge period was designed to permit the continuation and completion of critical activities of the MCHIP Associate Award (AA) (April 2011 – June 2015), particularly in support of two of the Ministry of Health's national priorities: the Model Maternity Initiative (MMI) and National Cervical Cancer Prevention and Control Program (CECAP), which include support for postpartum and interval family planning, respectively.

Scale-up of quality, high-impact, and respectful MNH interventions in 125 maternities: During this reporting period, MCSP supported the ongoing scale-up of quality, high-impact, and respectful MNH interventions in 125 maternities. Five additional health facilities received and passed an MOH-led external evaluation (financed by MCSP) to confirm their status as a national Model Maternity Facility in recognition of their sustained performance of 80% or more in all areas of the MMI Performance Standards. To date, a total of 11 health facilities have achieved this status, of which 5 have been publically recognized. Respectful MNH care practices were also expanded, as noted in the graph below which highlights trends in selected respectful MNH indicators during the implementation of MCHIP and MCSP Bridge. During the Bridge Program, specifically, over 89% of newborns were breastfed within the first hour of delivery and had immediate skin-to-skin contact with the mother in September 2015. In addition, over 65% of women were accompanied by a companion for labor and delivery.



	2009	2010	2011	2012	2013	2014	2015 Jan-Sep
% of Women with a Family Companion during Labor/Delivery	0.0%	24.0%	12.2%	45.0%	51.7%	60.8%	65.4%
% of Deliveries in Vertical and Semi-Vertical Positions	0.0%	25.0%	12.5%	30.7%	26.4%	20.0%	20.7%
% of New-Born Babies with Immediate Skin-to-Skin Contact with the Mother	0.0%	75.2%	72.3%	79.8%	84.5%	85.3%	88.2%
% of New-Born Babies Breastfed Within the First Hour after Delivery	0.0%	71.9%	70.4%	92.1%	96.3%	97.6%	97.8%

High-impact interventions were expanded, supported, and reinforced including: completed partographs, treatment of severe pre-eclampsia and eclampsia (PE/E) with magnesium sulfate (MgSO4), and active management of the third stage of labor (AMTSL). The institutional maternal mortality ratio at MMI facilities declined over the course of 5 years as implementation of the 3 key high-impact interventions increased.[7]

Support for scale-up and integration of cervical and breast cancer prevention services into RH/FP services: In alignment with MOH policy, MCSP supported expansion of services for the prevention of cervical and breast cancer using the single-visit approach (SVA) and increased the overall coverage of referral services (LEEP and colposcopy) for follow-up of patients with severe lesions detected by visual inspection with acetic acid (VIA). Specifically, MCSP supported the training of 111 health professionals in the VIA screening approach and cryotherapy treatment during the Bridge period, increasing access for women to these vital services. By the end of September 2015, the VIA screening rate was 48%, more than triple the baseline (14%), and 95% of eligible women received cryotherapy on the same day or the days following screening. MCSP also trained 13 health professionals from 3 referral health facilities to provide LEEP and colposcopy services.

At the community level, MCSP mobilized community groups to lead or engage in efforts to improve the health of their communities. The program provided financial support and supported community mobilization to conduct 96 mobile brigades, which included vaccination for 3,380 children, and educational sessions with 6,070 community members regarding family planning, the importance of pre-natal and postpartum consultations, the new Rotavirus vaccine, exclusive breastfeeding, nutrition, institutional births, and diarrhea. MCSP also provided refresher training to 297 co-management committee (CMC) members to strengthen capacity in themes including CMC tasks and objectives, elaboration of plans, and reporting results.

Way Forward

Beginning on October 1, 2015, MCSP will transition to a multi-year follow-on program focused on providing continued support to the central-level Ministry of Health as well as the provinces of Nampula and Sofala for facility and community based services. The new program will apply as its theory of change a modified socio-ecological model which incorporates a family-centered lifecycle approach[8] as central for multi-sectoral, integrated service delivery and demand creation for improved RMNCH, including nutrition and malaria. The new program will incorporate lessons learned from MCHIP and MCSP Bridge, particularly those experiences gained through implementation of the MMI and integrated CECAP and FP programming. MCSP will utilize an integrated referral network approach to deliver quality, high-impact RMNCH, nutrition, and malaria interventions at the various levels of health service delivery, with the majority of resources focused at the district level, including primary level health facilities and communities. Technical priorities in the new program include Maternal Health, Newborn Health, Child Health, Immunizations, Reproductive Health (including CECAP), Family Planning, Nutrition, Malaria, and WASH. The program will also place a strong focus on strengthening the Ministry of Health's leadership, planning, and monitoring capabilities at the provincial and district levels to deliver quality, high-impact RMNCH, nutrition, and malaria programs.

[7] The HMIS does not currently disaggregate severe from moderate cases of pre-eclampsia; therefore, the denominator for the indicator % of pre-eclamptic and eclamptic women is inflated and includes moderate cases which do not require treatment. This disaggregation is included in the newly revised RMNCH registers and therefore the quality of information reported on this indicator is expected to improve in 2016.

[8] Centre for Maternal, Adolescent, Reproductive, and Child Health (MARCH) , London School of Hygiene and Tropical Medicine.

Namibia Summary & Results

Lauren Anneberg/MCSP

Strategic Objectives

- Increased coverage of Namibian communities with an integrated package of Primary Health Care/HIV/TB services through the National Health Extension Program (HEP)
- Improved quality and sustainability of Namibia's implementation of the integrated National HEP
- Increased access to and quality of integrated HIV/sexual and reproductive health (SRH) services for vulnerable populations, including adolescents and young women
- Improved availability of quality data for the HEP
- Improved capacity at health facility, district, and national levels to implement the new health information system
- Enhanced management and interoperability of Ministry of Health and Social Services (MOHSS) health information systems

Program Dates	August 2014–September 2015 (approved May 7, 2015)		
PY1 Approved Budget	[redacted]		
Geographic Focus Area	**National**; **7 regions** (Kavango, Zambezi, Oshana, Ohangwena, Omusati, Oshikoto, and Khomas); **16 districts** (Rundu, Nyangana, Katima, Engela, Okongo, Omuthiya, Tsumeb, Tsandi, Outapi, Onandjokwe, Oshakati, Oshikuku, Okahao, Khomas, Keetmanshoop, and Walvis Bay)		
Geographic Presence	**No. of regions (%)**	**No. of districts (%)**	**No. of facilities and/or communities (%)**
	7/14 (50%)	16/34 (47%)	153 health facilities 879 communities 7/7 Namibian Planned Parenthood Association (NAPPA) clinics (100%)
Technical Interventions	PRIMARY: Child Health; Community Health and Civil Society Engagement; Reproductive Health; OTHER: HIV; Adolescent Sexual and Reproductive Health; Health Information Systems		

Selected Programmatic Data

Selected Programmatic Data	
Number of people trained through USG-supported programs	595
Number of individuals who received HTC services for HIV and received their test results	7,581
Percentage of HIV service delivery points supported by PEPFAR that are directly providing integrated voluntary family planning services	100%
Number of supportive supervision visits implemented at site level	57

Key Accomplishments

MCSP carries forward the momentum and lessons learned from the highly successful MCHIP interventions, which started in Namibia in October 2012. During the first year of implementation (August 2014–September 2015), MCSP Namibia completed start-up activities, filled several key technical advisor positions, and launched or re-launched activities in support of the Ministry of Health and Social Services (MOHSS) agenda to: 1) implement and scale up the national Health Extension Program (HEP); 2) increase access to and quality of integrated HIV/SRH services, particularly for HTC and care and treatment among adolescents and young women; and 3) support the development of community health indicators, and improve the quality and use of health data.

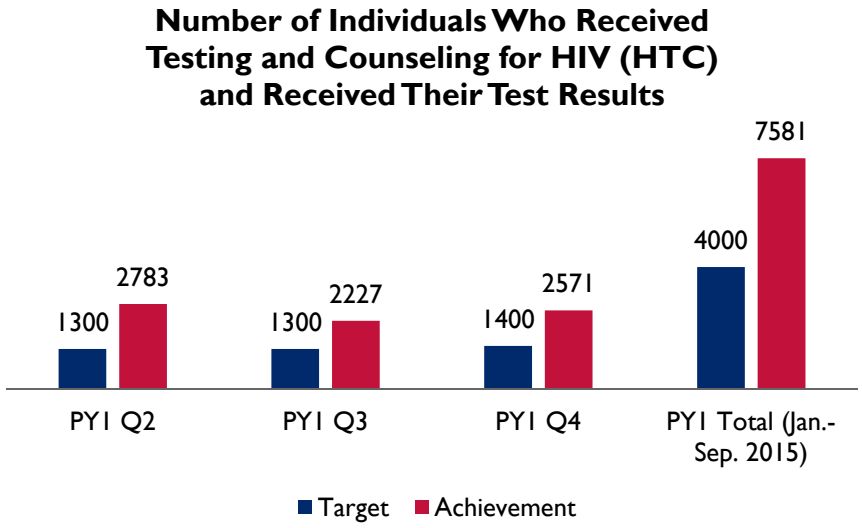
National Health Extension Program: MCSP worked with the National HEP Steering Committee and regions to improve quality and ensure institutionalization through: support to national and regional HEP review and planning meetings in 6 regions, the identification of district HEP focal people, and the establishment of 6 regional Steering Committees. The project conducted HEP orientation workshops for health workers in 6 regions and 16 districts, reaching 120 nurses, and conducted community sensitization workshops that reached 872 community members. In support of the MOHSS, MCSP established task forces to drive the integration of iCCM and HTC into the HEP platform, and coordinated revisions to the iCCM training package as well as developed a concept note for HTC piloting. Finally, to further strengthen quality, the project drafted and finalized a supportive supervision package, and conducted 57 supportive supervision visits reaching a total of 323 HEWs. These activities are part of a transition strategy to ensure that high-impact RMNCH and TB/HIV services are integrated into the MOHSS' HEP and are sustainable at the community level to maintain national reductions in women, infant, and child morbidity and mortality.

HIV/Sexual and Reproductive Health Program: MCSP supported the working relationship between the MOHSS and MCSP's civil society organization partner, the Namibian Planned Parenthood Association (NAPPA). The project conducted site assessments at 3 NAPPA clinics, which informed future activities to: strengthen the capacity of clinical staff to provide youth-friendly, quality HIV/SRH services; expand access to and quality of clinical services to meet the needs of their communities; improve quality assurance/quality improvement, mentoring, and M&E systems; improve linkages with communities; and improve clinic infrastructure to accommodate additional services. All service providers from Zambezi, Khomas, and Erongo clinics were trained on provider-initiated testing and counseling, and nurse-initiated and managed ART training was provided to nurses from Khomas and Erongo clinics. This training has strengthened SRH and HTC service delivery at all NAPPA clinics and has laid the foundation for initiating community testing with active linkages to care at NAPPA facilities and the initiation of care and treatment at 3 NAPPA clinics in PY2. The project's work with NAPPA

addresses critical gaps in access to care and adherence retention services for young women and adolescents living with HIV in priority, high-burden areas.

Strategic Information/National Health Information System: Building on MCHIP's earlier work, MCSP conducted routine HIS performance strengthening (PRISM) training for MOHSS national-, regional-, and district-level staff and worked with the MOHSS team on the selection of maternal and child health indicators for the new DHIS 2.0 in order to review, consolidate, and ensure that HEP indicators are included. The project team also reviewed and consolidated HEW data collection tools and reporting methods and supported the inclusion of the HEW reporting formats in the earlier DHIS 1.43 and the new DHIS 2.0 platforms. Finally, the project developed, tested, and applied tools to improve the supportive supervision of HEWs, and supported M&E training for 10 HEP-implementing regions and 3 regional HEP directors. In support of HIV/SRH activities, the team conducted M&E assessments at 3 NAPPA facilities and introduced quarterly data review and verification meetings at all NAPPA facilities. Supporting the MOHSS at national and sub-national level through cross-cutting HIS and M&E support to the HEP and to NAPPA will improve reporting and use of community data at the district level as well as further up the information chain.

The chart below shows MCSP's achievements in terms of the number of HTC clients who received their test results (as compared to the targets, which were exceeded in each quarter).



Way Forward

In PY2, the project will intensify its effort to address the HIV burden in priority regions by achieving high rates of targeted HTC and improving linkages to care and treatment at the community and health facility levels. MCSP will continue to focus in 16 health districts in 7 of the country's 14 regions (Kavango, Zambezi, Ohangwena, Omusati, Oshana, Oshikoto, and Khomas). These are the new PEPFAR priority regions, selected on the basis of high population density and relatively high HIV prevalence. By concentrating efforts in these priority regions, MCSP will be able to increase access to integrated HIV, SRH, and RMNCH services for populations with the highest HIV rates in the country. The primary focus of MCSP's technical assistance, capacity building, and collaboration will continue to be MOHSS officials at provincial, district, and health facility levels, NAPPA service providers, and the community-based HEWs and their supervisors. In this way, MCSP will continue to strengthen the capacity

of regional and district health teams to implement community- and facility-based activities that lead to further reductions in maternal, infant, and child morbidity and mortality and, eventually, the achievement of an AIDS-free generation.

Nigeria Summary & Results—MAMA

Karen Kasmauski/MCSP

Strategic Objectives

- Develop, test, and begin delivering culturally relevant educational content to pregnant women by optimizing the Mobile Alliance for Maternal Action's (MAMA's) core educational content for Nigerian women through landscape analyses, technical review, and user testing through SMS and voice channels.

Program Dates	October 1, 2014–September 30, 2016 (approved April 8, 2015)		
PY1 Approved Budget	[redacted]		
Geographic Focus Area	Regional		
Geographic Presence	**No. of provinces (%)**	**No. of districts (%)**	**No. of facilities and/or communities (%)**
	N/A	N/A	N/A
Technical Interventions	PRIMARY: Maternal Health; Newborn Health OTHER: m/eHealth		

Selected Programmatic Data	
MCSP Global PMP Indicator	Data not available at the close of PY1

Key Accomplishments

The MAMA Nigeria project aims to improve the quality of life for pregnant women, new mothers, and their children and families in Nigeria through age- and stage-based mobile messaging. Year 1 of the program focused on the backbone elements of the project. These include the first phase of technology platform development, including design of the framework for interactive voice response to accommodate low-literate users of the platform, development of relationships with mobile network operators and aggregators, an intensive service design process, and adaptation of Baby Center/MAMA's global content repository for the Nigerian context. The English versions of these adapted messages were reviewed by an expert committee and are now being localized, translated, and recorded. These messages will be available in Hausa, Ibo, Yoruba, and Pidgin.

The project also developed local brand elements, mobilized key resources, and completed stakeholder mapping. The team finalized the M&E framework and completed a landscape assessment and literature review. The project also established a steering committee and set up a partnership management structure.

Way Forward

In the upcoming year, MAMA Nigeria will aim to complete development and pilot the deployment of the technology platform that will integrate with and support the work of the Federal Government of Nigeria to increase demand for and uptake of maternal health services in Nigeria. Health facility workers will be trained in enrollment of clients to the system, and promotional/information, education, and communication materials will be distributed. After the pilot phase, a critical analysis of the project outputs (client enrollment, messages sent) will be examined and rapid refinements to the methodology, technology, and approach will be recommended for subsequent scale-up phases. Ultimately, MAMA Nigeria will be rolled out in FCT, Ebonyi, Kogi, and Cross-River States.

Nigeria Summary & Results—MNH

Strategic Objectives

- Improved quality of facility-based maternal and newborn health care (MNH) services
- Improved information systems to monitor and evaluate health outcomes
- Increased use of life-saving innovations

Program Dates	October 01, 2014–September 30, 2015		
PY1 Budget	[redacted]		
Geographic Focus Area	Ebonyi and Kogi States		
Geographic Presence	**No. of provinces (states) (%)**	**No. of LGAs (Local Government Areas) (%)**	**No. of facilities and/or communities (%)**
	2 states (5.5%)	Kogi: 2 LGAs (100%) Ebonyi: 13 LGAs (100%)	Phase 1: 120 facilities (12%)
Technical Interventions	 PRIMARY: Maternal Health; Newborn Health; Nutrition; Reproductive Health (Post-Partum Family Planning)		

Selected Program Data	
Number of people trained in MNH through USG supported program	154 (129 F, 25 M)
Number of people trained on FP/RH with USG funds	62 (F)
Number of ANC visits at USG supported facilities	29,017
Number of pregnant women that attended antenatal clinic for at least 4 times	3,093
Number of deliveries with skilled birth attendants	4,393
Number of women receiving immediate post-partum Uterotonic drugs in the third stage of labor	1,851
Couple years of protection (CYP) in MCSP program	3,515
Number of counselling visits for FP/RH as a result of USG support	9,800
Number of new acceptors of FP methods	4,825

** MCSP Nigeria's program start-up was delayed by the 2015 National Elections which caused insecurity, violence, and heightened tension as well as numerous months of health care worker strikes leading to closure of virtually all project-supported health facilities. Hence, program interventions were not rolled out until the 4th Quarter. Therefore, the data reported as achieved was only for the Phase I health facilities (120 of them) and only for Quarter 4.*

Key Accomplishments

MCSP/Nigeria's maternal and neonatal health (MNH) program focuses on improving the quality and utilization of MNH services in public and private facilities in Kogi and Ebonyi States. MCSP builds on the work of previous USAID global programs, ACCESS and MCHIP, in northern Nigeria to contribute to a reduction in maternal and neonatal mortality, and increase utilization of quality emergency obstetric and newborn care (EmONC) services by pregnant women, mothers, and their newborns.

At the beginning of the project, consensus was reached at the national and state levels on a quality of care framework, priority quality improvement objectives, and associated metrics and implementation support groups. This created a solid foundation for implementation of the planned quality improvement interventions. MCSP, in partnership with the Federal Ministry of Health (FMOH), mobilized key stakeholders at the national level and in Kogi and Ebonyi states to champion the use of a single harmonized Quality of Care approach for providing MNH services in Nigeria and as a critical measure for ending preventable maternal and child deaths. This quality of care framework is being developed around the most recent WHO quality of care framework for MNH services. The stakeholders meetings led to: 1) the development of a draft Quality of Care Framework for Improving MNH services in Nigeria; 2) the development of goals, standard measures, and plans by Ebonyi and Kogi State governments for improving MNH service delivery; and 3) the inauguration of a Quality Improvement Committee (QIC) and re-composition of Quality Improvement Teams (QITs) in Kogi State to drive the QoC improvement process in the state. The draft document will be further reviewed by an expanded group of stakeholders to finalize and present it to the National Council of State for adoption in August 2016.

This past year, MCSP increased the capacity of health care workers and educators to deliver MNH services at different levels in Ebonyi and Kogi. MCSP collaborated with key stakeholders to: 1) train 31 midwifery tutors in using anatomical models to train their students, thus strengthening pre-service education in Nigeria, including in Kogi State; 2) train 28 master trainers on insertion and removal of Implanon NXT, a step towards making clinicians at state-level capable of actualizing Nigeria's transition from the use of Implanon Classic to Implanon NXT; 3) train 31 health care workers in postpartum family planning (PPFP) counseling services, 4) train 60 staff of MCSP's professional association partners (SOGON, NISONM, PAN, NANNM) on leadership and organizational, project, and financial management skills; and 5) orient 27 MCSP Nigeria staff and focal persons in Ebonyi and Kogi states on gender-related personal values and attitudes which can affect and/or improve maternal and child health.

Information has been generated for use to guide project planning and establish baseline MNH facility readiness measures for the program in Kogi and Ebonyi. MCSP conducted a baseline Maternal and Newborn Health facility readiness assessment in 322 health facilities, and a complementary Rapid Health System Assessment (RHSA) in Ebonyi and Kogi states to identify barriers to MNH services. The facility readiness assessment was conducted using a harmonized tool which was agreed on by the other USAID-funded implementing partners in Nigeria thus avoiding duplication of effort and promoting comparability of findings. The tool consisted of components of the WHO's modified Service Availability and Readiness Assessment (SARA) tool and tools used by Pathfinder International for the Saving Mothers Giving Life (SMGL) Project. Key findings show that there are infrastructural challenges mainly at the PHC level (e.g., only one-third of primary health care facilities have electricity; bed-sharing among MNH patients at 17%), as well as limited ability of health facilities at primary and secondary levels to meet key EmONC signal functions which affects the quality of care. These findings are being used to: 1) inform MCSP's program design and interventions, including the selection of 120 Phase I facilities (comprising 69 PHCs, 43 general/mission hospitals, 4 private hospitals, and 4 tertiary hospitals) for initial project implementation; and to 2) advocate to the State

governments and stakeholders to bridge identified gaps and challenges in health infrastructure, equipment, supplies, and personnel. The report is being finalized and dissemination of findings to the health facilities and among stakeholders at different levels (district, LGA, and state) will be completed in PY2.

The quality of care research protocol was prepared and approved by USAID and is now in the process of obtaining relevant IRB approvals; preparation of other research plans (including bubble-cPAP) were initiated.

MCSP helped improve the national environment and knowledge base for implementing MNH interventions. MCSP supported several high-profile MNH-focused events in Nigeria, including: 1) the Saving 100,000 Newborn Lives stakeholders' meeting and 1st Nigeria National Newborn Conference in Abuja, during which hundreds of local and international stakeholders brainstormed and suggested evidence-based interventions for addressing newborn mortality in Nigeria; 2) the National Family Planning Conference in Abuja, during which the Nigeria FP Blueprint, the National Strategic and Implementation (2013–2015) plan, and Increasing Access to Long Acting Reversible Contraceptives in Nigeria plan were launched; and 3) a series of Quality of Care and Clinical Governance Stakeholders Meetings in Abuja, Abakaliki, and Lokoja.

Way Forward

MCSP will continue to build the capacity of various cadres of health workers in Kogi and Ebonyi states to provide quality maternal and newborn health and postpartum family planning services at different facilities in the two states. To this end, the program will support/facilitate a range of capacity building activities including: 1) training on Helping Mothers Survive Modules for 240 health care providers; 2) orientation of 60 midwives (new graduates) on Midwives Service Scheme (MSS); 3) training on Essential Newborn Care Course (ENCC) and modified Essential Newborn Care Course (mENCC), adapted from the Helping Babies Survive Modules, for 96 national level trainers and 250 health care providers; and 4) PPIUD training for service providers from selected Phase I health facilities. MCSP will also strengthen the teaching and instructional design skills of 30 preservice education tutors, and create a conducive atmosphere to support first-time parents for healthy timing and spacing of pregnancies. MCSP will work with the State Governments to improve facility infrastructure; establish newborn care, sick newborn units, and Kangaroo Mother Care (KMC) spaces where needed; procure lifesaving commodities; strengthen referral and record-keeping systems; and introduce alternative health financing mechanisms such as the Mothers Savings and Loans Clubs.

MCSP will also support the introduction of the new Quality of Care framework and associated improvement interventions in health facilities with a focus on the Day of Birth care to improve the quality of MNH services at health facilities in the states. MCSP will work with the Professional Association partners to scale-up training on Respectful Maternity Care and introduce Maternal and Perinatal Death Audits as well as facility-based onsite mentorships. MCSP will partner with the MAMA Project to educate pregnant women and their families on the benefits of antenatal care and delivery in health facilities. MCSP will in PY2 finalize the preparation of research plans/concept notes, and implementation of the learning agenda activities (e.g., use of bCPAP equipment for respiratory distress syndrome in preterm babies, and low-dose high-frequency training approach for MNH).

In collaboration with FMOH, USAID's Center for Accelerating Impact and Innovation (CAII), Dalberg and other development partners, MCSP will also support the national scale-up of chlorhexidine for cord core, as well as direct implementation in Ebonyi and Kogi States.

Nigeria Summary & Results—Polio Research

Karen Kasmauski/MCSP

Strategic Objectives

- Develop a research report, including primary data and a linked appendix, on the scope of research, methodology used, main findings, and the link between the findings and strategic implications for future polio action in Nigeria.
- Present the report to key polio partners in Nigeria for discussion and consideration as an empirical input for program strategy, with specific reference to social mobilization and communication (and training for vaccinators and advocacy at the local, state, and national levels).
- Develop a manuscript based on the research for publication in a peer-reviewed journal.

Program Dates	July 2014–June 2015 (approved March 11, 2015)		
PY1 Approved Budget	[redacted]		
Geographic Focus Area	3 states: Sokoto, Kano, and Bauchi in northern Nigeria		
Geographic Presence	**Number of provinces (%)**	**Number of districts (%)**	**Number of facilities and/or communities (%)**
	3/36 (8.3%)	N/A	N/A
Technical Interventions	PRIMARY: child health and immunization		

Selected Programmatic Data	
MCSP Global PMP Indicator	Data not available at the close of PY1

Key Accomplishments

This activity accounts for Phase II of a research study that was carried out in Nigeria by partners of the Maternal and Child Survival Program (MCSP), the Communication Initiative, and Public Health Services and Solutions—a Nigerian nongovernmental organization. MCSP's immunization team provided technical review and oversight.

The purpose of the research was to understand household factors affecting the demand for polio vaccination and the continuing high rates of children who are missed from this vaccination in northern Nigeria. During Phase I, which was largely completed under the Maternal and Child Health Integrated Program (MCHIP), the study was designed; it was then vetted by the Ministry of Health and polio and immunization partners in Nigeria. Also during Phase I, data collection was completed, and the initial data set was prepared by Public Health Services and Solutions and submitted to the Communication Initiative. During Phase II, the following activities were completed: data cleaning, collecting some additional data, analyzing study findings, engaging stakeholders in Nigeria to generate recommendations, and preparing and disseminating the report.

The final report, in electronic and print versions, was distributed at the end of September 2015; it can be downloaded from this website:
https://www.comminit.com/files/perceptionsofinfluence.pdf.

A manuscript was also prepared and submitted to the *Social Science and Medicine* journal in September 2015, and it is in the peer-review process.

Way Forward

The polio study revealed several key implications at the state, household, and settlement levels, and these implications are included in the report. At the state level, the data showed that operational focus should be maintained (or restored) in the Northwest alongside the focus on Kano and Yobe-Borno transmission zones. Furthermore, state programs were encouraged to strengthen their capacity (including developing qualitative and quantitative data gathering methods) to analyze program performance at the settlement level to identify persistent, localized gaps in the performance of supplementary immunization activities.

Nigeria Summary & Results—Routine Immunization

Jennyfer Don-Aki Oluyemisi/MCSP

Strategic Objectives

In Bauchi State, the objectives of the Maternal and Child Survival Program (MCSP) are to:

- Support state led and state owned efforts to achieve >50% routine immunization (RI) coverage in every ward by the end of December 2016, and >80% RI coverage in every ward by the end of December 2017.
- Support state-led and state-owned efforts to expand the availability and quality of RI services by providing targeted technical assistance in the areas of capacity-building and training, supportive supervision, monitoring and use of data, supply/cold chain, and community engagement.
- Promote the transition of all responsibility for sustaining and building on these gains to the state by January 2018, by improving capacity to promote, deliver, and monitor RI services at the state, local government authority (LGA), health facility, and community levels.

In Sokoto State, MCSP's objectives are to:

- Support state-led and state-owned efforts to achieve >80% RI coverage in every ward by the end of December 2018.
- Support state-led and state-owned efforts to expand the availability and quality of RI services by providing technical assistance in the areas of capacity-building and training, supportive supervision, monitoring and use of data, supply/cold chain, and community partnership.
- Promote the transition of all responsibility for sustaining and building on these gains to Sokoto State by January 2019 by improving capacity to promote, deliver, and monitor RI services at the state, LGA, health facility, and community levels.

Program Dates	September 1, 2014–September 30, 2015		
PY1 Approved Budget	[redacted]		
Geographic Focus Area	National, Bauchi State, and Sokoto State		
Geographic Presence	**Number of states**	**Number of local government authorities (%)**	**Number of health facilities (%)**
	2/36 (5.5%)	National: 43/774 (5.6%) Bauchi: 20/20 (100%) Sokoto: 23/23 (100%) **Number of wards (%)** National: 547/ 9,572 (5.7%) Bauchi: 323/323 (100%) Sokoto: 224/224 (100%)	Bauchi: 958/1,059 (90%) Sokoto: 487/785 (62%) Both: 1,445/1,844* (78%) ** Bauchi and Sokoto only*
Technical Interventions	PRIMARY: immunization		

Selected Programmatic Data	
Percentage of children less than 12 months of age who received DPT3/Penta3 vaccine in areas supported by the Maternal and Child Survival Program (MCSP)	24% (Bauchi State) and 25% (Sokoto State)*
Number of people trained through US government-supported programs	1,559 (Bauchi State)* and 200 (Sokoto State)**
New vaccines introduced with MCSP support	2: inactivated polio vaccine (IPV), pneumococcal conjugate vaccine (PCV)

* *Baseline DPT3 coverage for Bauchi State was estimated at 59%, based on available HMIS data. However, it important to note that this baseline figure is widely believed to be inaccurate and grossly overestimated, due to poor HMIS data quality as well as inconsistent health facility reporting. For Sokoto State, the 25% coverage figure provided represents baseline data, as Sokoto's multi-partite RI strengthening MOU had not yet begun by the end of PY1.*

** *Reflects data only from the fourth quarter of PY1*

Key Accomplishments

In Nigeria, Maternal and Child Survival Program (MCSP) is working in Bauchi and Sokoto under a new framework for routine immunization strengthening. The framework includes a quadripartite Memoranda of Understanding (MOU) that is negotiated state by state between the State Primary Health Care Development Agency (SPHCDA), the Bill & Melinda Gates Foundation (BMGF), the Dangote Foundation, and the United States Agency for International Development (USAID). MOU partners, including MCSP on USAID's behalf, work according to a partnership framework that requires state government's ownership, leadership, and overall responsibility for delivering functional routine immunization (RI) services—including sustained financial investment in RI. In planning for this unique program, MCSP completed rapid assessments of the RI situation in Bauchi and Sokoto in September 2014 and disseminated its findings widely and to relevant stakeholders at the national and state levels, before completing its own planning process. MCSP initiated technical support shortly after the assessment visit in January 2015.

In Bauchi, where MCSP focuses on four technical areas—monitoring and use of data, supportive supervision, community partnership, and capacity-building, including training—the program team is fully engaged and under the state's leadership as an active implementing partner of Bauchi State's Harmonized RI Work Plan. In PY1, MCSP completed partner and RI service mapping, as well as community partnership and training needs assessments. Encouragingly, PY1 saw a significant increase in the number of health facilities providing RI services—from 860 in July 2014 to 958 by the end of September 2015.

This increase was made possible through factors such as:

- Disbursement of dedicated RI funds from the state, BMGF, and the Dangote Foundation to newly created health facility bank accounts;
- Development of a financial tracking tool with support from Solina Health, BMGF, and MCSP to monitor the disbursements;
- Increase in direct-drive, solar cold chain equipment at satellite cold store health facilities;
- Support to the state to transition from a "pull" to a "push" system for vaccine delivery, as well as the establishment and rollout of a weekly vaccine monitoring dashboard at the local government authority (LGA) and health facility levels; and
- Contributions to on-the-job training of service providers through intensified supportive supervision and monthly LGA and health facility level review meetings.

During the fourth quarter, 4,380 (77%) of all fixed-RI sessions and 4,336 (83%) of all outreach-RI sessions were conducted as planned in Bauchi with MCSP's support. Additionally, through

Bauchi's Social Mobilization Working Group, MSCP supported the state to develop an orientation guide for traditional barbers on the use of referral cards to refer newborns to health facilities for RI services. As a result, 956 traditional barbers associated with all health facilities currently providing RI services have received an orientation to the referral cards; these cards are anticipated to be in use in the first quarter of PY2 in all 20 LGAs.

In Sokoto, the program team conducted an in-depth diagnostic of the state's RI program to complement a vaccine cold chain review completed by Solina Health and began providing targeted technical support to the Sokoto SPHCDA in the third quarter of PY1. During the fourth quarter, Sokoto State and other RI MOU signatories worked to finalize a quadripartite, RI strengthening MOU similar to that of Bauchi, and the Sokoto State government prepared to sign the national policy on Primary Health Care Under One Roof (PHCUOR) into state law as a condition for establishing the MOU. At the time of this report's submission, Sokoto's quadripartite, RI strengthening MOU has been signed by all four signatories: Sokoto SPHCDA, USAID, BMGF, and the Dangote Foundation. In the fourth quarter of PY1, anticipating the signing of this MOU, MCSP supported the Sokoto SPHCDA in training 200 individuals. This effort included training 37 traditional leaders and 23 LGA primary health care staff on RI implementation—including financial accountability—as well as 140 LGA health education officers, monitoring and evaluation officers, and LGA immunization officers on the topics of demand-creation and monitoring and evaluation for RI.

At the national level, MCSP continues to use its limited but strategic presence in Abuja to facilitate policy, planning, and partner coordination efforts and to promote bidirectional knowledge sharing and learning. This includes working closely with the NPHCDA and participating in the National RI Working Group to facilitate RI-related information sharing between the national and state levels. In PY1, MCSP contributed technically to the 2015 Gavi Joint Appraisal exercise and quarterly EPI reviews and shared experiences and lessons learned from Bauchi's RI MOU implementation. The program was also honored by the appointment of MCSP's National Immunization Technical Advisor as Chair of a newly-formed National RI Working Group's sub-committee tasked with improving RI performance, data, and accountability at the national and state levels.

Way Forward

MCSP's RI program assistance in Bauchi and Sokoto focuses on sustainably strengthening the RI system and substantially increasing immunization coverage rather than on achieving rapid and transitory results. As a continued priority over the coming year, the program team will work very closely with its state and other RI MOU implementing partners to build capacity in RI program management, promotion, implementation, and monitoring and evaluation. Key PY2 activities will include supporting the SPHCDAs of both states, along with other RI MOU partners, to develop their respective 2016 state harmonized RI MOU work plans and budgets. In both states, MCSP will support multiple strategies to scale up RI services, including:

- Initiating RI sessions in health facilities not formally providing RI services;
- Prioritizing increases in fixed-RI sessions in health facilities that are already providing RI services;
- Strategically increasing the number of RI sessions among apex health facilities or those with functional cold chain equipment; and
- Providing capacity-building support, working closely with other MOU partners, to help the SPHCDA scale up implementation of the Reaching Every Ward approach.

Monitoring of ongoing program support and MOU implementation progress will take many forms, including regularly scheduled, joint monitoring visits and check-in meetings with USAID, BMGF, the Dangote Foundation, and high level state counterparts.

In Sokoto, the number of technical and program support staff will be expanded in PY2 to provide technical support to the state, across the state, for MOU implementation at scale. Drawing from Bauchi's experiences and working closely with other partners, an initial priority activity for MCSP under the state's new RI MOU will be to respond to the state's request to determine capacity-building gaps across key Reaching Every Ward components. Findings will inform the state-led development of an RI capacity-building plan as well as the state's efforts to establish an RI Training Unit under the coordination of the National Training Working Group. This is a high-priority initiative that the state has asked MCSP to support.

MCSP's national level technical support during PY2 will include:

- Contributing to updating relevant training modules for dissemination and use at the state level;
- Supporting continued, phased introduction of IPV and PCV nationwide; and
- Contributing to the development of rotavirus and MenAfriVac vaccine introduction proposals for submission to Gavi.

National RI Working Group discussions and activities will also focus on planning for Nigeria's upcoming measles and rubella vaccine campaign, which will be conducted nationwide in two phases.

Rwanda Summary & Results—EPCMD

Strategic Objectives

- **Objective 1:** Improve the quality, equity, gender sensitivity, and sustainability of reproductive, maternal, newborn and child health (RMNCH) and malaria services along the continuum of care.
- **Objective 2:** Support the scale-up of high-impact interventions to improve RMNCH and malaria outcomes in the public and private sectors.
- **Objective 3:** Increase community mobilization for, participation in, and utilization of high-quality RMNCH and malaria services.
- **Objective 4:** Build capacity to use data for decision-making and action at all levels of the health system.
- **Objective 5:** Increase capacity to manage and control malaria in Rwanda as the country approaches pre-elimination of this disease.

Program Dates	April 2015 to September 2016 (approved September 11, 2015)		
PY1 Approved Budget	[redacted] (18 months)		
Geographic Focus Area	National/Regional/District—Musanze, Nyabihu, Kamonyi, Nyamagabe, Huye, Nyaruguru, Nyagatare, Gatsibo, Rwamagana, Ngoma, Gasabo, Kicukiro, Nyarugenge, Kayonza, Kirehe, Ruhango, Gisagara, Burera, Gakenke, and Rubavu		
Geographic Presence	**Number of provinces (%)**	**Number of districts (%)**	**Number of facilities (%)**
	4/5 (80%)	20/30 (67%)	315
Technical Interventions	 PRIMARY: child health, community health and civil society engagement, malaria, maternal health, newborn health, and reproductive health; OTHER: adolescent sexual and reproductive health, health system strengthening, quality improvement, and gender		

Selected Programmatic Data	
MCSP Global PMP Indicator	Data not available at the close of PY1

Key Accomplishments

In Rwanda, the Maternal and Child Survival Program (MCSP) is building on the successes of previous and current programming efforts to end preventable child and maternal deaths (EPCMD) by drawing on the technical and programmatic expertise gained under the Maternal and Child Health Integrated Program (MCHIP). Starting in 2009, with support from the US government, MCHIP provided technical support to the National Malaria Control Program (NMCP) and the Community Health Desk to accelerate efforts in malaria in pregnancy (MIP) and integrated community case management (iCCM) at both the health facility and community levels. In October 2010, MCHIP was awarded a bridge project to connect the successes of multiple awards that were ending in Rwanda, including ACCESS, BASICS, Twubakane, and Capacity, with the beginning of a new bilateral effort, the Family Health Project, funded by the United States Agency for International Development (USAID). In November 2014, USAID in Rwanda requested MCSP to support its continual effort to EPCMD; USAID also requested MCSP to support the government of Rwanda's Vision 2020 and its second Economic Development and Poverty Reduction Strategy 2 (EDPRS 2).

As part of the MCSP program development process, MCSP's technical teams and USAID/Washington conducted a three-week assessment visit to meet with various RMNCH and malaria stakeholders in February 2015. The aim of the visit was to acquire information on the current situation of RMNCH and malaria interventions in Rwanda as well as solicit advice relating to work plan priorities and approaches. MCSP conducted a workshop, which was attended by 30 Ministry of Health (MOH) officials, including Ministry of Child and Community Health's heads of units and cross-cutting staff (information technology, monitoring and evaluation, nutrition, etc.), hospital and health center staff, and members of medical and nursing associations. The team also visited the Musanze District Health Unit, Ruhengeri Hospital, Karwasa Health Center, and one community health worker. Issues presented during the visit included:

- High turnover of community health workers (CHWs);
- New CHWs not trained on maternal and newborn health (since 2010);
- Few health care providers trained on emergency obstetric and newborn care (EmONC), including Helping Babies Breathe ([HBB], last training in 2012);
- Few providers trained on integrated management of childhood illness (IMCI) (last training in 2013); and
- Lack of sufficient and appropriate equipment.

The visiting team also assessed the organization and structure of the Rwandan health system and opportunities to strengthen service delivery and data available for decision-making, which is a core component of the MCSP Rwanda program. The assessment team's visit informed the objectives and priorities for MCSP's efforts in Rwanda.

MCSP Rwanda received approval of its work plan in September 2015, and in collaboration with the MOH, organized and conducted 16 one-day, district level planning workshops. These workshops introduced MSCP and involved districts in determining key health priorities that need to be addressed in order to EPMCDs in their respective districts. The workshops also aimed to develop district-specific action plans for fiscal year 2016 and enabled MCSP to compile a detailed implementation plan addressing district and MOH priorities and build relationships to facilitate program implementation.

In Year 1, MCSP conducted site visits to assess the sites of the anticipated capacity-building centers in Musanze and Rwamagana districts. Findings showed that hospital leadership were willing to avail adequate rooms and were supportive of the establishment of a capacity-building

center within their facilities. A user guide for the capacity-building center in Rwamagana has been drafted. MCSP also finalized the protocol and data collection tools and initiated the training of data collectors with MOH for the health facility baseline assessment. The goal of the assessment was to explore the readiness of public health facilities in MCSP-supported districts to provide comprehensive RMNCH services prior to the introduction of interventions. This effort will help determine baseline data so changes over time can be measured.

MCSP rapidly reviewed protocols for adherence to best practices and integration of gender, youth, male involvement, respectful maternity care, existing facility and community RMNCH norms and protocols, training materials, SBCC materials, and job aids. Family planning norms and protocols were further identified and compared with Rwandan RMNCH protocols. These were deemed up-to-date, but training manuals were in need of updating based on the Demographic and Health Survey of 2014–2015, Medical Eligibility Criteria—5th edition, and the latest high-impact interventions (postpartum family planning and the Low-Dose, High-Frequency [LDHF] approach). A workshop is scheduled for the next quarter and updated training manuals will be available in December 2015. Additionally, postnatal care guidelines are currently being reviewed and basic EmONC (BEmONC), essential newborn care (ENC), and IMCI training manuals are being adapted for LDHF training.

Way Forward

In fiscal year 2016, implementation of the Rwanda EPCMD program is in full force:

- Strategic Objective 1
  Priorities include a rapid situation assessment of the district, health center, and community level services in order to prioritize needs, interventions, and key activities for project implementation in the 10 RMNCH districts. MCSP will also establish two capacity-building centers, one per region, including a skills lab in two designated district hospitals for use in onsite training, including refresher training of health center and district hospital staff. Using existing quality improvement tools and based on the results of a gender and equity assessment, MCSP will work to strengthen the capacity of RMNCH service providers in district hospitals and health centers to provide gender-sensitive and adolescent-friendly services.
- Strategic Objective 2
  MCSP will focus on key next steps in advancing MCSP's learning agenda by focusing on the scale-up of two high-impact newborn health interventions: HBB and chlorhexidine. With support from the MCSP's Newborn Health and Learning and Implementation Science Teams, MCSP will finalize concept notes that define the scope and processes to be followed and then convene stakeholder meetings to develop plans for systematic documentation and analysis of program implementation, in consultation with central MOH and district counterparts. In addition to the scale-up learning agenda and in close consultation with the MOH, MCSP will advance its broader learning agenda through support from the Newborn Health and Learning and Implementation Science Teams to finalize concept notes and obtain necessary approvals from USAID and The Johns Hopkins University School of Public Health's Institutional Review Board.
- Strategic Objective 3
  Key priorities include working with the Rwanda Health Communication Center's Health Promotion Training Working Group and other MOH departments to support district, sector level social clusters and contracted local nongovernmental organizations (NGOs) to develop SBCC for family planning, newborn, and maternal and child health coordination plans; and to strengthen capacities of district, sector level, social clusters and contracted local NGOs to implement and supervise SBCC activities.

- Strategic Objective 4
  MCSP will support capacity-building of district health units at the district level, including the use of DQA, by supporting District Health Management Teams to supervise district hospitals and supporting capacity-building of monitoring and evaluation offices at the facility level, including the use of DQA and supportive supervision at health centers.
- Strategic Objective 5
  Key priorities include mapping the origin of malaria cases, supporting case investigation and surveillance, providing support to the Malaria and Other Parasitic Diseases Division (Mal&OPDD) on supervision at district hospitals and health centers, and supporting the Mal&OPDD to monitor net durability and insecticide resistance.

Rwanda Summary & Results—Malaria

Strategic Objectives

- **Objective 1:** Conduct an implementation research study for the intermittent screening and treatment intervention in three districts to assess the effectiveness of intermittent screening and treatment in preventing malaria in pregnancy.
- **Objective 2:** Contribute to strengthening quality standards for malaria diagnostics.
- **Objective 3:** Support the Malaria and Other Parasitic Diseases Division (Mal&OPDD) to implement active surveillance and case investigation in two epidemic-prone districts (Gakenke and Rubavu) in order to strengthen the capacity for identifying and extinguishing new malaria cases.
- **Objective 4:** Support Mal&OPDD's behavior change communication (BCC) efforts at the national level by conducting a knowledge, attitude, and practice survey and finalizing the BCC sub-strategy.
- **Objective 5:** Provide assistance to Mal&OPDD to implement key monitoring and evaluation (M&E) activities, including program documentation.
- **Objective 6:** Support Mal&OPDD in carrying out routine assessments, supervision visits, and M&E-related activities.

Program Dates	October 2014–September 2016 (approved April 22, 2015)		
PY1 Approved Budget	[redacted]		
Geographic Focus Area	National, regional (Gisagara, Burera, Gakenke, Rubavu, and Ruhango), and district		
Geographic Presence	**Number of provinces (%)**	**Number of districts (%)**	**Number of facilities (%)**
	4/5 (80%)	11/30 (37%)	153
Technical Interventions	PRIMARY: Malaria		

Selected Programmatic Data	
Percentage of targeted lab technicians trained in malaria diagnostics using rapid diagnostic tests (RDTs) and microscopy, including determining parasite density and species	32/100
Proportion of health facilities with malaria diagnostic quality control/assurance procedures in place and strengthened	100% (11 health centers and one district hospital in Rubavu and 21 health centers and 2 district hospitals in Gakenke)

Selected Programmatic Data	
Proportion of health centers in the 2 epidemic districts with at least four nurses trained in rapid diagnostic test (RDT) use for case investigation	100% of health centers with 3 trained nurses and 1 lab technician
Number of malaria confirmed cases in the 2 epidemic-prone districts	30,981
Percentage of confirmed malaria cases correctly treated in accordance with international and national guidelines in the 2 epidemic-prone districts	100% (All confirmed cases were treated according to the national malaria guidelines)
Proportion of data managers trained on surveillance system	100% (all data managers and CHWs in charge at health center level in Gakenke and Rubavu were trained)
Number of district monitoring and evaluation (M&E) staff trained in the use of health resources, data quality, analysis and data synthesis for decision-making	102 MOH staff (64 trained in the Census and Survey Processing System (CSPro) and 38 trained on the new web-based resource)

Key Accomplishments

While there was a gap between the Maternal and Child Health Integrated Program (MCHIP) and Maternal and Child Survival Program (MCSP) programs in Rwanda, the MCSP Rwanda program builds on the lessons learned in MCHIP and supports the Malaria and Other Parasitic Diseases Division (Mal&OPDD) in implementing the Malaria National Strategic Plan. Key areas of focus for the MCSP's Rwanda Malaria program include implementation research to assess viability of approaches to prevent malaria in pregnancy, increasing capacity and quality standards for malaria diagnostics, strengthening surveillance and case investigation, supporting implementation of assessments and strategies to improve behavior change communication, and improving the use of data for decision-making.

In support of the overall Rwanda Malaria pre-elimination strategy, MCSP supported Mal&OPDD to train one lab technician from each health center in the Rubavu and Gakenke districts. Thirty-two lab technicians were trained on malaria diagnostics, including quality control by determining parasite density and species. As a result of the training, microcopy for all positive cases identified through a rapid diagnostic test (RDT) is now systematically performed according to the malaria pre-elimination strategy.

In addition to Malaria diagnostics, malaria surveillance training took place in Year 1 with 87 health care providers receiving training in two pre-elimination districts—Gakenke and Rubavu. Training participants developed skills in case surveillance strategies and practice as well as how to complete and utilize pre-elimination tools and forms. Participants also developed initial plans for pre-elimination activities in their respective geographic areas. Participants from this training are now involved in ongoing malaria case notification and investigation, and investigation forms are available and used at health facilities.

In Year 1, 64 participants, including 32 data managers and 32 facility in-charges of community health workers (CHWs), were trained in malaria surveillance strategies, including recording positive cases into an electronic malaria surveillance system developed by Mal&OPDD by using the CSPRO software and ensuring data quality, editing, and monthly data submission to Mal&OPDD/RBC. At the end of the training, the software was installed onto the data managers' computers, and all participants were able to use the malaria pre-elimination database that allows Mal&OPDD to monitor all malaria cases.

As part of the pre-elimination strategy for Rwanda, University of California San Francisco (UCSF) was selected as an MCSP partner to support Mal&OPDD to conduct the pre-elimination

assessment. UCSF supported Mal&OPDD prior to MCSP and has globally recognized expertise in this area. The first phase included participating in the Second Round Rwanda Malaria Pre-elimination Forum hosted by the National Malaria Control Program as well as analysis of Rwanda's progress toward pre-elimination. During the second phase, a trip was organized in April 2015, and the team from UCSF worked with Mal&OPDD to collect data on the malaria program and conducted interviews with malaria stakeholders. The third phase was organized in July 2015 by drafting the feasibility assessment report with Mal&OPDD and a series of field visits assessing technical assistance needs, financial support, and health worker performance. Results of the field visit showed that malaria pre-elimination activities have been ongoing in these two districts since January 2015. Several challenges and barriers were identified at the district hospital and health center level, which were used to develop targeted technical assistance plans. A workshop was then conducted in Kigali, which gathered 15 participants from Mal&OPDD, teaching hospitals, district hospitals, district pharmacies, and MCSP. Participants at the workshop used the 3rd Version of the WHO Guidelines for treatment of Malaria to review and adapt the national guidelines.

With MCSP support, Mal&OPDD/RBC carried out the 2015 routine data quality audit at the national and decentralized levels with particular attention on key selected indicators related to malaria case management at all levels, drug and other commodities management, data management, and services organization. Data collection was performed in 137 health facilities of 34 district hospitals. All district hospitals with malaria incidence above one percent were included in the sample while health facilities with 10% and above of malaria proportional morbidity were randomly selected. The DQA findings revealed that: malaria treatment guidelines and flow chart were present in the majority of health facilities, slight discrepancies existed between treated malaria cases in HMIS reports and in the OPD registers in some health facilities, each health facility has at least one functioning microscope, LLIN management tools were available and used in the majority of health facilities, and artemether lumefantrine stock cards were filled on a regular basis.

Way Forward

In Year 2, MCSP will implement several activities planned for Year 1 that were delayed, including three malaria studies: the knowledge attitudes and practice (KAP) survey, intermittent screening and treatment (IST), and the iCCM survey. The KAP and iCCM are biannual surveys conducted by Mal&OPDD and will be supported by MCSP in developing protocols, data collection, and analysis, which will inform strategies for improving care-seeking behavior and malaria prevention.

Based on results from a previous study in Ghana, the IST study in Rwanda will test whether an approach that uses RDTs for screening pregnant women and an effective antimalarial for treating malaria is feasible and appropriate within the Rwanda context as an approach to preventing malaria in pregnancy. As part of the IST study timeline of activities, MCSP working with Mal&OPDD and PMI/CDC will finalize the protocol, submit the protocol for ethical approvals at The Johns Hopkins University and Rwanda National Ethics Committee (RNEC), and begin study implementation (after receiving ethical approvals).

MCSP will also continue working with Mal&OPDD in providing supportive supervision of pre-elimination activities in Gakenke and Rubavu as well as providing technical assistance and financial support. MCSP will work with district counterparts to record all positive cases, map origin of malaria cases, and support case investigation and follow up. As part of this pre-elimination effort, MCSP will also continue training data managers on new software and how to work closely with case investigators. Building off the momentum and work from Year 1, MCSP will also work with Mal&OPDD to finalize the national malaria treatment guidelines and in Year 2, present the guidelines to the Rwanda MOH for approval. MCSP will provide support to

conduct a routine data quality audit in 167 health centers and analysis and work with Mal&OPDD to draft and disseminate the malaria death audit report.

MCSP has developed a relationship with Peace Corps Rwanda and will develop plans to maximize MCSP's program activities and strategies, with support from Peace Corps volunteers in malaria program-supported districts. In Year 2, MCSP malaria and EPCMD workplans will merge. At the time of this report, the MCSP Rwanda program is nearly fully staffed and important linkages between Malaria staff and MNCH staff are taking place, which we expect will facilitate integration and coordination between different technical areas.

Tanzania Summary & Results

Charles Wanga/MCSP

Strategic Objectives

- Improve the environment for RMNCH services through technical leadership and coordination to roll out high-impact, integrated RMNCH interventions at scale.
- Strengthen key health systems to deliver quality RMNCH services.
- Strengthen involvement of civil society and supporting institutions and improve uptake of innovations.

Program Dates	June 1, 2014–September 30, 2015 (approved July 6, 2015)		
PY1 Approved Budget	[redacted]		
Geographic Focus Area	National, Regional (Mara and Kagera) and 16 Districts Limited scope of work in an additional 5 regions: Zanzibar, Tabora, Simiyu, Iringa and Njombe		
Geographic Presence	**Number of provinces (Number of regions) (%)**	**Number of districts (%)**	**Number of facilities (%)**
	2/30 (6.67%)* *limited scope of work in an additional 5 regions	16*/168 (9.5%) *100% of districts in Mara and Kagera	221/563* (40%) *total health facilities in Mara and Kagera
Technical Interventions	 PRIMARY: community health and civil society engagement, immunization, malaria, maternal health, newborn health, reproductive health; OTHER: gender, health systems strengthening, HIV, pre-service education		

Selected Programmatic Data

Selected Programmatic Data	
Number of (national) policies drafted with US government (MCSP) support	5 • The National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania 2016-2020: One Plan II • National CECAP and Control Advocacy Plan for VIA based program • National technical guidance tool for repair/maintenance of CECAP treatment machines • CEmONC Learning Resource Package including standards and job aids • ANC Learning Resource Package, QI tool and standards, job aids to include prevention and management of malaria in pregnancy
Number of MCSP-supported health facilities actively implementing a quality improvement approach	215
Number of districts that have introduced new vaccines with MCSP program support	13
[1]Percentage of children aged <12 months who received Penta3 vaccine in MCSP-supported areas	10%+ based on administrative reports
Percentage of women receiving uterotonic in the third stage of labor in MCSP-supported areas	88%
Percent of babies born in health facilities who received newborn resuscitation	13%
Number of civil society organizations (CSOs) receiving US government (MCSP) assistance engaged in health advocacy to promote RMNCH	8

Key Accomplishments

MCSP/Tanzania builds on the successes of the MAISHA (Mothers and Infants, Safe, Healthy and Alive) Associate Award, the MCHIP Immunization program, and also incorporates results from the Morogoro Evaluation Project (MEP). MCSP/Tanzania is one of MCSP's largest country programs and was one of the earliest to which funding was committed. It has a 3-year scope of work from FY 2015-17.

National Level Activities

In collaboration with the Ministry of Health and Social Welfare (MOHSW), MCSP supported the finalization of several key, national-level documents including the National Road Map Strategic Plan to Improve RMNCAH in Tanzania (2016–2020) – One Plan II, the National Community Based Health Programs Strategic Plan, the curriculum for the National CHW Cadre, to which MCSP also contributed gender modules, an indicator reference guide for the national Health Management Information System (HMIS), a national data quality assessment (DQA) tool and

[1] Mean coverage estimate for Tabora, Simiyu and Kagera during the first half of 2015 from administrative reports, which are normally 10-15% higher than survey estimates. MCSP uses administrative data between surveys to monitor trends in coverage but does not consider them to pain an accurate picture of immunization coverage.

the review/update of the Reaching Every Child (REC) strategy guidelines for use in Tanzania's immunization program.

The program also supported the review and updating of several learning resource packages (LRPs) including: malaria in pregnancy (MIP), focused antenatal care, the VIA/Cryotherapy/ LEEP LRP and CECAP and Control Advocacy Plan, an integrated supportive supervision (ISS) tool and LRP to be used to identify gaps and develop appropriate actions to address facility management and clinical oversight, and LRP on comprehensive emergency obstetric and newborn care (CEmONC), which for the first time incorporated guidelines for use of anesthesia. The program supported the MOHSW and Ministry of Health, Zanzibar (MOHZ) to finalize the postpartum family planning (PPFP) and postpartum intrauterine contraceptive device (PPIUCD) LRPs.

MCSP supported the national EPI review, the WHO/UNICEF joint immunization reporting and Gavi annual reporting processes, including the HSS report. MCSP also worked with the MOHSW to plan and launch the measles-rubella vaccine introduction and was an important participant in Tanzania's highly successful Integrated Measles Rubella campaign that was completed in September 2015. The immunization team also provided technical guidance and worked in collaboration with USAID|DELIVER to develop the Vaccines Information Management System (VIMS) that will harmonize vaccine stock and other immunization data and strengthen the immunization supply chain. The VIMS prototype was completed and the new system will be ready for roll out in PY2, Qtr 3.

To strengthen the application of Comprehensive Council Health Plan (CCHP) guidelines in annual planning, MCSP started the process of documenting and conducting a problem-solving activity (using immunization as a content focus for analysis) in Ngara and Muleba districts of Kagera Region. Documentation and analysis will continue during the 2016 CCHP planning/budgeting cycle with findings and recommendations to be disseminated in the course of the program's work in years 2 and 3.

Finally, MCSP is supporting national-level efforts to improve the coordination of the country's multiple vertical health management information systems (HMIS). The goal is to achieve interoperability of selected HMIS tools under a uniform health information system architecture that will ultimately produce better quality data, make those data more accessible to decision-makers and encourage evidence-based planning and problem–solving at all levels of the health system. In PY1, MCSP worked with the MOHSW to form an Enterprise Architecture (EA) Technical Working Group (TWG) that is actively working toward these long-term goals; provided expert technical consultation to develop a performance monitoring systems for the Government of Tanzania's Big Results Now initiative; and facilitated the development of the M&E section, with indicators, of the Government of Tanzania's Health Sector Strategic Plan 4.

Regional Level Activities

In collaboration with MOHSW, MCSP assessed the degree to which evidence-based maternal and newborn interventions recommended in the Every Newborn Action Plan (ENAP) are being implemented in Kagera and Mara using the Every Newborn Bottleneck Analysis Tool. The final report, with inputs from stakeholders, was disseminated at meetings with R/CHMTs in Kagera and Mara. This initiative will inform the development of a country-level ENAP.

MCSP performed an assessment of staff availability and distribution based on the MOHSW Staffing Level Guideline 2014 in 4 Councils, in order to support development of an action plan, to address critical human resource shortages in Mara and Kagera. We introduced the MTUMA health system mapping exercise in two councils in Mara (Butiama DC and Musoma MC) with input from regional and district-level MOHSW stakeholders. The two councils identified their

priority HSS challenges and opportunities and developed corresponding capacity-building/district health system strengthening plans, taking advantage of resources, tools, and partnerships available locally.

To make integration of HIV and RMNCH services a reality, the project supported printing and dissemination of the National Operational Guideline on Integration to Mara and Kagera regions, and supported the development of HIV/RMNCH integration action plans by the Kagera and Mara Regional Referral Hospitals, the 10 MCSP-supported Health Training Institutes, and the Lake Zonal Health Resource Centre that oversees Kagera and Mara. The project also supported 9 PEPFAR partners (Management and Development for Health, Elizabeth Glaser Pediatric AIDS Foundation, Ariel Glaser Pediatric AIDS Healthcare Initiative, PSI, ICAP, IMA World Health, Christian Social Services Commission, Tanzania Health Promotion Support, TUNAJALI) in rolling out different RMNCH interventions under their existing HIV platform.

In an effort to improve the quality of midwifery competencies, the project supported the first follow-on continuous quality improvement (CQI) assessment after baseline assessment in 10 Health Training Institutions. A big improvement was observed at all schools, whereby the overall score over the 4-month period improved from 39% to 70% in Kagera and from 33% to 56% in Mara. The tool is now commonly used in schools to identify gaps and develop action plans to address them.

To strengthen data quality and use, MCSP supported RMNCH DQAs and conducted onsite data sharing and review meetings with all 16 councils in Kagera and Mara. These provided an opportunity to analyze and discuss the data being captured at the facility level and review the facility scorecard and performance on MCSP indicators. We coached health facilities to use their data to identify gaps and make informed decisions to improve the quality of service provision. Health care providers received coaching and mentoring on data management and record keeping.

MCSP supported the Iringa RHMT to improve access to CECAP services in outreach services. CECAP is meant to reduce the cervical cancer among clients with HIV infection, and Iringa region has the highest rate of HIV infection in Tanzania. At five outreach sites where services were assessed, 842 women were screened with VIA, and 7.6% were found with pre-cancer lesions—all women were treated on the same day. Overall, a total of 5,748 new clients were screened for cervical cancer using VIA; 25% of overall clients screened were HIV-positive, 337 (5.86%) were identified as having pre-cancerous lesions (VIA-positive), and 98% of clients identified as having pre-cancerous lesions and eligible for cryotherapy treatment were treated on the same day.

MCSP supported the implementation of 23 new sites for kangaroo mother care (KMC) for premature infants and supplied 235 low-cost wrappers to facilitate skin to skin care practice. MCSP continued to strengthen immunization services in the 3 regions that were identified in 2012-2013 as being the home to approximately 40% of the country's under-vaccinated infants. To address this, the program supported REC training, implementation and supportive supervision at the facility level in priority districts in all three regions. The immunization program team also worked on supportive supervision and follow-up on routine REC implementation at the facility level in Arusha and Iringa regions during national Mid-level Managers' training courses.

Training

MCSP also used the new and previously-developed LRPs to train providers and supervisors in Mara and Kagera. We trained 290 health facility in-charges and oriented 112 Regional and Council Health Management Teams (R/CHMTs) on ISS. 360 providers were trained on MIP, 41 on CEmONC, 284 on KMC and 228 on basic emergency obstetric and newborn care (BEmONC).

118 providers in Mara, Kagera and Zanzibar were trained on PPFP and IUCD. The PPFP and IUCD training materials were also used to orient R/CHMTs in Kagera and Mara on addressing barriers to FP/PPFP and PPIUCD uptake and how to ensure consistent availability of FP commodities to support the expected demand for FP services generated through the CHW linkages mentioned below. MCSP trained a total of 547 CHWs on an integrated RMNCH resource package that included FP/ PPFP with the goal of increasing FP uptake. The CHW training also included gender integration modules geared toward addressing gender norms that impede utilization of services. The trained CHWs are linked to back up health facilities through trained CHW supervisors in both Kagera and Mara, and supportive supervision to all CHWs trained was conducted to provide technical support on effective implementation of CHW roles. It is expected that CHWs will support the demand creation for RMNCH services through mobilization and client register and follow-up at community level. Our immunization team conducted refresher, middle-level manager (MLM) training for 37 Trainings of Trainers (TOTs) in the Arusha and Iringa Zonal Health Resource Centres and trained 19 regional and district medical officers on MLM. These trainings provide the fundamental guidance for better management of vaccination services in the districts. MCSP also conducted IIP trainings for 398 RIVOs, RRCHCOs, DIVOs and DRCHCOs (as trainers) and HCWs from the MCSP-focused regions and districts and oriented 330 health governance committee members on immunization protocols and their role in the districts of Karagwe, Kyerwa, Urambo and Itilima.

The Way Forward

PY2 will strategically build on PY1 with most interventions centered on strengthening the foundation laid during the first year on capacity building to service providers and relevant tools and guidance for service provision on RMNCH services in geographical focus. Significant investment will be made on intensifying the capacity-building work done in Year 1, including post-training follow-up in all trainings conducted in year one, site strengthening, and clinical mentorship. These activities will provide a platform for health system strengthening and an enabling environment for high-quality service delivery and hence increased uptake of services, in partnership with regional and district health management teams.

The project will invest heavily on strengthening service providers' proficiency in high impact intervention for RMNCH in all project sites. The main focus is on improving the quality of RMNCH service delivery while continuing to increase the number of CHWs for RMNCH promotion at community level to increase uptake of services. The project will also continue to support regional health management teams to conduct assessments that will inform the performance status of supported health facilities.

Uganda Summary & Results

Jhpiego

Strategic Objectives

- Strengthen the Uganda National Expanded Program on Immunization (UNEPI) institutional/technical capacity to plan, coordinate, manage, and implement immunization activities at the national level.
- Improve district capacity to manage and coordinate the immunization program as guided by the UNEPI leadership.

Program Dates	July 2014–September 2019 (approved December 5, 2014)		
PY1 Approved Budget	[redacted] (PY1 confirmed, FS and Core funding)		
Geographic Focus Area	National and district levels Regions: Central and Western Districts: Butaleja, Kanungu, Busia, Iganga, Kabale, Kapchorwa, Rukungiri		
Geographic Presence	**Number of provinces (%)**	**Number of districts (%)**	**Number of facilities (%)**
	2/4 (50%)	7/112 (6%)	411/5,715 (7%) • 24/24 Butaleja (100%) • 52/52 Kanungu (100%) • 28/28 Busia (100%) • 56/56 Iganga (100%) • 149/149 Kabale (100%) • 19/19 Kapchorwa (100%) • 83/83 Rukungiri (100%)
Technical Interventions	PRIMARY: immunization		

Selected Programmatic Data	
Number of children who at 12 months have received 3 doses of DPT/Penta vaccination from a US government-supported immunization program (Standard 3.1.6–61)	86,918 (Source: DHIS2)

Selected Programmatic Data	
Percentage of planned routine immunization (RI) sessions that were conducted in the year	86.2% (Based on data for the quarter January to March 2015)
Number of National level guidelines, manuals and tools in which REC-QI concepts are incorporated (IP custom)	2; The Immunization Policy 2014 and the Immunization in Practice manual (IIP)
Number of people trained in child health and nutrition through US government-supported programs	1,271
Percentage of MOH/UNEPI TWG coordination meetings held where Routine Immunization was discussed in a year	83%

Key Accomplishments

At the request of the Uganda Ministry of Health (MOH and USAID/Kampala, Maternal and Child Survival Program (MCSP) is providing support to the Uganda National Expanded Programme on Immunization (UNEPI)'s effort to strengthen routine immunization (RI). It follows on work that was funded as part of USAID's predecessor global project, Maternal and Child Health Integrated Program (MCHIP). In addition to work at the national level, the MCHIP program focused on implementing Reaching Every Child—Quality Improvement (REC-QI) in 5 districts (Busia, Iganga, Kabale, Kapchorwa, and Rukungiri). Work on sustaining REC-QI was continued in those 5 districts during the first year of MCSP. In addition, 2 new districts (Butaleja, and Kanugu) were added during MCSP's first year.

National achievements:

The MOH/UNEPI, with technical input and financial support from MCSP, successfully wrote and printed over 600 copies of the Uganda Immunization Policy 2014, which will be disseminated by the MOH/UNEPI throughout MCSP PY2. This policy both facilitates a positive policy environment for strengthening routine immunization and brings an additional advocacy tool to national level decision makers. As a result, a law on Immunization financing that will regulate immunization service delivery and uptake—is pending approval.

MCSP and other partners provided technical and financial support for public dissemination of immunization performance data through the production of three quarterly editions of newspaper immunization pull-outs. The pull-outs proved to be critical catalysts for mobilizing action towards improved immunization coverage. For example, upon reading the pull-out from Q2 2015, The Ugandan First Lady, who is also the minister for Karamoja region, was concerned by the declining performance of Karamoja region and mobilized resources for a project to support the region and reversed trend. In the same spirit, Hon. Minister of state for health supported Sheema district, which she represents in parliament, to solve the challenges of RI and the district started showing improvement in performance.

MCSP went further to support MOH/UNEPI by incorporating key concepts and tools from the REC-QI approach into the national updated version of the Immunization in Practice (IIP) manual, the MOH/UNEPI operational level (OPL) training materials, and the national pre-service training reference material. In addition, MCSP created a REC-QI "How to Guide" which will be used to convey the essential knowledge and tools required to carry out REC-QI as a systematic, but flexible, approach. To build and broaden the capability to support the REC-QI approach, MCSP conducted National Training of Trainers initial and refresher courses for 40 new trainers and 31 previously trained trainers on the REC-QI approach and tools. These activities have proven successful ways to amplify the reach of MCSP. By training national

trainers, MCSP has increased its human resources capacity to strengthen immunization service delivery and quality in more districts, communities and facilities.

Finally, the MOH/UNEPI and partners, including MCSP, conducted a national EPI Review and used the findings to update the national comprehensive Multi-Year Plan (cMYP) for Immunization. The cMYP is important as a process and as a tool as it sets national goals in line with the Global Vaccine Action Plan (GVAP), creates an annual strategy and identifies tools to operationalize this plan.

District level achievements:

MCSP continued providing supportive supervision and collecting quarterly data from the five districts supported by MCHIP which after completing the REC-QI package have adopted key elements of REC-QI. Lessons learned from review and analysis of REC-QI implementation under MCHIP is being used to refine the process in the new MCSP districts.

MCSP conducted situation analyses in the two new districts (Kanungu and Butaleja) in order to obtain basic information needed to adapt implementation of REC-QI to these districts. In addition similar analyses were conducted in the districts that were supported as part of MCHIP in order to understand the situation at endline for these districts. What has been learned from the analyses of MCHIP supported districts is being used to refine our approach to implementing REC-QI in the new districts.

The situation analysis and NFR have been finalized and has been accepted by the first two districts and endorsed by UNEPI, which will make it easier to facilitate signing by District Health Management Teams in subsequent districts. This approval and adoption will allow for smooth transition when MCSP leaves the district and greater chances of sustainability.

Finally, UNEPI and district data management personnel have improved their capacity to analyze and use data. This is evident in supportive districts that are demonstrating increased capacity to identify and solve their own RI problems through 'Plan-Do-Study-Act' (PDSA) cycles.

REC-QI is a holistic health systems strengthening approach with a guiding principle "Assign/allocate REC tasks to health system levels basing on their capacity". Its implementation needs to be undertaken by the appropriate health system level equipped with the capacity to champion, and use approaches such as the PDSA. In the past year, our experience with implementing REC-QI have confirmed the following lessons: When empowered to own the program, district and lower level health workers innovative and provide working local solutions to solve EPI problems. The most successful example for PY1 took place in Kapchorwa and Iganga districts that procured stand-by gas cylinders for EPI fridges as a direct response to an evaluation of their own RI problems using PDSA cycles.

Way Forward

National Level

In PY2, MCSP plans to strengthen UNEPI's institutional and technical capacity to plan, coordinate, manage, and implement immunization activities at a national level. MCSP will finalize the REC-QI "How to Guide" and distribute to key routine immunization partners and a core group (central) of trainers will be trained in immunization and the REC-QI approach. MCSP will provide technical and financial support for the production of newspaper pullouts (three quarterly) sharing the EPI data. Uganda plans to introduce the Inactivated Polio Vaccine (IPV), which MCSP will provide technical support for the introduction into RI program. In addition, MCSP will help update the National Comprehensive Multi-Year Plan (cMYP) for immunization using the findings of the 2015 EPI review. To continue to strengthen the UNEPI

program at the national level, MCSP will co-locate one technical staff at MOH/UNEPI to support policy and document support, and multiple capacity building strategies at national level.

District Level

At the district level, MCSP will continue to improve district capacity to manage and coordinate the immunization program as guided by UNEPI leadership. MCSP will support the two districts (Butaleja, and Kanugu) from PY1 with key elements of REC-QI functioning (i.e. Supportive supervision conducted by district health management team as planned; RED categorizations, data analysis and feedback conducted quarterly). In order to ensure sustainability, MCSP will continue to support Kapchorwa, the weakest of the five MCHIP districts. In PY2, MCSP will expand implementation of REC-QI into four new districts, conduct situational analysis, collect data, and launch activities. In addition, MCSP will support UNEPI and district data managers on improving their capacity to analyze and use data.

Zambia Summary & Results

David Burrows/MCHIP

Strategic Objectives

To reduce maternal mortality by 50% in target districts and to reduce neonatal mortality, particularly due to birth asphyxia, by reaching the following objectives:

1. Improve the quality of labor/delivery, postpartum and newborn health services in MOH/MCDMCH facilities in 12 SMGL target districts.
2. Expand the availability of quality postpartum family planning services in MOH/MCDMCH facilities in the Mansa/Chembe District.

Program Dates	July 1, 2014–June 30, 2015 (approved December 3, 2014)		
PY1 Approved Budget	[redacted] (*plus additional core funds of* [redacted])		
Geographic Focus Area	4 Provinces: Luapula, Central, Eastern, and Southern 12 Districts: Chembe, Lunga, Kabwe, Samfya, Chipata, Choma, Pemba, Zimba, Kalomo, Lundazi, and Nyimba districts		
Geographic Presence	**Number of provinces (%)**	**Number of districts (%)**	**Number of facilities and/or communities (%)**
	4/10 (40%)	12/89 (13%)	192
Technical Interventions	PRIMARY: maternal health, newborn health, and reproductive health; OTHER: HIV		

Selected Programmatic Data	
Couple of years of protection in MCSP-supported areas	728.8
All women who delivered in MCSP-supported facilities	1,645
Number of women receiving prophylactic uterotonic in the third stage of labor (immediately after birth)	5,951
Percentage of women receiving uterotonic in the third stage of labor in MCSP-supported areas	93%
Number of babies not breathing/crying at birth born in MCSP-supported areas who were successfully resuscitated	305
Percentage of babies not breathing/crying at birth who were successfully resuscitated in MCSP-supported areas	94%

Key Accomplishments

MCSP worked with the MOH, MCDMCH, Saving Mothers Giving Life (SMGL), and other partners in the SMGL target districts to build on MCHIP's successes. MCSP expanded SMGL interventions by working at the national, district, and community levels to revise and standardize national training packages, implement activities to improve the quality of clinical care, and generate demand for maternal health services.

Built Capacity of Skilled Health Care Providers to Provide Quality EmONC and ENC Services

MCSP expanded the skillset of national trainers and trained additional health care providers. MCSP trained 128 national EmONC and ENC trainers in three key ENC approaches—Essential Care for Every Baby, Helping Babies Breathe, and Kangaroo Mother Care—to facilitate integration of these approaches into all EmONC trainings in Zambia. MCSP provided training and mentorship in EmONC/ENC to 43 health care providers in five SMGL target districts (Kabwe, Mansa/Chembe, and Samfya/Lunga) and additional trainings and mentorship in ENC were provided to Choma/Pemba, Kalomo/Zimba, Nyimba, Chipata, and Lundazi, resulting in 40 providers trained and 429 providers receiving mentorship. Trainings utilized the national EmONC training package with an integrated newborn resuscitation component using the HBB approach. For ENC training, an integrated newborn resuscitation HBB/ENC/ECEB training package was utilized.

Community Level Support to Increase Uptake of Facility-Based Labor/Delivery and ENC Services

MCSP trained 260 community-based Safe Motherhood Action Group (SMAG) members who are well-respected within their communities to deliver key messages and promote delivery at health facilities, access to family planning, and ANC and postnatal services. This resulted in 100% of facilities in Mansa/Chembe and 83.9% of facilities in Samfya/Lunga (up from 35.5% at baseline) having active SMAGs that meet at least quarterly. SMAG members were provided with supplies and promotional materials (such as umbrellas and gum boots for rainy season) to support their work, and received continuous mentorship over the course of the project to build knowledge and capacity in promotion activities. The SMAGs provided support toward increasing the utilization of facility-based services and at the same time, provided an opportunity for continued care for women and neonates while in the community. SMAGs also further strengthened the community-to-facility referral pathway to support increased uptake of MNCH services by the communities.

Routine Onsite Mentorship by Trained District Clinical Mentorship Teams

MCSP built upon previous success under MCHIP in Mansa/Chembe and Samfya/Lunga while also expanding into Kabwe by providing routine, onsite mentorship to health facility providers through teams of district mentors to ensure sustained knowledge and application of skills acquired during the in-service training. In Mansa/Chembe and Samfya/Lunga, all 63 facilities that provide labor and delivery services were receiving mentorship support on at least a quarterly basis. In Kabwe district, 25 mentors were trained and began conducting mentorship support visits in May. As a result, a couple of years of protection (CYP) for PPIUCD in MCSP FP target facilities in Mansa/Chembe has increased from 0 at baseline to 82.8 during Q3; a total of 3,010.4 CYPs cumulatively was realized by Q3 of the MCSP project year.

Way Forward

Under SMGL, MCSP and partners were tasked with the ambitious goal of reducing maternal mortality by 50% in target districts. There are many lessons learned from the four years of SMGL implementation through MCHIP and MCSP that can be used for future programming. Notably, the mentorship approach is a low-cost intervention that can build on and sustain the

benefits of higher-cost interventions in training and site strengthening while fostering a sense of community among providers. Through mentorship, the program not only ensured that high-quality EmONC services were delivered consistently, but also altered the relationship between health care providers and supervisors/mentors. Within a few months of the program's start, providers began to welcome mentors into their health facilities and were able to voice and request assistance in filling gaps rather than feel that they had to hide their shortcomings. The positive shift in morale from the district community medical offices (DCMO) down to health facilities was an important result and will be essential to continued service delivery improvements over time. In Luapula, MOH scaled up mentorship by introducing the approach in other districts using its own funding. Mentors from the provincial and district health offices were used to lead the rollout of these services to other districts. Intensive investment in a targeted geographic area enabled pooled resources and local government engagement in coordinating and leading the implementation process, thus resulting in quick results and local ownership of the process. Although the MCSP Zambia program has ended, future programs should draw upon its lessons learned to improve on capacity-building through mentorship.