



USAID
FROM THE AMERICAN PEOPLE

MATERNAL AND CHILD HEALTH INTEGRATED PROGRAM (MCHIP) MID-TERM EVALUATION



JULY 2011

This publication was produced for review by the United States Agency for International Development. It was prepared by Joy Riggs-Perla, Nancy Franczak, Bettina Schwethelm, and Mary Nell Wegner, through the Global Health Technical Assistance Project.

Cover Photo: “Kangaroo Father Care”
by Arith Rakhmawati, MCHIP Bireuen District Coordinator

MATERNAL AND CHILD HEALTH INTEGRATED PROGRAM (MCHIP) MID-TERM EVALUATION

DISCLAIMER

The authors' views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

This document (Report No. 11-01-507) is available in printed and online versions. Online documents can be located in the GH Tech website library at <http://resources.ghtechproject.net>. Documents are also made available through the Development Experience Clearing House (<http://dec.usaid.gov>). Additional information can be obtained from:

The Global Health Technical Assistance Project

1250 Eye St., NW, Suite 1100
Washington, DC 20005
Tel: (202) 521-1900
Fax: (202) 521-1901
info@ghtechproject.com

This document was submitted by The QED Group, LLC, with CAMRIS International and Social & Scientific Systems, Inc., to the United States Agency for International Development under USAID Contract No. GHS-I-00-05-00005-00.

ACKNOWLEDGEMENTS

The MCHIP Midterm Evaluation Team is grateful to the many individuals within USAID and MCHIP Headquarters and USAID Missions who shared valuable time and knowledge to improve the team's understanding of how MCHIP functions. The team is also indebted to the MCHIP staff and USAID Missions in India, Indonesia, Kenya, and Malawi who supported the field visits; gave generously of their time; and provided opportunities for us to see firsthand the various ways in which the project is working at a country level. Additionally, the team's understanding of MCHIP would not have been possible without the information and insights shared by a number of MCHIP partners: Ministries of Health; UN agencies; donors; PVOs/NGOs; and clients served by MCHIP-supported sites.

CONTENTS

ACRONYMS	v
EXECUTIVE SUMMARY	ix
Country Impact.....	ix
Global Leadership.....	ix
Meeting Mission and Bureau Needs	x
Integration	x
Adapting to the Global Health Initiative.....	x
PVO/NGO Component.....	x
Monitoring and Evaluation (M&E) Systems and Standards-based Management – Recognition (SBM-R).....	xi
MCHIP Organization and Management	xi
USAID Program Management.....	xi
I. INTRODUCTION	1
Evaluation Purpose, Scope, and Objectives	1
Summary Statement of Work.....	1
II. USAID MCHIP PROJECT	3
Overview of Project Rationale, Content, and Management Structure	3
Mandate and Intended Role of MCHIP as a Global Project.....	4
III. EVALUATION METHODOLOGY	5
IV. FINDINGS/CONCLUSIONS	7
Analysis of Implementation Progress and Lessons Learned.....	7
PVO/NGO Component.....	25
Monitoring and Evaluation (M&E) System and Standards Based Management— Response (SBM-R)	31
MCHIP Organization and Management	35
USAID Project Oversight	38
Overall Conclusions.....	38
V. RECOMMENDATIONS FOR MCHIP ACTION	41
Technical and Strategic.....	41
Management and Administration.....	43
VI. RECOMMENDATIONS FOR USAID	45
Current Program	45
Advice for the Future	45

ANNEXES

ANNEX A. SCOPE OF WORK.....	47
ANNEX B. INTERVIEWS/CONSULTATIONS FOR MCHIP EVALUATION	61
ANNEX C. DOCUMENTS REVIEWED FOR MCHIP MIDTERM EVALUATION	67
ANNEX D. MONITORING AND EVALUATION	71
ANNEX E. ATTACHMENTS	83

FIGURES

Figure I. MCHIP Results Framework.....	52
Figure D-1. Number of High-impact Interventions where the Indicated Documents to Support Implementation and Scale-up Exists in Four Countries.....	76
Figure D-2. Number of High-impact Interventions at the Indicated High Stage of Scale-up in four Countries	77
Figure D-3. Current Number of High-impact Interventions Implementation Activities being Carried Out by MCHIP.....	78

ACRONYMS

AAP	American Association of Pediatrics
ACCESS	Access to Clinical and Community Maternal, Neonatal and Women's Health Services [Program]
AIDS	Acquired immune deficiency syndrome
AMTSL	Active management of the third stage of labor
ANC	Antenatal care
AOTR	Assistance Officer's Technical Representative
BASICS	Basic Support for Institutionalizing Child Survival
BEmONC	Basic emergency obstetric and neonatal care
BMGF	Bill and Melinda Gates Foundation
CB	Community based
CBD	Community-based distribution
CCM	Community case management
CDC	Centers for Disease Control
CH	Child health
CHW	Community health worker
COP	Chief of party
CSHGP	Child Survival and Health Grants Program
CSTS+	Child Survival and Technical Support Plus
DHMT	District Health Management Team
DHS	Demographic Health Surveys
DIP	Detailed Implementation Plan
DRC	Democratic Republic of the Congo
EmONC	Emergency obstetric and newborn care
EMT	Executive management team
ENC	Essential newborn care
EOC	Emergency obstetric care
EPI	Expanded Program on Immunization
FP	Family planning
GAPPS	Global Alliance for Prevention of Prematurity and Stillbirths
GAVI	GAVI Alliance (formerly the Global Alliance for Vaccines and Immunization)
GDA	Global development alliance
GHI	Global Health Initiative
HBB	Helping Babies Breathe
HIDN	Health Infectious Disease and Nutrition
HIV	Human immunodeficiency virus
HMIS	Health management information system
iCCM	Integrated community case management
ICDDR,B	International Centre for Diarrhoeal Disease Research, Bangladesh

IIP	Institute of International Programs
IMCI	Integrated management of childhood illness
IT	Information technology
ITN	Insecticide-treated net
IYCF	Infant and young child feeding
JHU	Johns Hopkins University
JSI	John Snow, Inc.
KMC	Kangaroo Mother Care
LAC	Latin America and the Caribbean
LAM	Lactational Amenorrhea Method
LiST	Lives Saved Tool
MaMoni	Integrated Safe Motherhood, Newborn Care and Family Planning Project
MC	Male circumcision
MCH	Maternal and child health
MCHIP	Maternal and Child Health Integrated Program
MCP	Malaria Communities Program
MDG	Millennium Development Goal
M&E	Monitoring and evaluation
MIP	Malaria in pregnancy
MNC	Maternal and newborn care
MNCH	Maternal, newborn and child health
MNH	Maternal and newborn health
MOH	Ministry of Health
MOHFW	Ministry of Health and Family Welfare
MVA	Manual vacuum aspiration
NGO	Non-governmental organization
NICHD	National Institute of Child Health and Human Development
OP	Operations research
ORT	Oral rehydration therapy
PAC	Postabortion care
PAHO	Pan American Health Organization
PATH	Program for Appropriate Technology in Health
PE/E	Pre-eclampsia/eclampsia
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
POPPHI	Prevention of Postpartum Hemorrhage Initiative
PP	Postpartum
PPC	Postpartum care
PPFP	Postpartum family planning

PPH	Postpartum hemorrhage
PQI	Performance and Quality Improvement
PSI	Population Services International
PVO	Private voluntary organization
QI	Quality improvement
QOC	Quality of care
ORT	Oral rehydration therapy
RED	Reaching Every District
RFA	Request for application
RH	Reproductive health
SBA	Skilled Birth Attendant
SBM-R	Standards-based management and recognition
SC	Save the Children
SNL	Saving Newborn Lives
TAG	Technical advisory group
TOT	Training of trainers
TWG	Technical working group
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
WHO	World Health Organization

EXECUTIVE SUMMARY

In late April and May of 2011, a mid-term evaluation of USAID's Maternal and Child Health Integrated Program (MCHIP) was conducted to assess project performance to date and recommend any changes needed to enhance MCHIP's likelihood of achieving its goals, objectives, and outcomes. MCHIP, a Leader with Associate Award with Jhpiego, spans the period October 1, 2008, to September 30, 2013. Therefore, the mid-term evaluation presents an ideal opportunity at midpoint to assess the pace and quality of implementation, as well as make any adjustments to strengthen the project. A team of four public health specialists assessed progress by interviewing stakeholders at global and country levels, visiting 4 of the approximately 30 MCHIP country programs, interviewing staff of six additional USAID Missions, reviewing relevant documents, and analyzing project performance information. Key findings and recommendations were presented to USAID and MCHIP leadership on May 24, 2011.

The findings were organized around key questions raised in the evaluation scope of work. The overall conclusions are that MCHIP has assembled the necessary technical expertise both at headquarters and at the field level to undertake the required work and is making good progress toward helping USAID Missions in the participating countries introduce high-impact maternal, newborn and child health (MNCH) interventions. For the remainder of the program, MCHIP, with support from USAID, needs to put more concerted effort toward developing evidence based on country-level experiences for programmatic approaches that yield the best results in achieving outcomes; institutionalizing them; and ensuring sustained MNCH programs over the long run. Other findings include the following:

COUNTRY IMPACT

- MCHIP has undertaken quality of care and other assessments to advocate for service improvements and has demonstrated ways to strengthen MNCH services in a variety of settings.
- Several MCHIP country programs (e.g., India) are providing good models for scaling up tools and approaches introduced by MCHIP by working to expand and strengthen local government-funded programs. This work is being carried out in cooperation with bilateral projects and through the formation of alliances with other partners, including corporations.
- Three key challenges remain: (1) the difficulties associated with developing holistic strategies for interventions and country activities, given the reality that Missions or governments do not always provide the scope or funding for MCHIP to do this; (2) the challenge facing MCHIP programs in planning effectively for scale up by working proactively with available in-country partners; and (3) the need for MCHIP to document creative strategies to help overcome common health system deficiencies that impede sustained improvements in maternal and child health across countries.

GLOBAL LEADERSHIP

- MCHIP is making valued contributions to the work of other global partners in specific elements of MNCH. MCHIP is recognized in maternal health for its work on postpartum hemorrhage (PPH), pre-eclampsia/eclampsia (PE/E), postpartum family planning (PPFP), and essential and emergency obstetrical care. MCHIP is also contributing to work in newborn health, specifically through the Helping Babies Breathe (HBB) alliance and HBB's work at the field level. In child health, MCHIP is well-regarded for its work in integrated community case

management (iCCM) and immunization programs. In HIV/AIDS prevention, male circumcision is an area of MCHIP expertise.

- The profile of child health in general needs elevation, with some traditional programs (such as oral rehydration therapy – ORT) yet to have become fully institutionalized within countries despite several decades of donor support. The need for increased advocacy for child health is important. MCHIP leadership is not evident in areas such as nutrition or prevention of mother-to-child transmission of HIV partly due to limited funding and the fact that other USAID partners have taken the lead for these programs.
- MCHIP is not far enough along in synthesizing and documenting globally convincing evidence on the impact, cost-effectiveness, and sustainability of selected MNCH programmatic approaches in the field.

MEETING MISSION AND BUREAU NEEDS

- Missions are generally pleased with MCHIP’s technical and programmatic inputs into country MNCH programs. MCHIP’s predecessor projects have helped MCHIP launch country programs quickly and effectively. Both headquarters and country staff are viewed as having strong technical expertise.
- In some cases, Missions would like to see better documentation of lessons learned and more credible strategies for scale up of MCHIP-supported programs.
- Missions and some Bureau staff also value the ability to access MNCH expertise from one central project rather than from several more specialized projects.

INTEGRATION

- While specific definitions of integration vary, MCHIP is forging ahead with advocating for and supporting “smart” integration where there are clear advantages for doing so within country programs.
- A better evidence base needs to be established to understand when integration of services makes sense, as well as both the costs and benefits involved. Child Survival and Health Grants Program (CSHGP) and Malaria Communities Program (MCP) grantees are well-positioned to contribute to this process.

ADAPTING TO THE GLOBAL HEALTH INITIATIVE

- MCHIP is functioning in ways that reinforce and operationalize Global Health Initiative (GHI) principles as well as USAID’s Best Action Plans.
- MCHIP should take advantage of its partnership with private voluntary organizations (PVOs) to help learn more about how to improve equity by developing specific strategies to overcome factors related to social, economic, and health-related marginalization.

PVO/NGO COMPONENT

- MCHIP is providing the kind of support to CSHGP and MCP PVOs and non-governmental organizations (NGOs) that was envisioned during MCHIP design, and has made substantial progress in developing productive partnerships with these groups.
- Greater collaboration with the CORE Group in the development of tools and guidelines has the potential to disseminate MCHIP innovations and approaches even more widely, given the huge population reached by PVO/NGO programs worldwide. At the country level,

MCHIP staff are not as aware as they should be about the need to involve key PVO/NGO partners.

MONITORING AND EVALUATION (M&E) SYSTEMS AND STANDARDS-BASED MANAGEMENT – RECOGNITION (SBM-R)

- MCHIP is working to strengthen country-level M&E systems and using data to improve program performance. However, improving data quality and use is not always a part of MCHIP interventions.
- MCHIP's performance monitoring plan could be improved to better capture important project outcomes; suggestions to do so are provided in the report.
- SBM-R is a valuable mechanism to support sustained quality of care improvements in MCHIP countries. Strategies need to be developed to improve institutionalization of the needed tools and processes.

MCHIP ORGANIZATION AND MANAGEMENT

- MCHIP headquarters management through the Executive Management Team is functioning well and serves as an effective interface with USAID.
- Management issues at the field level – in many cases complicated by administrative fragmentation – need to be addressed to avoid an adverse impact on field programs.

USAID PROGRAM MANAGEMENT

- Systems developed for multiple USAID technical advisors and the Assistance Officer's Technical Representative (AOTR) management team to assist with MCHIP oversight are working well. USAID Missions generally believe they get the support they need from USAID headquarters on issues they encounter with MCHIP implementation.

Recommendations

Sections VI and VII present high-priority recommendations to MCHIP leadership as well as to USAID that directly relate to the findings in each priority topic area, as listed above. Among the highest priority are the following recommendations:

1. Operationalize the use of the scale-up road maps to ensure that MCHIP- supported interventions become institutionalized and sustainable.
2. Develop country-level maps of all high-impact interventions that identify where countries are in the scale-up continuum, the partners that are working on them, and the additional components required to achieve scale.
3. Develop and implement immediately a strategy for global “knowledge creation” to establish evidence on the impact and costs of MNCH **programmatic approaches** in ways that contribute to achieving global consensus. Impact should include looking at service coverage and costs as well as measures of institutionalization and sustainability.
4. Through targeted pilot activities, establish new evidence and synthesize it with other available evidence to determine when integration of services is advisable, the costs and benefits involved; develop guidance for future program planning and implementation.
5. Develop more explicit mechanisms for increasing three-way learning among MCHIP, CORE, and the PVO community.

6. Strengthen MCHIP's performance monitoring plans by developing selected global-level performance indicators for interventions based on the scale-up road maps; these should include indicators measuring country ownership and uptake.
7. Take steps to address administrative issues to improve program management at the field level to further strengthen relationships with, and engender the confidence of, USAID Missions.
8. USAID should use lessons learned from MCHIP on the best programmatic approaches to scale up, institutionalize, and sustain high-impact interventions to design any follow-on program.

I. INTRODUCTION

EVALUATION PURPOSE, SCOPE, AND OBJECTIVES

The MCHIP mid-term evaluation was commissioned by the USAID Global Health Bureau's Health Infectious Disease and Nutrition (HIDN) Office to analyze progress and achievements at the project's midpoint and identify any recommendations needed to improve performance during the second half of the project's five-year life. The mid-term evaluation's two primary goals were to: (1) assess whether MCHIP is achieving its objectives and planned outputs, as stated in the MCHIP Agreement and approved implementation plans; and (2) make recommendations to improve implementation of the current project as well as inform follow-on projects. The evaluation questions were organized around six priority themes: country impact, global leadership, meeting Mission and Bureau needs, integration, management, and adapting to GHI.

SUMMARY STATEMENT OF WORK

The Mid-Term Evaluation, managed by the GH Tech project, was conducted during a five-week period in April and May 2011. The evaluation methodology is summarized in Section III of this report. A retired senior foreign-service officer with a public health background led a team of three technical experts with backgrounds in maternal and child health, private voluntary organization/non-governmental organization (PVO/NGO) programs, program evaluation, and health systems strengthening to conduct this performance evaluation (as defined in the new USAID Evaluation Policy).¹ The deliverables included: the evaluation framework, including data collection tools, two presentations of findings and recommendations (one to USAID and the other to MCHIP staff), the draft evaluation report, and a final report, reflecting as appropriate the comments and suggestions of USAID and MCHIP.

¹ USAID Evaluation Policy dated January 11, 2011.

II. USAID MCHIP PROJECT

OVERVIEW OF PROJECT RATIONALE, CONTENT, AND MANAGEMENT STRUCTURE

The request for application (RFA) issued in April 2008 for the MCHIP Leader with Associate award, specified “increased use and coverage of high impact MNCH interventions” as the strategic objective, with three sub-objectives:

1. Introduce these interventions at the country level
2. Provide MNCH global leadership including further development and promotion of the improved approaches
3. Assist PVO/NGOs and their local partners, supported by the CSHGP and PMI MCP programs, in designing, implementing, monitoring, and evaluating innovative, effective, and scalable community-oriented strategies that deliver integrated high-impact interventions to vulnerable populations.

The project was designed to serve the needs of USAID Missions funded through “field support” transfers for in-country programs as well as the global leadership supported by core funds allocated by the Global Health Bureau. MCHIP’s overall goal is to help achieve reductions in under-5 and maternal mortality and morbidity, and accelerate progress toward reaching Millennium Development Goals (MDGs) 4 and 5. USAID recognized that the project would contribute toward that goal rather than being solely responsible for it. MCHIP’s targets and outcomes are stated in mortality reduction terms to keep the attention focused on the following ultimate targets:

- Contribute to reductions in maternal and under-5 mortality in 20 countries
- Contribute to an estimated 118,000 mothers and 7.2 million children under 5 saved in two high-burden countries
- 20 countries demonstrating improved coverage in use of MNCH services, with 5 of these benefiting from an integrated package of high-impact MNCH interventions
- Five countries demonstrating greater equity in coverage of MNCH services
- All 68 MDG Countdown countries benefiting from MCHIP-promoted learning tools and approaches

The MCHIP Leader with Associate Agreement with a ceiling of \$600 million was awarded to Jhpiego as the lead organization, with sub-agreements with John Snow Inc. (JSI), Save the Children (SC), and Macro International as the main partners. Johns Hopkins Institute for International Programs (JHU-IIP), Program for Appropriate Technology in Health (PATH), Broad Branch Associates, and Population Services International (PSI) all have smaller but important roles as specialized technical support partners in MCHIP. The main partners have formed a small Executive management team (EMT) that guides the overall program and serves as primary liaison with USAID. In each country office, a lead partner is designated based on a consensus between the USAID mission and MCHIP. The MCHIP chief of party (COP) provides overall leadership for the program, including the work of all partners. MCHIP began on October 1, 2008, and is scheduled to end on September 30, 2013.

MANDATE AND INTENDED ROLE OF MCHIP AS A GLOBAL PROJECT

As a global rather than a country-specific bilateral project, MCHIP has a mandate to further global knowledge in the areas of MNCH. The mandate is bidirectional. First, it is intended to bring high-impact interventions and global best practices into country programs. These high-impact interventions have been defined by USAID in two guidance documents entitled “Maternal Health Pathways” and “Child Health Pathways.” Second, the RFA states that “MCHIP will promote the further development of high-impact MCH interventions by testing new approaches and tools for more effective implementation and adaptation in the field and *conduct appropriate analyses to document the effectiveness and cost-effectiveness of strategies to deliver proven interventions.*”² The intent of this mandate is to learn from country-level experience concerning the most efficacious *programmatic approaches* to implementing high-impact interventions. The purpose of the analysis is to generate globally credible learning about the approaches that yield the best results in terms of impact, scale up, institutionalization, and sustainability. The expectation is that this kind of programmatic learning can help development partners understand the approaches that have the best development impact over time. Analyzing and sharing those findings is an important part of MCHIP’s mandate.

² MCHIP RFA dated April 23, 2008, page 18.

III. EVALUATION METHODOLOGY

The evaluation team assessed project performance by:

- Reviewing a wide range of documents such as the RFA, the MCHIP cooperative agreement, annual work plans, annual and semiannual reports, project monitoring plans (PMPs), country-specific documents, technical briefs, and other project-generated documents (Annex A)
- Interviewing a broad variety of stakeholders including: USAID and MCHIP headquarters staff, USAID Mission staff, MCHIP country staff, in-country partners such as Ministry of Health personnel, managers, providers, some clients, and international PVOs and NGOs, UN agencies and donors (Annex B)
- Conducting site visits in selected countries to view activities and talk to implementers of MCHIP-supported activities
- Analyzing progress, achievements, and challenges in relation to the project's stated objectives and targets

For the stakeholder interviews, the team used a question guide developed prior to beginning the work, which ensured obtaining information on a standard set of topics related to the evaluation's scope of work.

The team visited four countries (Kenya, Malawi, India, and Indonesia) and interviewed USAID Mission staff in six additional countries (Bangladesh, Ghana, Madagascar, Nepal, Paraguay, and Zimbabwe).³ The selection criteria for the visits included countries with:

- A significant amount of field support funds invested in the MCHIP project, both recent and for longer durations
- Seed core funds that were catalytic for initiating a larger program
- An integrated program (maternal, newborn, and child health-child health-family planning [MNH-CH-FP])
- Some of the expired five vertical projects for technical assistance before transitioning to the MCHIP project
- Work with bilateral projects and/or coordination with the Child Survival Health Grant programs (CSHGP), if applicable
- A program that had transitioned from field support to Associate Award
- Missions that have reported challenges to the MCHIP Assistance Officer's Technical Representative (AOTR)

The one-week country visits were brief and intended to help the team understand the variety of ways MCHIP is working at the country level as well as the challenges faced. These visits were neither long enough nor planned in a way to constitute an evaluation of the MCHIP programs in those countries.

³ The selection of Missions to interview was, in large part, opportunistic. When Mission-based staff responded to a request from GH Tech for an interview, one was arranged. In several cases, the Missions requested to be interviewed or the team added a country based on information provided by an interview. The evaluation team recognizes that this subset of Missions may not be representative of all Missions. At the same time, the selection did provide a diverse set of MCHIP programs and country circumstances, and included 10 of the 22 countries where MCHIP has full-time in-country staff.

Sections VI and VII summarize the recommendations resulting from this mid-term evaluation. These recommendations are aimed specifically at improving implementation during the remainder of the project. This evaluation report notes some of the project's accomplishments, but does not constitute an exhaustive description of all of MCHIP's accomplishments and activities, as this information is available in other reports and the time available for this evaluation was limited. Instead, this report focuses on providing an analysis of what is working well, noting where progress is lagging, and identifying the practical steps that can be undertaken to strengthen the program.

IV. FINDINGS/CONCLUSIONS

ANALYSIS OF IMPLEMENTATION PROGRESS AND LESSONS LEARNED

Country Impact

Country perception of the MCHIP program: From all accounts the MCHIP program is well perceived in countries where it is working. Focus activities have been developed in close collaboration with national ministries of health, and usually at their request. During discussions with stakeholders, the following themes consistently emerged as reasons for the satisfaction:

Continuity: In most cases, MCHIP program activities have built on the valued work of previous projects, including Access to Clinical and Community Material, Neonatal and Women's Health Services (ACCESS), Basic Support for Institutionalizing Child Survival (BASICS), Prevention of Postpartum Hemorrhage Initiative (POPHI), IMMUNIZATIONbasics, and bilateral agreements with MCHIP partners. The MCHIP program continues with staff who are well-respected in terms of expertise and in the way they work with the ministries of health (MOHs); in almost all cases, these are national staff. In countries where MCHIP partners have bilateral activities, the partners' organizational areas of expertise in pre-service training, maternal health, and family planning (Jhpiego), community and newborn health (SC), child health and immunization (JSI), social marketing and private sector (PSI) are also acknowledged as valuable components of the MCHIP program.

Quality and effectiveness of personnel: The quality of the technical assistance provided by MCHIP is universally praised, a description that applies to country programs as well as to regional/headquarters staff. With few exceptions, the MCHIP country staff are acknowledged as valued partners in technical working groups for their technical and administrative contributions as members and for bringing new ideas and local implementation experience to the discussion. One country stakeholder observed: "If you're at the table and want to discuss something and have MCHIP, you feel good...(you) have an organization that is trusted."

Stakeholders value the expertise MCHIP brings to the table. For example, MCHIP brings expertise from outside the country, particularly in the areas of maternal health, immunization, and male circumcision in countries visited by the evaluation team. The program also organizes cross-country visits for specific topics (e.g., standards-based management and recognition [SBM-R], male circumcision, Kangaroo Mother Care [KMC]). Finally, MCHIP provides an opportunity for sharing through regional meetings, organized/co-organized by MCHIP and with national participation funded by the program. The Africa Regional Meeting (February 2011) focusing on prevention and treatment of postpartum hemorrhage (PPH), pre-eclampsia/eclampsia (PE/E), and newborn health was frequently cited for sparking new interest in some interventions; training on Helping Babies Breathe (HBB) was singled out as bringing momentum to introduction/scale-up in some countries in Africa. The report of this meeting needs to be shared widely. MCHIP advocacy and support for pilot-testing implementation has strengthened national acceptance of high-impact interventions and strategies at the country level in areas that include the following:

- Community case management (CCM)
- Pneumococcal and rotavirus vaccines
- Introduction of neonatal health interventions, including newborn resuscitation
- Community follow-up strategies for immunization (Reaching Every District – RED) and using a similar methodology for prevention of mother-to-child transmission (PMTCT) in Kenya

Approaches that had not previously been introduced in some countries or regions have been accepted with MCHIP advocacy and support for implementation (e.g., linking IUD insertion with postpartum FP in India, community-based distribution [CBD] of FP methods in Sylhet, a socially conservative district in Bangladesh, and CCM for common childhood illnesses in a number of countries.)

Working as a partner to support national MOHs: MCHIP was identified as fully supporting ministry plans and activities, with program activities seen as supporting national agendas and plans. There were no examples where MCHIP was perceived as “going off on its own.”

Funding support for MOH activities: Where national budgets are insufficient, MCHIP has filled funding gaps for such activities as national-level coordination meetings, joint supervision from the central and provincial levels on down, training costs, and special meetings and national health days on various topics. This support was perceived as valuable and often essential for the activity to continue.

A cross-cutting activity supporting health systems strengthening most often mentioned as highly valued inputs is MCHIP’s follow through with national committees to ensure that policies, guidelines, and training curricula reflect nationally accepted practices. Respondents singled out as greatly contributing to the quality of skills in graduates MCHIP’s efforts in performance-based pre-service training to improve the quality of clinical training and preceptorship by ensuring that appropriate models and tools are available as new methodologies; MCHIP also ensures that preceptors in clinical training sites are trained to check clinical competencies. Among MCHIP interventions appreciated in countries are strengthening of monitoring and supervision – revising and integrating checklists, joint supervisory visits for training in use of these tools – as well as day-to-day support at the national and, in some cases, district levels in MCHIP focus areas. The monitoring and evaluation (M&E) support consistently identified as highly useful is the microplanning process for follow up of Expanded Program on Immunization (EPI) and PMTCT dropouts (e.g., in Kenya, Democratic Republic of the Congo [DRC], and India).

MCHIP is pilot testing the service-level collection of program indicators (developed internationally and/or in collaboration with ministries); in some cases, these have been accepted for inclusion in the national health management information system (HMIS). In Kenya, MCHIP is actually developing information technology (IT) capacities within the Department of Family Health, so department staff can better access and utilize HMIS as well as program data the technical divisions want that are not part of the HMIS.

Effectiveness and impact: Within select facilities and working areas, MCHIP has documented successful facility-level changes in provider behavior and service use (increase in deliveries by Skilled Birth Attendant (SBA), immunization rates) and some evidence of changes in outcomes based on provider behavior (facility decreases in maternal deaths and newborn sepsis [Dominican Republic and Malawi]).

MCHIP has reported on program activities, with grey literature (and some peer-reviewed documents) documenting changes resulting from interventions in some cases, (such as malaria in pregnancy). The program has also identified the strong and weak components of implementation strategies and described steps to mitigate problems. MCHIP has conducted quality of care (QOC) assessments of services to prevent and manage maternal and newborn complications in multiple countries (four nationally representative surveys⁴) and has used the results to effectively advocate for changes in policies and guidelines, as well as to improve training related to the documented weaknesses. In addition, special studies have added to the evidence base for

⁴ Ethiopia, Kenya, Malawi, and Rwanda.

adapting specific interventions to country-specific situations (e.g., rational antibiotic use for newborn sepsis in the DRC and Nigeria).

Scope and scale of country-level work varies greatly, depending on history and funding sources. MCHIP has provided short-term technical assistance in at least 6 countries⁵ and has an in-country presence in 27 countries (5 of which are new for MCHIP in Year 3 of the project). In many cases, the programs have (either through design or in the course of activities) identified implementation partners who received MCHIP technical assistance and then implemented activities on a larger scale and longer timeframe than is feasible under MCHIP; this occurred in locales including the DRC, Bangladesh, India, and Nepal. In other cases, MCHIP has a small number of focus areas where it supports the government or other partners implementing activities (e.g., in Bondo, Kenya, and several districts in Malawi). This support frequently consists of joint supervisory visits to service sites by MCHIP and district health managers.

The range of activities in an individual country depends primarily on Mission/MOH demand and programmatic needs. Among the countries where MCHIP has a presence, the technical areas that are *least* addressed are: nutrition (programming in 3 countries), water, sanitation, and hygiene (WASH) (in 4 countries), child health (8 countries), and HIV (12 countries), in comparison to maternal and neonatal health (22 and 25 countries, respectively) and activities to support quality and policy changes (in over 20 countries). MCHIP's HIV work primarily focuses on integrating PMTCT with antenatal care (ANC) and male circumcision, where funding has been provided for that activity. MCHIP and Missions noted that most HIV activities are funded through PEPFAR and that there is, in general, a lack of perceived need by Missions for technical assistance in child health, as activities have been ongoing for many years and are often covered by bilateral agreements.

In six countries where malaria is highly endemic and MCHIP has a country presence, the program has provided support to the President's Malaria Initiative (PMI) not only through integrating malaria prevention and treatment with that effort's PVO/NGO maternal and child health-supported activities, but also at a country level to improve national malaria strategies. In



Hand washing poster in Aceh Indonesia
Photographer: Joy Riggs-Perla

several other countries (e.g., Burkina Faso) MCHIP provided external technical assistance to assess malaria programs and develop strategies. Malaria activities beyond malaria in pregnancy (MIP) and CCM have included improving pre-service (Ghana) and in-service training, promoting use of the rapid test, and community preventive activities such as health education to increase demand for appropriate treatment and use of long-lasting insecticide nets. These activities have been implemented with ministries of health and through NGOs that received Malaria Communities Program (MCP) grants.

MCHIP has leveraged resources (frequently with USAID support) from the private sector and through partnerships with international organizations for such activities as pilot testing

⁵ Angola, Benin, El Salvador, Guatemala, Lesotho, and Senegal.

handwashing for newborn health interventions (India, Kenya, Indonesia) and funding expansion of services and printing of publicity and training materials (India). It has also formed partnerships with NGOs and other local organizations for pilot testing interventions (e.g., misoprostol with EngenderHealth in Bangladesh; point-of-use water treatment with a local NGO in DRC and PSI in India. In addition to these examples,

MCHIP plans to link testing of practical methods for using SMB-R (using computer notepads or tablets) for implementation of pay-for-performance plans funded by other donors (upcoming in Malawi).

Through partnerships with international organizations and collaboration with NGOs, MCHIP has also identified opportunities for scale up of interventions (Abt Associates for newborn health interventions in the Dominican Republic, Peace Corps for malaria prevention and control in Burkina Faso, and many different partners for Kangaroo Mother Care [KMC]). MCHIP appears to be most directly responsible for new national scale-up activities for HBB, KMC, and male circumcision (MC), when MC activities were requested.

However, explicit strategies for scale up are often lacking for other interventions, particularly those focusing on health systems strengthening, such as improved supervision and monitoring performance against standards (SBM-R), which are unlikely to result in any lasting systemic change unless scaled up. Given that MCHIP is not a long-term implementing partner, the evaluation team believes that activities should always be carried out with the view to sustainable scale up and institutionalization. Even interventions where scale up is occurring (KMC) have the appearance of occurring in an ad hoc manner. From reports, interviews, and review of PMPs, it seems that MCHIP country programs do not see achieving scale up (as opposed to advocating for introduction and demonstrating implementation) as a major responsibility.

The most commonly encountered process related to scale up was to advocate for others implementing specific practices by holding meetings to disseminate information. A proactive strategy to identify likely partners for scale up and think through the required systems and resources ahead of time was not evident for many MCHIP activities. In fact, a number of MCHIP interventions have built on earlier projects in which interventions have not yet been taken to scale (e.g., SBM-R, basic emergency obstetric and neonatal care [BEmOC] interventions, community-based services, etc.)

Conclusions about country impact: Overall, MCHIP country programs were assessed as sound and responsive to needs. However, three main issues were identified as key areas in need of strengthening: holistic strategies for interventions and country activities; use of MCHIP partners for scale up and improved strategies; and strengthening the process for developing the evidence base for implementation and institutionalization.

Lack of holistic strategies for interventions and country activities: Although Missions have been open to some new interventions that they did not initially ask for (e.g., newborn health in Zimbabwe), once programs started there seemed to be little demand from stakeholders for new interventions. This also includes attempts to try new implementation methods such as integration of services, or for trying new strategies for resolving common problems (such as low motivation, poorly functioning logistics or management systems, or insufficient funding and support for routine aspects of the health system). That is not to say that programs are stagnant—MCHIP successfully lobbied with Missions and ministries, and jointly agreed to additions to MCHIP’s scope of work as funds have become available – but it does result in some countries appearing to have programs that address pieces of a whole, without being placed within a holistic country framework that ensures the availability of high-impact MNCH interventions.

In some cases (Zimbabwe) MCHIP has been asked to conduct a situation analysis prior to defining activities. This is an ideal situation that is not always possible at the start of activities. Often the Mission or MOH has specific ideas about what it wants MCHIP to do in a country. However, given that high-impact interventions are sometimes implemented vertically and, in other situations, integrated in health service settings or households, a strategic assessment of a country's status vis-à-vis relevant high-impact interventions – especially in relation to the “pathway to implementation at scale” developed by MCHIP – might identify gaps that could be addressed relatively easily to provide more holistic care to mother and child. In Senegal, MCHIP has been documenting lessons learned across MNCH high-impact interventions (EPI, MNH, integrated community case management [ICCM]) that can provide information to advocate with the Mission on any identified gaps. Addressing gaps does not imply that MCHIP must carry out the work; rather, MCHIP is in a position to proactively identify opportunities for strategic partnering within MCHIP geographic focus areas, as well as scale up MCHIP-promoted strategies outside of focus areas. Systematic attention to strategic planning will help a country move forward in the continuum of ensuring a balanced package of MNCH interventions from the household to facility level. Lessons learned from some of the stronger and more holistic country programs (India, DRC) can be used to improve the consistency with which this approach is used during the first year of work in a country.

From the documents reviewed, it appears that the DRC Mission, for example, takes a reasonably holistic, health systems approach to high-impact interventions. The program addresses multiple interventions, using intervention-specific strategies that frequently include providing technical assistance to NGOs that carry out social mobilization (educating and creating demand); introducing community-level interventions, where appropriate; improving facility services; and strengthening systems components such as training providers and systems for assessing quality of care and information. As another example, the Ghana Mission also appears to be looking at its health portfolio in totality, having a clear idea of where MCHIP, with its focus on pre-service training, fits into the picture. India also is taking a comprehensive approach to immunization.

There are other country programs, though, where MCHIP seems to focus on particular aspects of an intervention (usually the supply side, such as training or developing guidelines) without addressing the follow-up and demand sides; or where MCHIP supports an intervention/strategy without sufficient focus on the health system support required for the strategy to be implemented effectively (such as ensuring that district and provincial supervisors routinely monitor some aspect of an intervention that will support adherence to standards as a routine part of their M&E activities). For example, Kenya had stock-outs of routine vaccines in districts where MCHIP was focusing on RED and introduction of new vaccines. In another case, SBM-R was newly introduced in health centers in Malawi but – although it had been planned – the District Management Team did not monitor implementation at the facility level to reinforce adherence and identify problems; the Evaluation Team noted that staff were not following through on expected SBM-R activities.

Although the HBB initiative in most countries includes curriculum, training, and scale up, there are few examples of follow-up system support. In Kenya, where MCHIP is financially supporting the pilot testing of HBB by other agencies, midwives in several facilities provided examples of cases where they felt the need for moral/technical support; working on their own, the midwives have developed a team approach, where they call each other for support when faced with a difficult case. The problems described are not unexpected and are likely addressed in intervention plans, but the systems strategies need more focus and rigor to help them function efficiently and effectively. MCHIP is working with the government of Kenya to develop an implementation plan for integrating HBB into its essential newborn care (ENC) program. Lessons learned by implementing partners in Kenya should be used to inform the integration of

HBB into ENC programming and follow-up strategies to support quality implementation of practices in health facilities.

Use of MCHIP and other partners for scale up and improved strategies: Some existing expertise appears to be underutilized, specifically expertise within PSI for addressing demand, and within BroadBranch for helping strategize to motivate staff and sustain system improvements achieved under MCHIP, particularly where Missions fail to include these areas in their scopes of work. In addition, nutrition and WASH are cross-cutting interventions that are not funded or addressed in a systematic fashion in many country programs. There is an opportunity for stronger advocacy by MCHIP and USAID/Washington in instances where there are clear programmatic gaps.

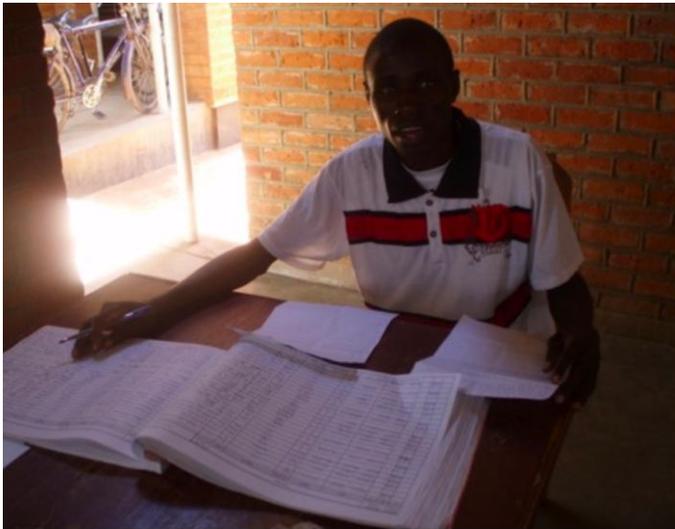
There are examples—both in MCHIP focus areas and in outside focus areas—where MCHIP partners or other respected NGOs are implementing high-impact interventions bilaterally and opportunities are missed to better coordinate to improve the availability of holistic strategies for clients, or to scale up through on-the-ground implementation. Kenya and Malawi are examples where reports identify opportunities for working toward effective partnering but the evaluation team noted these were not necessarily followed in practice. There are large bilateral projects and NGO/PVOs working in many countries that could serve as prime candidates for supporting scale up of interventions, with collaborative planning and donor support.

The evaluation team noted missed opportunities for collaboration among implementers to reinforce systems aspects of interventions, particularly when implementers work with the same clients and the same service site, or the same provider is responsible for a variety of interventions. A clear example is where MCHIP could engage with implementing partners so that each supports the other's program (where one project works on BEmOC and one on ENC in the same facility; or where one project is working at the community level on aspects of MNCH and the other at the facility level). During field visits the team did a quick checklist on the facilities visited to assess the presence of basic infrastructure and supplies for BEmOC and ENC, regardless of who was supporting the interventions. There were consistent findings of missing guidelines as well as missing equipment – manual vacuum aspiration (MVA) for post-abortion care (PAC), and occasional stock-outs of supply of MgSO₄ in cases where MCHIP was not working on these services, but other projects either were or had done so in the past. The team visited sites where MCHIP partners had bilateral agreements for CCM and were working with the same community health workers as the MCHIP project, but strategic synergies were lacking.

Although there usually has been some discussion prior to a new partner starting activities in an area where another works, there is not consistent recognition of the need to plan to work holistically with service providers. Given that providers (particularly at community and health center levels) are often responsible for multiple services, experience has shown that when overworked and under-recognized, providers will focus on activities that are receiving external attention, at the expense of equally important activities that are less visible.

Lack of evidence base for implementation and institutionalization: MCHIP reports identify problems, including stock-outs, lack of staff motivation, and frequent staff transfers, as issues that negatively impact country program work. These are universal and persistent problems in countries with weak health systems and issues that should ideally be addressed by MCHIP in a systematic fashion to add to the body of evidence and knowledge for “best practices in implementation.” In the global community, examples abound of situations in which programs built capacity and demonstrated changes in process and outcomes – but when program support was withdrawn, staff members with developed capacity were left to work in weak systems and the improvements disappeared. MCHIP has an opportunity and responsibility to contribute to seeking solutions to address this major development challenge.

The MCHIP approach to strengthening M&E in districts by revising supervision checklists and joint supervision with district supervisors has been shown to work when external



Statistician in Malawi coding diagnoses
Photographer: Nancy Fronczak

support/oversight is available. But global experience indicates that these systems tend to disappear when the external support leaves and the staff must function in a system that has not changed. Oral rehydration therapy (ORT) corners, community hand washing to prevent illness, community treatment of common childhood illnesses, and building “volunteers” into health system strategies are all examples of current activities that are being recycled. Given development experience over the past several decades, it is important to note lessons learned about why, in many instances, such programs have not been sustained over time so these

findings can be integrated into program strategies. Where these lessons may have been incorporated into individual country-level strategies but not identified by the evaluation team (given the limited site visits and timeframe for the evaluation), they need to be shared with all country-level staff where applicable, and raised at international forums to minimize the need for country-by-country relearning of the same implementation lessons

A valuable contribution to the state-of-the-art for implementation will be achieved if MCHIP can better document creative strategies to help implementers overcome or mitigate the impact on performance and outcome of the well-known system and resource weaknesses that consistently impede sustained improvements in maternal and child health. To do this, a process for weaning implementers from external support, and an understanding of how this process impacts sustained quality of activities is important. Working with bilateral donors and NGOs with long-term program activities, or focusing on activities from predecessor projects where “weaning” is theoretically desirable and feasible, may provide more opportunities for this type of knowledge generation and for creatively addressing problems that arise so that lessons can be learned.

Global Leadership

MCHIP’s Role and Contributions: MCHIP involvement and contributions at the global level are manifested in various ways, including contributing to working groups of global development partners in setting standards; developing indicators and globally acceptable tools; contributing to defining, advocating for, and tackling global learning issues; and providing logistics and support functions where needed to help global actors move agendas along in content and accelerate implementation at the country level. Although the MCHIP teams include global experts in various technical areas, when activities are funded by USAID, the Agency takes on the leadership and provides guidance to MCHIP’s global initiatives to ensure their alignment with USAID priorities.

Overall, MCHIP staff and activities received high marks from global partners on technical expertise related to MNCH. Key informants credited MCHIP with leading most strongly in the areas of maternal care, immunization, and iCCM, as illustrated below.

Maternal health care and family planning: Approaches and indicators are developed by a small group of agencies including USAID and MCHIP, WHO, and UNICEF. Because these partners are not always inclusive of other stakeholders outside their small circle, other agencies contacted were less aware of key MCHIP staff and achievements and, as a result, may be less likely to own and disseminate resulting products and tools. USAID and MCHIP could work toward opening the “inner circle of collaborators” (WHO, UNICEF, D.C.-based agencies) for greater inclusion of other key global actors. This might contribute to greater ownership of standards and best practices.

MCHIP is clearly recognized for its work on PPH, PE/E, Emergency Obstetric Care (EMOC), and postpartum family planning (PPFP), as well as related pre-service education of nurses and midwives, at least in part due to the strong foundation and continuity with the preceding ACCESS and ACCESS FP projects. Picking up from the ACCESS FP Project, MCHIP is providing technical leadership in postpartum IUD insertions and integrating FP into other postpartum services. USAID headquarters and WHO recognize the scale-up maps initiated for PPH and PE/E for their potential for monitoring and comparing country progress globally. The scale-up maps appeal to key informants for the visual presentation of complex health system components. The Addis Ababa meeting (cited earlier) on PPH, PE/E, and HBB, attended by more than 300 participants from 36 countries, co-funded by the Bill & Melinda Gates Foundation, received glowing comments from country and global stakeholders alike for technical content, relevance, and organization.

Global partners also expressed some reservations. WHO is sensitive to the introduction of new interventions (e.g., misoprostol at the household level), when the evidence has not yet been fully aggregated, published in peer-reviewed journals, and subsequently resulted in a change in technical guidance from WHO. However, given limited funding, WHO is dependent on USAID through MCHIP to provide resources for technical working group meetings on joint priorities and is appreciative of any support received via such channels.

Newborn care is a second area of intense involvement at the global and regional level. MCHIP is involved in two major USAID Global Development Alliances centering around newborn resuscitation and prevention of sepsis through hand washing with multiple partners (National Institute of Child Health and Human Development [NICHD], Save the Children, Laerdal Medical, American Academy of Pediatrics, Unilever, London School of Hygiene and Tropical Medicine, Centers for Disease Control [CDC], and The International Centre for Diarrhoeal Disease Research, Bangladesh ICDDR,B). MCHIP also collaborates with UNICEF, WHO, the Partnership for Maternal, Newborn and Child Health, Countdown to 2015, Bill & Melinda Gates Foundation, and the Global Alliance for Prevention of Prematurity and Stillbirths (GAPPS).

Key informants expressed the view that neonatal resuscitation is an integral component of the WHO maternal and newborn package, and there appears to be some concern at WHO with the more vertical HBB approach. Newborn health staff may want to work closely with WHO to ensure that HBB’s vertical approach is not seen as distracting from the integrated package used by WHO and UNICEF. It appears to the Evaluation Team that neonatal sepsis and HBB country activities in the Africa and Asia region will provide new and rich information on implementation challenges at the facility and community level. These will need to be analyzed in the remainder of the project to develop and disseminate global standards in this relatively new focus area with strong potential for mortality reduction.

With respect to the Latin American and Caribbean (LAC) region, where USAID funding for health is declining, the impact on policy development is already evident through MCHIP’s role in chairing the LAC Neonatal Alliance (USAID, PAHO, UNICEF, UNFPA, MCHIP, URC/HCI, the CORE Group, MesoAmerican Health Initiative, Save the Children, and regional professional associations) to promote newborn health and the adoption of evidence-based policies and

programs in the region, focusing on vulnerable populations. The Alliance – recognized through a PAHO resolution signed by various ministries of health – provides leadership on newborn health and affects programming in many countries in the region.

Child health: MCHIP was recognized by key informants for its role as secretariat for the iCCM working group at the global level. In addition, MCHIP's role in documenting best practices (Senegal and DRC) and its close collaboration with partners at the country level was much appreciated by WHO and UNICEF. However, on the broader child health arena, MCHIP is perceived by USAID and international and country partners as somewhat weak in its global child health expertise due to the limited number of staff at headquarters who combine a strong global perspective with country implementation experience. CORE, as MCHIP's partner in the community dialogue, could potentially strengthen MCHIP's child health expertise in the global arena.

Efforts are needed to raise the profile of the unfinished agendas in child health. While UNICEF appreciates the Country Child Health profiles MCHIP developed as good advocacy tools, a more concerted strategy may be needed to raise the profile of child health challenges. MCHIP and its country programs, for instance, have picked up old child health issues, e.g., revitalization



Immunizing children in Jharkhand in India
Photographer: Joy Riggs-Perla

of ORT corners. Given years of lessons learned, it is clear to the evaluation team that MCHIP learning must focus not on demonstrating that it can increase coverage, but on clearly identifying those factors that will institutionalize and sustain the prevention and treatment of child diarrhea.

Immunization: The area of immunization benefits greatly from decades of investment, continuity of expertise available, and the substantial contributions going back a number of years. Active participation of the staff on the global level is widely evident and undisputedly effective. Investments in this

area are shaping the global agenda through emphasis on sustaining routine immunization efforts, while participating in the introduction of new vaccines and applying lessons learned. Technical papers, peer-reviewed articles, and lectures are contributions of the immunization team (especially the team leader) to the global immunization agenda.

HIV is one area where MCHIP is definitely not perceived as a leader at the global level. According to USAID, MCHIP is usually not invited to key HIV meetings (e.g., PEPFAR) and is not well-positioned to contribute significantly in this area. USAID (HIDN and the Office of HIV/AIDS) may want to consider costs, and whether there is value added or improved efficiencies to be gained by promoting greater integration of HIV-related activities into MCHIP's existing platform of MNCH programs.

Malaria: MCHIP participates at the global level with Roll Back Malaria, President’s Malaria Initiative, and the Alliance for Malaria Prevention. MCHIP has provided leadership in developing evidence for strategies to integrate MIP with reproductive health, including developing documents on lessons learned in MIP programming. Malaria is one of the key interventions MCHIP is addressing in its global CCM work.

Conclusions about MCHIP’s global leadership role: In addition to its country impact (as described earlier in this section), MCHIP is successfully introducing globally identified best practices to field programs.

The evaluation team saw less evidence that MCHIP’s experience at the country level is being used as a “learning laboratory” to establish globally convincing evidence about the impact, cost effectiveness, and sustainability of selected MNCH programmatic approaches. Admittedly, MCHIP programs in most countries are only about a year old, and therefore one would not expect to see much analysis or documentation yet. However, the evaluation team is concerned that specific planning for this kind of knowledge generation is insufficiently advanced for MCHIP to contribute convincingly to global knowledge on the best approaches to achieve sustained impact.

MCHIP’s Year 3 work plan does identify the need to develop a “learning agenda” that will “guide the documentation and diffusion of MCHIP learning through 2013.” Key themes prioritized for focus in Year 3 include:

- Factors required for successful scale up
- Effective applications of mHealth interventions drawing from activities already being implemented in MCHIP Country Programs and by CORE members
- Necessary conditions to facilitate effective performance of community health workers, at scale and in a sustainable manner
- Equitable approaches that are effective in reaching the most underserved and disenfranchised populations

Additional themes that will be considered for future program learning emphasis in Years 4 and 5 will include:

- Necessary conditions required for appropriate integration (i.e., integration resulting in improved overall program performance) based on specific country experiences where MCHIP is working
- Conditions under which a focus on community-based (CB) service delivery detracts from or enhances facility-based delivery of services
- Learning across the project on how to deliver a package of CB MNCH interventions or a focused package of postnatal/postpartum care⁶

These all seem to be reasonable topics for the learning agenda. The evaluation team believes that specific planning and analysis must begin very soon to ensure that the information needed to draw conclusions about these approaches is based on credible data.

The evaluation team also believes that MCHIP’s learning agenda regarding scale up is central to understanding how to position a USAID global project to achieve the maximum potential for program scale up at the country level. Central projects such as MCHIP are generally envisioned to be technical assistance vehicles for introducing new interventions, or adding new approaches to old interventions, to accelerate reductions in newborn, child, and maternal mortality. The

⁶ MCHIP Year 3 Work Plan, page 10.

“field support” funds in central projects are generally much smaller than the funding for the larger bilateral programs. Therefore how central projects can be used to catalyze change that will result in significant health impact is a key issue.

Selected MCHIP country programs are beginning to think consistently about scale up but not all are proactive in this regard. However, in several countries, MCHIP has already has uncovered key lessons that should be captured and shared for the benefit of Agency global learning on how these projects should be designed and best way for Missions to use them appropriately in the future. The evaluation team observed several promising models while looking at the various ways in which MCHIP engages at the field level. These models include:

1. MCHIP activities embedded within a bilateral project: Nepal is an example of a Mission nestling MCHIP work within a bilateral project to help the Ministry of Health amplify and use the results of pilot work supported by MCHIP.
2. MCHIP as a technical assistance arm of government-funded programs: In India, MCHIP is providing technical assistance to state and district governments to roll out programs of the National Rural Health Missions (which has adequate funding, but has found the lack of technical and managerial capacity at the lower levels in the system a significant constraint). In this case, MCHIP’s relatively small resources can have a large effect as the tools and approaches introduced by MCHIP are picked up and expanded by large-scale programs. Indonesia is another country where resources are available, but there is a lack of capacity at the district level where MCHIP is playing an important role.
3. MCHIP forging or participating in partnerships with other donors, corporations, or bilateral projects such that large amounts of money are mobilized in a coordinated fashion to achieve scale up of MNCH interventions. The Hand Washing Alliance in Indonesia, the work with the Bill and Melinda Gates Foundation (BMGF) in India for PP/IUCD, the LAC Neonatal Alliance, among others, are good examples.

Meeting Mission and Bureau Needs

Mission Needs: As noted earlier in this report, MCHIP appears to be responding well to the technical and programmatic expectations of USAID Missions overseas. Many of the programs in the countries interviewed have changed over time, often beginning as efforts to introduce a single program area and then expanding in both scope and duration. The Missions, in general, felt that MCHIP has been responsive in terms of accepting and planning for changing Mission requirements, often with help from MCHIP headquarters staff. Some Missions expressed frustration about wanting to have MCHIP take on broader programs within MNCH but not having enough non-PEPFAR funds (maternal and child health [MCH] money) to do so. A number of Missions also stated that MCHIP assistance was not necessarily needed for a broader set of MNCH activities, as those needs are already being addressed by other programs within the Missions’ portfolios or by other development partners.

In many countries, predecessor projects such as IMMUNIZATIONbasics, ACCESS, and ACCESS FP were functioning prior to MCHIP’s advent. The staff and activities of these programs were pulled into MCHIP as a base for the planned MCHIP program. In cases where those projects had already built credibility and good relationships with the MOH and Mission staff, MCHIP came in with an advantage. The previous projects also helped accelerate the initiation of MCHIP activities within countries, given they reduced the organization and preparatory activities that otherwise must precede the launching of a new program. In contrast to the earlier projects, the management advantages of having a single central project that can address all MNCH issues was noted as an important asset by most Missions interviewed for this evaluation.

Missions also frequently commented that MCHIP’s strength is that its activities are in direct support of a country’s Ministry of Health in implementing the government program, and that

MCHIP does not operate independently of that structure. The technical assistance role is especially evident in countries where the government has a sufficiently well-funded system but is trying to improve the quality of services and the capacity of lower-level managers and providers. In the case of the Associate Award in Bangladesh, the Integrated Safe Motherhood, Newborn Care and Family Planning Project (MaMoni) project is working in two districts with government to deliver an integrated package of MNH and FP services at the community level with a referral system to demonstrate how government can link community services to the formal health care system. MCHIP is also working on supporting the national roll out of Helping Babies Breathe, the White Ribbon Alliance and other national-level activities. The Bangladesh Mission is pleased with the role MCHIP is playing on both elements of the program. The Associate awards have longer time horizons and more substantial funding than other MCHIP activities at the country level.

When Missions mentioned problems with the MCHIP program, the problems noted were most often administrative or financial in nature, rather than technical or programmatic, as noted later in this section under MCHIP Organization and Management. However, there were some concerns expressed, as described below:

- 1. Insufficient documentation of lessons learned:** While MCHIP officially began in October 2008, it has only been operational in most countries since 2010. Nevertheless, several Missions expressed the view that MCHIP was already learning lessons that should be captured (Kenya, India, Bangladesh). This may in part be the result of viewing MCHIP activities as building on predecessor projects so that there is sufficient field experience to begin to analyze and document lessons. Among the 10 Missions interviewed, MCHIP activities in India, Indonesia, Bangladesh, Malawi, Nepal, and Ghana were all built on earlier predecessor programs.
- 2. MCHIP role:** In a number of Missions, MCHIP's role was described as technical assistance with no part in implementation aside from assisting the government in improving or expanding their programs. In a few Missions, the team found some dissatisfaction that there had not been as much emphasis as they had expected on program scale up and developing strategic plans that reflect adequate thinking on how programs will be sustained over time. Several Missions specifically expressed concerns regarding MCHIP's work in limited areas within districts, believing that MCHIP staff should do more to promote scale up and work with other partners in areas beyond their own geographic sites. Missions also noted several areas in which MCHIP is seen as technically weak, including nutrition; those contacted by the evaluation team suggested that MCHIP make fuller use of the expertise of its partners or hire more expert staff. That said, it should be noted that both MCHIP and USAID staff have made the point that funding provided for nutrition under MCHIP is low.

In some countries, the scope of MCHIP's mandate has been narrowly defined by the Mission as including specific programs (e.g., pre-service education of nurses in Ghana). In the case of Ghana, JSI implements a bilateral service delivery and health systems strengthening project in three regions of the country; Mission staff report that most other needs are covered by existing programs. MCHIP was selected for a specific gap that existed in the country's program. However, Mission staff interviewed pointed out that the narrow scope of MCHIP's involvement also reflects a lack of MCH monies, as most of their funding is from HIV/AIDS. These are the kind of field realities that inevitably shape country programs unless Missions learn to apply funds creatively. Presumably bilateral projects implemented by various MCHIP partners also support the same high-impact interventions and approaches advocated by MCHIP; such collaboration would be facilitated, given that the same organizations are involved.

Regional Bureau Needs: Africa Bureau staff had various opinions about how responsive and useful MCHIP has been to date, pointing out that the situation in each country is unique. They

recommended that the evaluation team query as many of the country Missions where MCHIP currently or plans to work as possible to obtain a clear snapshot of Mission perspectives. At the headquarters level, the staff appreciated the interaction with the diverse technical staff, but noted the delayed hiring in the child health technical area, which slowed start up. While they were pleased with the quality of the work of individual technical teams, several staff noted that MCHIP technical teams might produce greater results if they found more opportunities to work together to solve specific issues – for example, if the maternal, newborn, and immunizations teams collaborated to discuss improved provision of vaccines during ANC and immediately after birth. They see this collaboration as the added benefit of the integrated project but have yet to see the results in project implementation. The Africa Bureau did acknowledge the good work under way in immunization and iCCM as well as cited the usefulness of the maternal and newborn conference held in Addis Ababa.

Integration

Definitions: The evaluation team found almost as many different definitions of “integration” as stakeholders interviewed. Most of the definitions could be categorized in one of three ways:

- Multiple services provided at one site
- These strategies included adding one or more services to the one already established at the site (e.g. adding newborn care or postpartum FP to existing programs aimed at improving delivery care).
- Holistic strategies for one intervention
- These strategies included, for example, attention not only to providing a clinical service, but also to creating demand in the community for that service, including crafting a communication strategy; training providers in facilities to provide the service competently; ensuring logistics needed for the service, etc.
- Integrated planning and implementation strategies
- These strategies included explicit planning from the outset among MCHIP partners on providing multiple MNCH services, drawing on the skills of all partners.

MCHIP’s internal mid-term review produced similar findings, noting that until the definition issues are “clearer among donors, partners, and country offices, there will continue to be different standards for whether...MCHIP is meeting its program goals and how all partners can contribute.”⁷ While the evaluation team did not find the diversity of definitions a fatal program flaw, it recognized the challenge that multiple definitions present, especially for a flagship program for USAID with “integrated” in its name.

The team found an equally wide spectrum of ideas on how valuable integration is and whether it should be considered a goal or simply one of many approaches that may make sense to use in the field, based on the specific context in which MCHIP is working.

In discussions with the 10 Mission staff interviewed, fairly similar perceptions emerged on the value of integration as related to a project that could deal with multiple services within one program. Field staff repeatedly noted that they liked being able to choose from a variety of technical skill sets in one project. While many at USAID headquarters shared this view, an almost equal number cited concern over the impact of the potential loss of focus on key areas of intervention.

⁷Summary Report to USAID on MCHIP Internal Mid-Term Review, Mark Leach, April 14, 2011, page 3.

The MCHIP project has at least partially addressed the issue of differing definitions of integration and a range of perceptions on the value of integration by using the term “smart integration” to refer to the desire to integrate only when it makes sense to do so programmatically. In fact, the MCHIP program description of integration notes that consolidating a variety of technical areas into one program should not suggest that “all work is being or should be done in an integrated way” and the goal of improving the overall health of mothers, newborns, and children should be the principle that guides decisions on when to integrate services.

Additionally, some of the documents the team reviewed reflected ideas regarding desired integration strategies, but did not include conclusions about the process. As with the Mission and MCHIP staff interviewed by the Evaluation Team, there were a variety of views expressed, along with a clear desire to learn from the process of integration, but no mechanisms had yet been set up to do so. “Appropriate integration” is one of the seven themes identified in the Year 3 Annual Implementation Plan, but is among the three to be tackled later on. It should be noted that careful analysis of the theme will require planned design and data collection for a better understanding of the processes involved and should not be started too late in the program.

Approaches to Integration: For each of the main technical areas the MCHIP program is addressing (maternal health, newborn health, child health, and family planning), various approaches to integration, as part of program implementation, are evident. At the same time, it is the Ministry of Health that sets the agenda for each of these technical areas in all countries where MCHIP works. For this reason, MCHIP is placed in a supportive technical role within governments, which may affect ways in which MCHIP can work on integration.

Maternal Health: In maternal health, for example, the integration of services is being applied differently in each of the more than 25 countries where the issue is deemed a priority. In some countries (for example, Bangladesh, Ethiopia, Kenya, Liberia, South Sudan, etc.) there is a key intervention at the community level through which additional approaches can be integrated. In this way, whether the intervention is prevention of PPH through community-based introduction of misoprostol or distribution of iron to prevent maternal anemia or some other type of intervention, the community is an entry point for potential integration of additional approaches that may be specific to maternal health or may be designed for another target group, such as children.

In other countries (such as Bolivia, Ethiopia, India, Rwanda, and Zimbabwe), a primary focus of MCHIP interventions in maternal health includes work in pre-service education or work at the facility level, sometimes paired with community-level interventions. In this way, the primary platform for integration occurs before or as part of the actual delivery of clinical services. As such, some of these approaches take a broader look at improving the quality of service delivery, including the pre-service training based on standards that providers receive.

In India, for example, there is an integrated program approach that includes collaboration with the Indian Nursing Council to improve the quality of pre-service education for midwives through five nodal nursing education centers nationwide and Auxiliary Nurse Midwife training sites in three states; specific facility-based interventions designed to increase the quality of delivery care; postpartum FP offered directly after delivery and in conjunction with postpartum visits; and efforts to advance essential newborn care.



Midwives in Aceh Indonesia
Photographer: Joy Riggs-Perla

Newborn Health: MCHIP is working in newborn health in 23 countries and has a focus on essential newborn care that includes the three major causes of neonatal mortality: asphyxia, low birth weight/pre-term, and sepsis. The program also looks

carefully at the needs of the first week of life, the time period when newborns are most at risk. MCHIP's priority interventions include essential newborn care (ENC) (hygienic cord care, maintenance of warmth, and immediate and exclusive breastfeeding); neonatal resuscitation; kangaroo mother care; management of neonatal sepsis, and handwashing with soap.

In one facility the evaluation team visited, a newborn corner was set up with all of the appropriate equipment in a clean, well-lit area near where deliveries occur, but the management of deliveries was happening in a way not aligned with standards of care. In this scenario, it was important for staff to think in an integrated fashion and to reach out to try to improve the quality of delivery care in addition to newborn care, as the two activities were happening in the same environment and neglecting problems in the delivery room was an important missed opportunity. In fact, one of MCHIP's goals for 2013 is for newborn care elements to be integrated into or strengthened within existing quality improvement processes such as SBM-R, coupled with the use of in-service skills labs to help improve and maintain providers' skills. While theoretically ENC and emergency obstetric care (EMOC) are linked within SBM-R, the team noted that this was not the case in practice in some sites visited; this lack of linkage was also noted by some key informants.

Child Health: MCHIP is working on child health issues in eight countries, with a focus on the three major killers of children under 5: diarrhea, malaria, and pneumonia. The program also tries to integrate nutrition where countries include it as part of the overall package; at the same time, inclusion of nutrition is weak and could be strengthened, especially given that it is a main underlying cause of morbidity and mortality. Nutrition was rarely mentioned during site visits or interviews except in terms of "integrating FP and infant and young child feeding (IYCF)" and developing community-support mechanisms for breastfeeding. Specific strategies related to improving IYCF practices (e.g., appropriate weaning and young-child foods and feeding practices) are not evident in documents or from interviews or site visits, but this is, in part, also due to USAID funding of another mechanism for nutrition.

MCHIP's focus is on prevention as well as case management through the expansion of iCCM for diarrhea, pneumonia, and malaria. On the preventive side, interventions such as insecticide-treated bednets and handwashing with soap have been the cornerstone of community-based care, especially given that many of the poorest families have virtually no access to fully staffed and resourced facilities. Introduction of vaccines for pneumonia at facilities is also of growing importance as a prevention strategy. (One complication witnessed by the evaluation team is that while increasing the demand for pneumococcal vaccine had gone very well in some locations, there were stock-outs for some of the older vaccines, due to poor and fragile distribution networks, indicating a great need to work on overall health systems strengthening.)

MCHIP's approach to iCCM includes using community-level health interventions as entry points for integrating in health systems strengthening activities aimed at improving program efficacy as well as sustainability. In DRC, where a full spectrum of interventions has been implemented successfully, the MOH has now scaled up national policy on iCCM with support from MCHIP and other partners. Additionally, MCHIP was able to integrate FP into the approach so that parents of targeted children would also be able to address some of their needs. In Mali, newborn health has also been integrated with these elements; moreover, increased efforts to integrate vaccination remain a priority throughout those countries where child health is a focus.

While the overall portfolio of child health remains a small part of the MCHIP portfolio, the program's experiences with integrated programming at a country level, as well as its contributions to national policies and international working groups, position it well for key learning on approaches to integration.

Family Planning: The merging of ACCESS-FP has been one of the most recent additions to the MCHIP program. While MCHIP had dedicated FP staff from its inception, additional staff transferred from the ACCESS-FP project when it officially ended in June 2010, at which point many staff transitioned to MCHIP. For this reason, although there is a specific mandate to support integrated efforts in FP in three priority areas – global leadership for FP/MNCH integration, FP integration with maternal and newborn health, and FP integration with child health—this work is still fairly new.



Information about services at a clinic in Jharkhand
Photographer: Joy Riggs-Perla

Approximately half (16) of MCHIP countries have FP as a priority for MCHIP involvement and are using a variety of strategies to implement an integrated approach. In Ghana, for example, there is an emphasis on pre-service education for midwifery schools that includes postpartum FP as a specific issue in the curriculum and

also provides support to educators and preceptors on this topic. While there has been enthusiasm at the Mission and local level for this work, as well as appreciation noted for an additional technical support person who has provided “new energy and focus,” there is not yet a mechanism set up to track the progress of this work. Plans are under way to conduct operations research to determine the effectiveness of this integrated approach to improving the quality of care of PFPF services as measured by service uptake, client perspectives, and preceptor and student perceptions of the education process.

Guinea has taken a similar approach by using pre-service education as a starting point for integrating FP, and is addressing the issue through the use of SBM-R to strengthen maternal and FP components of medical pre-service education. Additionally, MCHIP is supporting work at the facility level to improve the knowledge and skills of providers in long-term and permanent methods for both postpartum and post-abortion care. It is also working with communities to strengthen referrals and increase knowledge of referral services for FP (especially PFPF), as well

as post-abortion care, in an attempt to increase the balance of demand with improvements on the supply side.

Additionally, MCHIP's FP team led an interagency collaboration that started in 2009 to look more closely at ways to integrate vaccination and FP, including linked referrals when mothers receive referrals for FP during immunization visits and integrated routine delivery when women have access to FP services during routine immunization visits to facilities or use outreach services. Out of the recognition that a six-week postpartum visit (as well as a newborn immunization schedule that ideally includes visits for vaccines at 10 weeks, 14 weeks, and 9 months) may be an opportune time to discuss FP with postpartum women, MCHIP is supporting in-country efforts to provide FP services during these visits if a woman is interested. Together with FHI, MCHIP completed a literature review and developed a brief on the topic, a presentation for advocacy purposes, and a mapping of active programs.

The evaluation team was able to see this approach to integration in action in Jharkhand State in India. With support from MCHIP, FP was being introduced into postpartum visits at health centers; at one facility visited, a separate area for FP counseling had been established. It will be important to make note of the success of this approach, as it appears to be an area ripe for integration across the spectrum of health interventions. For this reason, it will be critical to gather evidence on whether such combined programming yields higher immunization coverage rates while reducing the unmet need for FP services.

Adapting to GHI

Although the Obama Administration introduced the Global Health Initiative (GHI) in January of 2010 when MCHIP was already under way, the individual underlying concepts are not new and have been supported by MCHIP from its beginning. The evaluation team repeatedly found evidence in documents, site visits, and stakeholder interviews that the core principles of GHI are woven throughout MCHIP, a finding confirmed by USAID key informants at headquarters and in the field.

A basic premise of GHI is that health services in poor settings are often delivered in fragmented, ad hoc ways when a program has been set up to address a specific disease or match donor priorities rather than meet the holistic health care needs of an individual. Additionally, GHI recognizes that too often interventions are not part of a larger effort to strengthen health systems, so whatever progress is made on a particular condition may vanish if and when the system supporting the service crumbles. Finally, GHI highlights needs in three particular areas – maternal health, child health, and FP – as being of the utmost importance to improve the health care of families, communities, and nations.

The design of MCHIP directly addresses these areas through an integrated approach to maternal, child, and newborn health that includes some attention to issues such as FP, nutrition, and other cross-cutting themes with a direct impact on the health of women and children. MCHIP follows the seven basic principles outlined by GHI:

1. Implement a woman- and girl-centered approach: MCHIP programming posits women in the center of health care services, addressing them directly as the key client, and recognizing their critical role in caring for newborns and children. MCHIP also takes a strategic look at common barriers to women's ability to seek out and receive health care, constructing program approaches in strategic ways to overcome the impediments. For example, MCHIP works with men as supportive partners of women by bringing them into prenatal care, birth planning, FP counseling, and other areas where they can help women get the care they need and support them in the choices they make. MCHIP also addresses male circumcision, which

is of direct benefit to women in decreasing their vulnerability to HIV/AIDS, cervical cancer, and a range of sexually transmitted infections.

2. Increase impact through strategic coordination and integration: In principle, MCHIP's program seeks to learn how best to integrate services to improve the quality of the health care clients receive. MCHIP's integration efforts reach out to a broad range of partners to leverage the skill sets of each while managing the program in a way that is responsive to environments and client populations with changing needs.
3. Strengthen and leverage key multilateral organizations, global health partnerships, and private sector engagement: MCHIP plays an important role in coordinating country- and global-level partners, including multilateral organizations, donors, private corporations, and others invested in improving health outcomes. MCHIP staff also sit on technical working groups convened by UN bodies, where they both lead and contribute to the global body of knowledge on critical health issues and service delivery approaches.
4. Encourage country ownership and invest in country-led plans: MCHIP works by supporting governments (through ministries) in conducting the work countries see as their highest priority. In doing so, the program actively supports countries in setting and directing their own health care agendas.
5. Build sustainability through health systems strengthening: MCHIP maintains a focus on building capacity among providers and systems in the countries in which it works by collaborating on updating guidelines, strengthening policies, ensuring that training curricula match standards, and improving the environment in which health care services are delivered.
6. Improve metrics, monitoring, and evaluation: MCHIP plays an important role in tracking the progress of health care interventions and the populations they reach through the application of tools such as results pathways, collaborating on health indicator working groups, and contributing to the global dialogue on the costs and benefits of integrated programming.
7. Promote research and innovation: While MCHIP is not designed as a research program, activities under way contribute to the evidence base of what constitutes high-quality care, especially for women and children. MCHIP staff actively innovate, as evidenced by a variety of country interventions such as placing posters on "the golden minute" for newborns directly under the clock in delivery facilities; printing critical cold chain instructions on stickers that can be stuck to the freezers holding vaccines; using *m*-health approaches such as electronic tablets to help facilities improve their quality of care; and creating scale-up road maps to help country programs assess where they are and what they need to work on to scale up a particular set of interventions.

In addition to being directly aligned with GHI's basic structure, MCHIP also actively works to apply some of the principles to tools to support programming in the field. For example, MCHIP has worked closely with members of the CORE group to better understand underlying principles of equity to ensure that MCHIP programs are reaching the most socially and economically disadvantaged. Working from a CORE paper on equity, MCHIP has designed an "equity checklist" to help country-based programs think strategically about how to reach the most vulnerable populations in the areas they cover.

At the same time, the evaluation team failed to see evidence that MCHIP has learned any significant lessons up to now on how to design programs that creatively overcome the constraints imposed by social exclusion. Working with the PVO community, MCHIP may yet be able to make a contribution in this area.

PVO/NGO⁸ COMPONENT

The decision to integrate the PVO/NGO component into USAID's maternal and child health flagship provided unique and important opportunities for capacity building and scale-up via the US PVOs and their partners. In fact, USAID's rationale for incorporating the PVO/NGO component within MCHIP was to (1) continue the technical support to, and capacity development of, the Child Survival and Health Grants Program (CSHGP) and Malaria Communities Program (MCP) grantees, (2) use PVOs and NGOs as a way to advance the role of civil society institutions by disseminating/scaling up MCHIP's high-impact interventions through a broad set of non-governmental institutions and (3) advance global leadership through the analysis, synthesis, and dissemination of PVO/NGO best practices and innovations.

The CORE Group, an MCHIP implementing partner, is a PVO membership network focusing on maternal and child health, with a long history of fostering collaboration and capacity building of its member organizations. It was originally founded by CSHGP grantee PVOs, but its current membership of 57 PVOs includes organizations that no longer have such grants or have never received them. The members of the CORE Group have resources exceeding those of the USAID development budget and are reported to reach about 720 million beneficiaries. The CORE Group's intention is to function as a convenient one-stop interface and to allow efficient access to its PVO membership for USAID and its programs such as MCHIP.

The evaluation of the PVO/NGO component was informed by document and website review, interviews with USAID and MCHIP staff, and MCHIP presentations. In addition, the Director of the CORE Group, her staff, and five PVO headquarters staff provided input to the Evaluation Team on MCHIP and its relationship with the CORE Group and the PVO community. The PVO headquarters staff represented medium to large PVOs, and one a small PVO. All have had CSHGP grants, and one was also implementing an MCP project. While the group of respondents is small, these PVO representatives have been involved with CORE, Child Survival and Technical Support Plus (CSTS), and MCHIP in their work for several years, are on the CORE Board of Directors, or are active as working group chairs/co-chairs.

Evolution of the PVO/NGO Component

The USAID Modification No. 01, June 8, 2009, outlines the key approaches for this component as follows:⁹

- Support strategic information and monitoring needs of central PVO/NGO programs—support mechanisms established under CSTS and supporting the CSHGP and MCP grant cycle.
- Provide comprehensive technical expertise relevant to PVO/NGO programming.
- Identify and address critical and capacity-building requirements of PVOs/NGOs.
- Establish creative and efficient mechanisms for networking with a wide range of stakeholders relevant to PVO/NGO programming. This activity sees CSHGP grantees as the “platform from which MCHIP can advance the role of civil society institutions”... and CORE as having “a strategic role in terms of diffusing key learning that will emerge from MCHIP by

⁸ In this paper, PVOs are defined as non-governmental, not-for profit organizations (NGOs) registered in the U.S.; the term “NGO” is reserved for similar organizations registered in countries outside the U.S. CSHGP and MCP grantees are PVOs and NGOs with funding from the USAID CSHGP and MCP (PMI) grants mechanisms. These PVOs/NGOs have other sources of financial support for their activities (e.g., funding from other development agencies, foundations, private individual and corporate support, etc.) and may work in single or multiple countries, also as locally registered NGOs or with local NGO partners.

⁹ Excerpts from Modification 01, June 8, 2009, pp. 22-25.

mobilizing diverse partners at the country level through its existing networks... and raising visibility of PVO/NGO contributions to scale up high-impact approaches.”

- Support and strengthen identification and evaluation of PVO/NGO innovations.
- Synthesize and communicate promising approaches.

Over the course of the evaluation, it became clear that the PVO/NGO component of MCHIP has evolved in a positive direction since its conception in the request for application (RFA). From what began as a PVO support component in Year 1, the stakeholders (MCHIP, the CSHGP and MCP grantees, the CORE Group, and USAID staff) have moved to an increasingly collaborative mode for working on several activities of mutual interest, some led by MCHIP and others by CORE. The work of the CORE Group and the PVOs is contributing to shaping MCHIP's work as an important partner, and this is reflected in the key activities of the Year 3 work plan. With CORE now a subgrantee in Year 3, the evaluation also assessed the CORE Group's contribution as a part of MCHIP and the potential for PVO learning to be the most productively and efficiently exploited and disseminated.

Findings

The evaluation team's findings are discussed in line with the structure of the Year 3 work plan, organized in line with the following five sections:

- 1. Support to existing CSHGP management systems:** Key informants agreed that the transition from CSTS to MCHIP for the support to CSHGP projects has been relatively seamless. In large part, this was attributed to the continuity and high level of commitment of the former CSTS staff that transitioned to MCHIP with this component. Program planning, implementation, and M&E tools are kept up to date and are perceived as highly useful and user-friendly by the PVO community and others. The strong involvement of CORE working groups in the development and revision of some CSTS/MCHIP tools increases PVO ownership and contributes to USAID-funded CSHGP grantees' setting the bar for other PVO/NGO activities.
- 2. Technical support to the active portfolio of CSHGP and MCP grantees:** The PVO/NGO team has provided technical support to ongoing CSHGP projects, currently totaling 39, with 17 of these falling into the “innovation” category. The assistance includes reviews of baseline assessments, input to the preparation of detailed implementation plans (DIPs) and operations research (OR) designs, DIP reviews, midterm and final evaluations, facility assessment designs, and equity design issues. It appears that contacts are monthly and more regular than before MCHIP. Similar support was provided by the team supporting the MCP grantees, including the implementation of regional workshops, reviews of annual reports, revision of guidelines and curricula, coordination of projects with country plans, and technical assistance via site visits.

The first round of CSHGP “innovation” grants started at about the same time as the MCHIP project. It appears that the level of effort involved in advising PVOs on the design of quality OR approaches were initially underestimated by MCHIP, but adjustments were made and additional technical assistance obtained from JHU-IIP.

Respondents gave the MCHIP PVO/NGO team high marks for timeliness in responding to individual PVO requests, as well as for the quality of assistance in terms of institutional support and sharing of lessons learned. One PVO with two current Child Survival (CS) and one MCP grant commented on the responsive (easy-to-access, high-quality, timely) technical assistance on multiple grant-related issues, as well as technical assistance for field implementation. Appreciation for “one-stop-shopping” (i.e., access to a range of services) was also mentioned. Two PVO respondents benefitted from inputs to their innovation grants and OR design. They mentioned that the help provided for

framing and development of OR activities was outstanding, both in terms of individualized assistance to their specific projects and the OR workshop for the broader cohort of projects.

During its field visits to one country, the Evaluation Team encountered one CSHGP grantee who was unclear about the MCHIP PVO/NGO team's role in the competitive grants selection process and feared that requests for technical support might compromise the grantee's ability to receive future USAID grants. While this may not be a widespread misconception, it does suggest that additional information needs to be shared with CSHGP grantees to clarify that MCHIP staff are not directly involved in USAID's grants selection and award process.

MCHIP tools (i.e., the regularly updated tools on the MCHIP NGO website, including M&E tools) are in use, with PVOs expressing appreciation that they are updated regularly. The PVOs also participate in MCHIP technical updates and brownbag presentations. However, a PVO staff outside the D.C. area and without a current CS project suggested that MCHIP make a greater effort to reach out to the larger PVO community beyond the immediate grantee program. This PVO is applying Jhpiego's SBM-R tools and would have valuable lessons learned to share with the relevant MCHIP team.

Currently, approximately half of the time of the PVO/NGO Support Team is allocated to direct grantee support, 50% to management support, and 50% to strategic analysis, documentation, and diffusion. Given the team leader's extensive understanding of both MCHIP and the PVOs, there is an opportunity to increase his focus to interlinking the PVO contributions with MCHIP priorities, and shifting more of the dissemination tasks to the CORE Group.

MCHIP's malaria group provides technical support for MCP grantees for the purpose of "presenting a comprehensive picture to the PMI." While this is technically sound, greater integration of CSHGP and MCP support might contribute to the cohesiveness of the overall PVO/NGO component, given that many issues addressed go beyond purely technical matters (e.g., community health worker (CHW) involvement, integration, scaling up, health systems strengthening, OR design and implementation, etc.). A suggestion for greater integration of technical and managerial support by MCHIP came from one of the PVOs with both CSHGP and MCP projects.

- 3. Strategic analysis and dissemination of CSHGP portfolio data:** The PVO/NGO Support Team has continued to elaborate and strengthen its web-based information. The well-developed and heavily utilized website, www.mchipngo.net, provides public access to grantee project information (including midterm and final evaluation reports), thereby greatly increasing PVO visibility. It also makes available user-friendly tools developed by or with the PVO community. The site has a separate link for confidential information about grantee projects accessible by USAID staff. The utility of information on the website has the potential of going much beyond PVO grantees' needs, providing easy access to an organized database of essential project management tools.

The PVO/NGO Team has also distilled lessons learned from the Grants Program and prepared briefs for USAID, MCHIP staff, and the public. This information was shared with the larger CORE Group community, with some of the portfolio analyses published in peer-reviewed journals. Ad hoc analyses of the CSHGP portfolio for USAID have looked at CS programs advancing innovation, opportunities for integrating FP and HIV, and community-based service delivery. With the USAID CSHGP team leader, the team

has also produced a brief on the innovation grants of 14 PVOs working in 16 countries to increase awareness of how PVOs address common implementation bottlenecks.

- 4. Program learning and diffusion through the CORE group:** The evaluation team learned that for a number of reasons (i.e., CORE Group and CORE bylaws that stipulate no competition with CORE members), the CORE Group was not initially fully engaged as a partner in MCHIP, even though its strategic role was recognized in advancing program learning for community-oriented programming as well as in several other technical areas. The CORE Group and its members were seen as providing information and field experience that might be useful to MCHIP, but as not involved in forward strategic thinking. However, by Year 3 the compelling advantages, complementary strengths, and opportunities provided by this PVO membership network were beginning to be better understood and appreciated by MCHIP staff. As explained by key informants, MCHIP staff were busy in Year 1 completing old projects and phasing over to the new MCHIP activities, while the PVO/NGO technical support component continued relatively seamlessly with the same dedicated staff from CSTS, the prior technical support contract. USAID stakeholders decided to support the CORE Group through MCHIP to leverage its NGO networking capacity.

As reported by USAID, the MCHIP PVO team, and the CORE Group, monthly meetings and focused presentations on the work of its members have contributed to CORE's gradual integration into MCHIP. With MCHIP's support, CORE continues to implement its annual five-day spring and two-to-three day fall meeting for membership capacity-building and exchange. These meetings, which have increasingly involved MCHIP staff chairing and contributing to technical sessions, are appreciated as an efficient mechanism for the diffusion of MCHIP expertise.

These efforts have resulted in a growing, yet still incomplete, appreciation by MCHIP staff of CORE's potential to foster program knowledge creation and contribute to learning and dissemination, using its comparative advantage and experience in community-level implementation. By the end of Year 2, the role of the CORE Group in MCHIP changed from an informal partnership to a subagreement, as noted earlier.

CORE and PVO/NGO Support Team "products" (some developed before the initiation of MCHIP) are being integrated into MCHIP. For example, the Rapid Health Facility Assessment Tool, developed under CSTS+, influenced MCHIP's QOC survey in Year 1. MCHIP headquarters staff, in particular those working on global issues and iCCM, appreciate the flow of ideas in both directions. For example, the community health worker activity is at an early stage of cross-learning for both teams (MCHIP and CORE); the mutual exchange around this important topic may contribute to reaching some consensus at the global level about these community-based cadres (volunteer or paid).

CORE's working groups and activities have contributed to the development and dissemination of the draft MCHIP Equity Paper, while MCHIP contributed to the development and finalization of the CORE-developed Community Case Management Essentials (co-branded with MCHIP), and The Nutrition Program Design Assistant Tool, which helps NGOs focus on key nutrition messages including anemia, an MCHIP priority nutrition intervention. The CORE Group also contributed to the writing and field-testing of the HBB Implementer's Guide, in collaboration with GDA partners. While some tools and activities have been completed with MCHIP technical and financial support, others were produced with external funding, thereby leveraging the investments of both USAID and the PVOs. CORE staff also provides input to the CSHGP learning agenda and portfolio analyses (e.g., CSHGP final evaluation results, testing of the equity tool, Elluminate learning sessions, technical advisory group (TAG) sessions on CHWs and volunteers, mHealth, and other relevant activities).

5. MCHIP technical priorities supported by the CORE Group and PVOs: MCHIP and CORE have significant joint interests in MNCH development topics and in the distilling of lessons learned. According to key informants, CORE and PVO involvement is becoming more “strategic” than “opportunistic” in supporting MCHIP’s agenda. In some of the MCHIP priority themes, CORE and its members have been the initiator or driving force (e.g., mHealth, approaches, iCCM). In others, MCHIP is leading the way (e.g., equity, working at scale). Contribution of organizational expertise, resources, and other factors contribute to the products being jointly finalized and owned. In addition, the CORE Group participates in the HBB Global Development Alliance and disseminates MCHIP information through Elluminate sessions and the CORE Listserv, which reaches 1,720 practitioners in the U.S. and overseas.

There are important synergies between the CSHGP and its PVO grantees, the CORE Group and MCHIP, that are facilitated through these growing collaborative processes:

- **Scaling up:** Scale-up maps are planned to be included in the final evaluation of three expanded impact projects of those CSHGP grantees that are ending this year, with MCHIP staff participating in the Malawi and Rwanda evaluations. The mechanisms needed for scaling up will then be used to inform MCHIP’s scale-up approaches. Through CORE Group meetings and listserv messages, lessons can then be broadly disseminated, using mechanisms that facilitate replication across organizations and country settings.
- **Integration:** Achieving smart integration, and learning about it, is a key feature of CSHGP’s innovation awards and a hallmark of its MCH programming. PVOs can make a significant contribution in determining where integration makes sense and how to do it right.
- **mHealth** activities of MCHIP, CORE members, and a high degree of interest in USAID have led to a survey of ongoing activities, as well as a CORE mHealth interest group with over 100 members, and several meetings hosted by CORE on this topic. USAID actively participates and encourages sharing of lessons learned between practitioners and technology specialists, encouraging broad experimentation with this new communication medium with great potential for reaching beneficiaries.
- **Community health workers:** Two back-to-back TAG meetings in late 2010, one hosted by CORE on lessons learned from the “care group” approach and the other related to national cadres of CHWs hosted by MCHIP, were attended mostly by overlapping groups of participants, offering a chance for dialogue to compare and contrast different community support systems. This activity led to follow-up meetings and the drafting of a CORE working paper “Understanding Community Components of a Health System,” to which MCHIP staff contributed.
- **Equity:** An equity paper developed by MCHIP’s PVO/NGO support team, involving global health leaders virtually and in person as well as CORE members, has been discussed extensively in CORE and MCHIP meetings for application. A shorter MCHIP job aid/checklist, produced and shared at the 2011 CORE spring meeting, provides both validation and ideas for improvement by CORE membership; the product will also be shared with MCHIP country offices. The paper and joint work has intensified discussions at MCHIP on how to address scale up and equity simultaneously. One of the PVO key informants in this evaluation is actively applying the equity approach and was asked to share its lessons with other PVOs planning projects. This also provided the PVO with good visibility by virtue of its being mentioned in MCHIP presentations and reports.

A potential spill-over effect of these tools beyond the immediate CSHGP and MCP grantee projects was noted. One PVO staff mentioned that the tools and approaches have increased the organization’s overall technical capacity and that the tools are also being applied in Canadian International Development Agency and European Union-funded projects. The MCHIP NGO

website is recommended to field staff and colleagues. This PVO representative stated that their “USAID-funded CS projects have become the gold standard to which other non-USAID funded programs are compared. The CSHGP program has set the stage of excellence for our programs to achieve.”

While the PVO key informants responded positively to MCHIP, they also expressed interest for further services, including

- More outreach to PVOs not currently engaged and PVOs outside the D.C. area
- A clear statement regarding MCHIP services that can be accessed by all PVOs
- More online technical assistance and courses, interactive Elluminate sessions, and targeted online presentations and exchanges
- More information related to nutrition and supportive care of children, water and sanitation, and indoor pollution, as well as more input to community-based concerns (working with volunteers, traditional birth attendants, etc.).

Some of the lessons learned from the PVO innovation operations research will not be completed or synthesized until after the lifetime of the MCHIP project. MCHIP may take advantage of ongoing opportunities to reflect on lessons learned. For example, with respect to the OR projects, preliminary findings could provide guidance before the final analysis of OR results on related activities. In addition, USAID may want to consider how lessons learned should feed into the development of a follow-on project.

Conclusions about the MCHIP PVO/NGO Component

MCHIP support to PVOs: As detailed earlier, MCHIP’s support role for CSHGP and MCP grantees received high marks by those interviewed by the Evaluation Team, and is clearly providing the kind of support that was envisioned during MCHIP’s design. In summary, the team had two findings linked to observations in the field and related comments from stakeholders:

1. A clear description is needed of MCHIP’s role with CSHGP and MCP grants and ways for PVOs to access technical assistance to facilitate transparent communication and collaboration in the context of staff changes at headquarters and field offices.
2. PVOs interviewed by the Evaluation Team reported that backstopping for CSHGP and MCP projects are handled separately by MCHIP and believed there could be added benefits from a more consolidated approach, if that is feasible, given the opportunities for cross-learning among these activities.

PVO/NGO Role: CORE and its members bring a different perspective on household and community-level issues, community mobilization, and demand creation that is complementary to MCHIP’s generally more national and health system-oriented approach. It appears that some MCHIP staff involved in global thinking or in development of the community health systems components have been most open to the exchanges and inputs from CORE and its members. This process, which has been facilitated by the PVO/NGO team and USAID, should continue to receive full support.

Strategic Engagement: MCHIP is moving in the direction of a more strategic engagement of the CORE Group and its PVO members. However, despite significant overlap in their technical interests, not all MCHIP staff are as aware as they should be about the PVO community’s relevant country and technical expertise.

The joint collaboration seems to be most effective at the headquarters level and via specific technical working groups (TWGs), such as iCCM. MCHIP country offices may need direction to involve PVOs at the country level, reduce missed opportunities for synergies, and increase

opportunities for two-way learning. A greater investment in the collaborative development of tools and guidelines with CORE and strategic dissemination through CORE to a wider group of PVOs/NGOs has the potential to disseminate learning efficiently and effectively across stakeholders and affect projects beyond those directly targeted.

MONITORING AND EVALUATION (M&E) SYSTEM AND STANDARDS BASED MANAGEMENT—RESPONSE (SBM-R)

M&E System

The evaluation team looked at M&E for MCHIP at several levels, including the following:

- Contribution to global M&E issues
- Strengthening of country-level M&E
- The MCHIP Performance Management System (for monitoring global and country project performance)

Contribution to global M&E issues: There was consensus that MCHIP is a valued member of global TWGs that are developing indicators to measure quality of care, specifically for iCCM and delivery/newborn care. MCHIP is field testing the collection of some of these indicators, experimenting with different methods for collating and collecting indicators, and advocating in countries for the importance of adding this information to countries' HMIS or program M&E strategies. MCHIP plans to pilot collection of service delivery indicators in a few sentinel facilities, which may or may not be implementing SBM-R, to study the simplest way to routinely collect accurate and complete information and then receive reports on the indicators (e.g., Malawi). In addition, MCHIP staff stated that they plan to work with the facilities to identify the best ways to build their capacity to analyze, interpret, display, and use the data for decision making. They also plan to study maternal responses to questions about care received in relation to actual care provided (e.g., Mozambique) in an attempt to validate recall for potentially collecting some of the desired programmatic information in the future through household surveys, such as the Demographic Health Survey (DHS).

In some cases the new indicators are being collected within the MOH system using revised registers and reporting forms (e.g., Indonesia, Malawi, Kenya, Nigeria, Mozambique, and DRC). In some instances, a vertical system is currently used while testing feasibility; in a few cases, the MOH has rejected testing of the indicators, stating they do not want parallel data collection systems.¹⁰ Lessons from these implementation pilots are being fed back to the global TWGs and the relevant sectors within the country's MOH. The MOHs state that they see the value of these program indicators and are enthusiastic about having information from these indicators in the future.

Strengthening country-level M&E: Often, in conjunction with advocating for collection of new global/program indicators, MCHIP is working with central-level MOHs to revise supervisory checklists and monitoring forms so it can support monitoring of new interventions and desired practices.

In several countries (e.g., Bolivia, Malawi, Indonesia, Mozambique, Rwanda), MCHIP is working with the MOH to revitalize maternal death audits. This process will also bring attention to reporting problems for maternal deaths that occur at home.

¹⁰ Malawi did not agree to MCHIP's addition of items to registers in cases in which it works to collect delivery practice information. Instead, MCHIP is advocating with the MOH and UNICEF for national register changes to include programmatic data items.

In Kenya and Malawi, MCHIP is working with District Health Management Teams (DHMTs) on processes for checking data quality and, in some cases, improving the use of information for planning. Overall, these activities appear to be aimed at improving project implementation, with follow through on the M&E activities highly dependent on joint MCHIP/DHMT action. The process of evaluating the methods used to strengthen M&E approaches, including whether they are suitable for scale up, is unclear. Promotion of data use at the facility level to support effective planning and implementation was also not evident in some of the countries visited by the Evaluation Team. With a few exceptions (staff at one health facility visited in Kenya had a good understanding of its immunization data, as did staff in Jharkhand in India), health facility staff often had no real idea of coverage statistics or how they perform in comparison to expectations on Performance and Quality Improvement (PQI). Visual presentations of information (e.g., wall charts) to facilitate staff awareness of facility or community achievements were not widely available. The Evaluation Team was only able to visit four facilities in each district in Malawi. Discussions with DHMT members and questioning of facility staff and MCHIP coordinators at facilities did not elicit information that would indicate the situation was much different at non-visited facilities.

One promising process being introduced is micro-planning for implementing the RED strategy for EPI (also being used for PMTCT-RED in Kenya). Country reports and interviews with DHMTs gave evidence that DHMT members find this methodology useful and see value in the process, as well as see value in better exhibit planning and allocation of resources based on the strategy.

The MCHIP performance monitoring system (for monitoring global and country project performance): The complexities of this project have been noted across stakeholders and MCHIP offices. This is evident when attempting to identify indicators that reflect “success” for a technical assistance project, when many factors that influence achievements are beyond the project’s influence. Much of the success is based on influencing ministries and missions, implementing partners, and clients to accept interventions, change behaviors, and scale up activities. This takes place in settings where competing priorities, insufficient resources, and weak management are common realities.

In addition, there are different timeframes, funding levels, and scopes of work across countries that complicate aggregation of indicators to derive a meaningful global project result. Establishing a denominator becomes very complex in this case. Although there are many complicating factors, there are always ways to improve the performance monitoring system.

Country project performance: Country PMPs vary in quality and usefulness. While indicators at the country level are often selected to highlight the need for specific activities or to provide information specifically requested by stakeholders, there are some variations for indicators among country PMPs that measure achievement of a similar objective (e.g., the indicator for postnatal care (PNC) indicating that PNC was received at different days – two, three, or seven days postpartum – depending on the country), which usually relate to the availability of data in the national HMIS.

There are a few PMPs for very poor countries that basically measure progress in terms of completion of the work plan. There are others that do not measure what would seem to be a critical indicator of success – for example, in one country the program is scaling up CHWs who are trained to advocate for facility ANC and deliveries, yet – possibly because delivery services are not a program intervention – the number of deliveries by skilled birth attendants is not a country indicator. In others, where hospital-level maternity services are a focus (and SBM-R is being implemented), an indicator that the aggregate results of many obstetric and community mobilization interventions has resulted in achievement of an objective (such as improvement in numbers of C-sections, numbers of stillbirth/newborn deaths) is not being reported as a part of

their PMP (although C-section information is collected for monitoring of SBM-R). Achievements in carrying out many different EOC interventions (active management of the third stage of labor [AMTSL], use of partograph, eligible women receiving magnesium sulfate) are included in many of the PMPs (with variation often related to availability of information at country level) and are important process indicators; even so, evidence that the implementation process is resulting in improved maternal/newborn outcomes would provide stronger evidence of an effective program. There are a lack of indicators for country ownership, the scope of intervention package, and progress in scale up, although some reasonable examples of indicators related to these topics are available in the India, Indonesia, and Malawi PMPs.

Global Project Performance Monitoring System

Indicators: There is a lack of baseline information even for interventions that are continuations of prior projects. Some estimates should have been obtained using end-of-project reports.

Although outcome is, in fact, one of the most powerful measures of success for this type of project, it is difficult to measure in countries without accurate vital registration systems. Currently, outcome is most commonly measured through survey methods every three to five years in MCHIP focus countries. Thus, a method for estimating outcomes such as the LiST methodology seems a reasonable (and convincing) way to estimate the project's global impact. LiST only provides an estimate of outcomes (defined as child lives saved), based on assumptions about levels (and quality) of selected newborn and child health interventions being provided; estimates using LiST do not take into account many confounding factors external to selected interventions that may impact mortality. LiST does not provide measures of achievements in maternal outcomes, nor of health system strengthening, which are also MCHIP objectives. Therefore process indicators are also important for presenting a picture of achievements. Measures of the degree to which introduction of high-impact interventions and scale up have occurred individually, and within a given country, provide substantiation for LiST assumptions, but also provide direct indicators of achievement. Indicators that reflect strengthening of health systems for service implementation are also important measures of MCHIP achievement.

The annual and quarterly reports for the MCHIP project provide good information, some aggregated for specific interventions. There are many convincing stories of the effectiveness of the MCHIP work within these reports. What is missing, however, is a summary picture of the package of high-impact interventions and where they are in the continuum from introduction to scale up within a country. The country profiles developed by MCHIP are a good step in this direction. Developing a few indicators that present a summary picture of progress in implementing a package of high-impact interventions along the “pathway to implementation” would help put the many pieces of information into a context, particularly if the situation prior to MCHIP can be estimated, and changes from the initiation of MCHIP activities measured. Indicators 13 and 14 in the PMP (revised April 2011) are moving toward this objective. Although defining and developing calculation methods for this type of indicator would require more discussion and input from more stakeholders than possible under the scope of work for this evaluation, Annex D provides ideas how this might be approached, as well as comments on specific indicators.

Developing a knowledge base for implementation processes: During discussions with stakeholders and MCHIP country office staff, many practical lessons learned for implementation emerged that, if captured and analyzed, could add significantly to the body of knowledge on effective implementation. Yet there is a perception among stakeholders that this component of MCHIP's global and country-level programming is weak. The expectations are that MCHIP will bring more rigorous analysis and documentation that will be useful to partners for intervention programming and implementation.

A review of documents and discussions with headquarters-level MCHIP staff demonstrates that MCHIP is well aware of the importance of developing a knowledge base that contributes to sustained implementation processes and proactively strengthens the program's activities in this area.

MCHIP has conducted a variety of evaluations for knowledge building for effective implementation processes. These include four Malaria in Pregnancy case studies and three iCCM Case Studies. While not all of the same quality, (and most are still in draft form), they provide examples of steps taken to resolve identified problems – which is the type of information needed for contribution to the body of knowledge for effective implementation.

MCHIP staff at the country level do not universally appear to understand the issues, or perceive that they have insufficient time (or funds) to document and analyze implementation processes for lessons learned and knowledge sharing. While this may be true, with support from headquarters, relatively simple changes in documentation processes could provide information to add to the knowledge base. As staff understanding of their role in contributing to global and national bodies of knowledge on implementing programs to achieve scale, program implementation will improve. While MCHIP has only been operating in some countries for a short time, many countries are building on prior programs where the same activities have been under way for years, providing a wealth of opportunities for learning. More rigorous (and costly/time consuming) analyses can be carried out periodically when there is sufficient evidence that there are lessons/knowledge to document that are globally applicable.

Standards-based Management and Recognition

The SBM-R system for improving quality is being rolled out in numerous countries at different levels: 1) as a methodology for assessing individual provider competency during training; 2) as a methodology for supporting adherence to standards in practice at the service level; and 3) as an institutional mechanism for assessing service level/facility level adherence to standards. The SBM-R methodology is currently being implemented to a greater or lesser degree in over 25 of the countries where MCHIP works. Although it is primarily viewed as a *performance improvement* approach, it seems that the value of the methodology in providing evidence of service/facility level adherence to standards is important for gaining support of managers and policy makers for implementation at scale and institutionalization. This was observed in both Indonesia and India at the district and state levels. During interviews in Malawi, a country where SBM-R has been adopted for all hospitals and is being introduced at lower-level facilities, it was evident that the MOH and stakeholders perceive SBM-R as a valuable methodology for assessing adherence to standards.

There is confusion among various stakeholders as well as country implementers as to how SBM-R differs from other quality assurance/improvement mechanisms they are familiar with, and also a universal perception that it is a “very complicated” system. A recent paper prepared by the Health Care Improvement Project with MCHIP input compares quality improvement approaches and should help clarify the commonalities and differences in these methods. There is also some concern about the “so what” factor in demonstrating that the process has led to improved adherence to standards. This is a valid point, since the issue is consistent adherence to standards, even when a provider is not being observed. Developing indicators for effective implementation of standards (e.g., documenting less PPH where AMTSL is introduced, documenting less postpartum (PP) infection where infection prevention measures have been prioritized) is valuable. MCHIP is working to improve indicators that demonstrate that standards are being followed consistently, and is advocating with implementers on the value of collecting this information (Mozambique, Malawi, Nigeria).

Despite confusion about the SBM-R methodology and concern about measuring results, an understanding of the importance of linking services to standards seems to be taking hold. Among some providers and MOHs where SBM-R has been taken to scale (Mozambique and Malawi), some of the responses to questions about the methodology were “finally we understand what we are supposed to do,” and “using standards for training” (and evaluating services) is important.” There has also been uptake by non-governmental implementers that are promising for SBM-R being brought to scale (e.g., Bolivia).

Issues relevant to SBM-R uptake and sustainability as a competency assessment mechanism used during clinical training, for on-the-job performance assessments, and as a means for monitoring facility compliance to standards need to be analyzed separately, depending on which mechanism the SBM-R system is focusing on. Although the ultimate objective is sustained improvement in service quality (with the goal of contributing to improved health outcomes), the two objectives are often achieved through different system mechanisms. The probable spillover effects of the competency-based training (with preceptors reinforcing standards in facilities during clinical training) onto the routine service delivery setting does not seem to be fully comprehended by some stakeholders, and perhaps needs to be explicitly documented.

Weaknesses that were identified in the implementation process for SBM-R include the following:

- The rationale for steps in the process is unclear – including why the system has evolved to include step-by-step listing of activities when assessing a service, instead of simply measuring a few key items – with some key informants referring to “hundreds of indicators” in the SBM-R assessment tools.
- In at least one hospital in Malawi, where SBM-R for infection control and reproductive health services is institutionalized, it was noted that the problem-solving component was not being followed after assessments. For example, a nurse explained the areas where she and her delivery unit practices were assessed as non-compliant, yet the issues – which were the responsibility of the facility for follow up and within the means of the unit to fix – had not been addressed. Most of the facilities visited by the team were newly implementing SBM-R; as internal performance assessments had occurred only once, evidence that this is a widespread system problem was not observed. From discussions with staff in these new SBM-R facilities in Kenya and Malawi, though, it was evident they did not understand the purpose of the PQI exercise, and district managers did not seem to perceive the problem-solving aspect as one they should facilitate. The process used for developing system support for institutionalizing the problem-solving component, along with the performance assessments, should be reviewed.
- Adaptation of the SBM-R process to new settings might require more flexibility and potentially a reduction in complexity.

Overall, however, the implementation of SBM-R in MCHIP countries can be a valuable mechanism for supporting sustained quality of care but must be better institutionalized, with attention to the issues discussed in this section.

MCHIP ORGANIZATION AND MANAGEMENT

The Evaluation Team assessed whether there were administrative or management problems that were constraining project implementation at either the central or field level.

Headquarters Management

The Executive Management Team (EMT) structure established at MCHIP headquarters appears to be functioning well. The team, an integrated senior team representing the main implementing partners, helps develop a unified strategic approach to the work, whether technical,

programmatic, or administrative. This structure also helps USAID's HIDN AOTR and the USAID expanded technical team work with MCHIP as a unified program. Issues related to the functioning of all partners are discussed and agreed upon within the EMT and discussed when necessary with the corporate representatives. At this stage in project implementation, there seems to be an agreed-upon approach among the partners on the division of responsibilities related to technical areas as reflected in the application, which was modified based on funding limitations and MCH core and country priorities. With support from USAID, the EMT and Jhpiego have allowed some exceptions (such as using JSI experts in maternal health and PATH experts in newborn health) in response to programmatic needs.

Whatever difficulties may have been present at the beginning of this partnership, they appear to have been overcome and the EMT is working well as a team.

Website Management: Several global-level partners and the evaluation team itself noted that the MCHIP website could be improved. Many people noted that the MCHIP PVO/NGO site (www.mchipngo.net) is a much more useful site than the main MCHIP site (www.mchip.net). Some guidelines and standards provided on the MCHIP website appear to be dated; interviewees said that it would be useful to know whether they are still considered current. Some current country and global activities are not mentioned in sections describing MCHIP activities in the program's various technical areas. For example, the section on postpartum hemorrhage does not describe the multicountry oxytocin potency study currently under way in Africa and Indonesia. More detail on some of these innovative activities would be interesting and useful to external partners and others, and could potentially facilitate linkages at the technical and country level. MCHIP staff clarified that establishing the site as an online technical resource has not yet been an expectation; rather, selected materials have been or will be posted to other sites serving as clearing houses for technical information. They are, however, open to the idea pending a discussion with USAID.

Cross-fertilization among country programs: More than a few interviewees at the country level, especially among ministries of health and their development partners, mentioned how useful they find meetings and conferences to discuss and compare approaches to dealing with MNCH issues across countries. In some countries, participation in such conferences has been co-funded between MCHIP and UN agencies such as UNICEF. These meetings also serve as a good opportunity to increase the sharing of information on lessons learned and new tools that have been developed. While MCHIP has sponsored such meetings (e.g., for male circumcision, SBM-R, and other topics), the team did not see a visible strategy for determining when such cross-fertilization would occur and what would precipitate organizing such meetings. Given the demand and perceived usefulness of such meetings, and how management-intensive and time-consuming organizing such sessions can be, it may be worth considering a carefully considered strategy for determining when to organize these events to maximize their impact and usefulness.

Country level—Administration

MCHIP is currently working in more than 35 countries. Of the 10 MCHIP countries interviewed, 3 of the USAID Missions had no management-related issues or problems. Many of the others, while satisfied with the program's technical and programmatic activities, cited some management-related issues. Most were not so serious that they were having a substantial impact on the program, but rather are small annoyances that could and should be corrected. Only 1 Mission of the 10 interviewed was highly dissatisfied, but acknowledged that progress was being made and the program was improving.

One issue causing problems at the country level is the fragmentation of program activities caused by the main MCHIP partners' functioning too vertically without a unified MCHIP

administrative structure. This has occurred despite assistance from MCHIP headquarters staff in developing administrative guidelines for some of the field offices. The problems seemed to be in part due to the fact that MCHIP's partners in some countries had already established offices and procedures under predecessor projects (Access, Access FP, IMMUNIZATIONbasics, Basics) and were transitioning to become MCHIP, but without developing a unified MCHIP management structure. Because various in-country staff work for different partners and, in some cases various partners are implementing activities in different geographic locations, unifying administration is challenging. Salary scales sometimes differ, vacation days and other benefits are not standardized across partners, and funds are disbursed directly from headquarters to designated individuals hired by each partner. As there is no consolidated MCHIP bank account, once the annual work plan is approved, each partner disburses funds separately for its designated activities and staff.

Several Missions expressed the view that MCHIP operates as two or three separate entities rather than as one consolidated project. Delays in disbursements of funds by one partner can result in a pipeline that looks to USAID as if funds are still available while funds available to particular partners may, in fact, be fully committed. The lack of uniform personnel policies does cause unnecessary friction and complications for the COP. In one instance, staff were hired for the project by a partner without consulting the COP; the COP in another country did not conduct performance evaluations of MCHIP staff provided by another partner. MCHIP headquarters staff are trying to deal with some of these issues by standardizing personnel policies, including salary rates. For programs in new countries, MCHIP reported that it is trying to consolidate most in-country operating expenses into the budget of the lead partner in that country, with other partners only paying for salaries to reduce problems.

For unity of command and in keeping with good management practices, it is important that the lines of reporting and authorities for the COP are clearly established for all MCHIP staff at the country level without consideration of institutional affiliation. In some of the countries visited or interviewed, MCHIP has achieved a remarkable degree of unity and team cohesion (e.g. India), with all staff strongly identifying themselves as part of the MCHIP team rather than identifying with the institution issuing their paycheck; these countries may provide lessons learned for a more cohesive approach. MCHIP should strongly advocate for this approach among its country teams.

Financial reporting: Several Missions also expressed dissatisfaction with the nature of the financial reports from MCHIP, saying that it is difficult to determine what funds are actually spent on. One of the Missions interviewed complained that it has been waiting since October for budget estimate for the proposed work plan, but has yet to receive it. Other Missions stated they did not receive regular budget reports but had no difficulties getting copies when the information was requested for determining quarterly accruals. MCHIP should submit quarterly financial reports to USAID Missions on a routine and regular basis.

Communication Issues: One Mission complained about delays caused by insufficient delegation of authority to the field, which caused delays in initiating activities. Many of those issues have now been resolved. In one country, MCHIP implemented an activity without Mission authorization, which impacted the relationship with the Mission, despite the fact that, in the end, the Mission was satisfied with the product. Another felt that the new MCHIP COP was not sufficiently knowledgeable about the role MCHIP should play in the country. These kinds of complications within field programs, inevitable in any program, are amplified by the number of countries where MCHIP now operates, as well as by MCHIP's programmatic complexity. A clear definition of roles and responsibilities of MCHIP field staff vis-à-vis headquarters may help alleviate some of these problems. MCHIP headquarters staff need to work with the USAID

AOTR to resolve issues as quickly and fairly as feasible, keeping the Mission informed before and as steps are taken.

Strategic involvement of MCHIP partners: The evaluation team noted that MCHIP does not yet appear to maximize the skills and expertise of all its implementing partners within country programs. That includes taking advantage of the contacts and resources that may already exist by virtue of other work undertaken by that partner. For example, PSI has a wide array of social marketing and demand-creation activities in many countries and is an enormously useful resource to MCHIP programs that may be looking to improve the availability of maternal and child health products or change certain health behaviors. PATH also has expertise in nutrition as well as water and sanitation activities in various countries that could benefit MCHIP country programs.

USAID PROJECT OVERSIGHT

USAID oversight of MCHIP involves eight technical specialists from USAID who are tasked with overseeing particular MCHIP technical components. This is necessary due to the project's technical scope and size and the number of USAID Missions involved. The AOTR, located in the MCH Division of HIDN, is tasked with overall responsibility for managing MCHIP on behalf of USAID. Several core team members assist her, along with an expanded number of technical specialists. Program oversight is accomplished through communication with field Missions, visits to field programs, and regular meetings with MCHIP staff at the headquarters level. At headquarters, the AOTR and her core team meet with MCHIP's EMT monthly to review progress and address issues. On a quarterly basis, a larger meeting is held to include USAID regional bureau staff, MCH Division senior managers and team leaders, and an expanded group of EMT and other team leaders at MCHIP. Technical teams from MCHIP and USAID also meet quarterly. At the Mission level, activity managers are assigned responsibility for monitoring implementation. The activities managers interviewed for this evaluation were knowledgeable about MCHIP activities and appeared, for the most part, to be interacting with project staff in appropriate and constructive ways. Staff turnover at USAID, while sometimes resulting in a lack of oversight continuity, has not caused serious problems evident to the Evaluation Team.

Despite the project's complexity and array of managers on both sides, the project's oversight system appears to be functioning remarkably well. The AOTR credits the fully integrated and well-functioning EMT at MCHIP with providing a conducive environment for mutual problem-solving and open communications. Field Missions uniformly credited the AOTR for her responsiveness to their issues and ability to solve problems on their behalf. The planning for the mid-term evaluation itself was a transparent process, with MCHIP given a copy of the evaluation scope of work. The Evaluation Team concluded that credit goes to both sides for ensuring that oversight and management systems work effectively.

OVERALL CONCLUSIONS

The Evaluation Team concluded that MCHIP has collected a highly qualified, and in some cases, well-recognized group of technical experts in MNCH at the headquarters level as well as excellent staff in the field to carry out this ambitious program. In general the project is responding well to the needs of USAID Missions to introduce high-impact MNCH interventions consistent with those defined in USAID's Maternal and Child Pathways. While there are a number of managerial and communications challenges that need to be overcome, MCHIP is well-positioned to make a significant contribution to intervention access and quality and to develop the systems needed to support those interventions in the future.

The most significant area of concern surrounds whether sufficient progress has been made to identify potential areas of programmatic learning from country-level experience and institute measures to collect the information needed by the end of MCHIP to convincingly contribute to the global body of knowledge on programmatic best practices. USAID may wish this to be done in collaboration with other USAID programs with health services research mandates. Even so, MCHIP must retain primary responsibility for ensuring that programmatic learning from its own sites is captured and analyzed. Other improvements should be made to improve the strategic cohesiveness of programs in some countries, enhance scale-up planning, bring more focused attention to challenges of institutionalization and sustainability, and strengthen strategic collaboration with PVOs.

V. RECOMMENDATIONS FOR MCHIP ACTION

This report has highlighted a number of areas where MCHIP is achieving excellent progress and functioning well. Listed below are this evaluation's summary recommendations, which are aimed at helping further strengthen the program. Some recommendations cover topics that have already been identified by either MCHIP or USAID as items for follow-up action.

Recommendations the Evaluation Team believes to be of the highest priority are marked as such. It is important, however, for USAID and MCHIP, as the parties with the most detailed knowledge of resource and time constraints, as well as USAID's own priorities, to discuss whether to accept each of the recommendations and, if so, how to act on them.

TECHNICAL AND STRATEGIC

Country Impact

1. Develop country-level maps for relevant high-impact interventions (regardless of whether MCHIP is working on the intervention or not), identifying where the country is on the scale-up continuum with each relevant high-impact intervention and identifying partners working on this in-country. **(High priority)**
 - Use the country maps to identify where there are gaps in interventions, determine where synergies and integration seem “smart,” and identify potential partners to strengthen the continuum of care (from household to hospital) approach for MNCH.
 - Develop proactive advocacy strategies with partners if significant gaps are identified.
 - This assessment process is similar to that in the country profiles and some of the summaries of where countries are with safe-maternity practices have already been collated by MCHIP.
2. Operationalize the use of the scale-up roadmaps at the country level to ensure that support for health systems strengthening is included to help institutionalize and sustain programs and make sure each partner involved is assigned specific responsibilities. **(High priority)**
3. Create scale-up and sustainability plans for every MCHIP activity—this does not necessarily mean that MCHIP will carry the plan through to completion, but that these issues are planned for from the start. **(High priority)**

Issues to be addressed in such a plan include the following:

 - Identification of partners, resources, and systems changes (such as institutionalizing supervision and data collection methods) that will support the continuation of the activity with an acceptable level of quality.
 - Mentoring and coaching post training (reinforce skills in real-life implementation; feedback for training/system changes needed for new practices to be sustained)
4. Advocate for follow up after training (in settings where training is a focus), and supervisory monitoring of adherence to standards in practice, even in non-MCHIP focus areas. Provide for increased opportunities for country-to-country, regional, and global exchange of lessons and experiences with MNCH approaches. Develop an explicit strategy that describes when these exchanges will occur.
5. Build on previous success by finding more opportunities to strategically use central and regional widely recognized experts to increase the credibility and impact of MCHIP MNCH advocacy activities (e.g., child health and nutrition).
6. Ensure MCHIP country programs draw on the experience, expertise, and skills of all MCHIP partners, despite the formal role assigned to them in the original proposal.

Global Leadership

1. Develop a strategy for global “knowledge creation” related to establishing evidence on the impact of programmatic approaches. Analyze and document programmatic approaches used across countries that have produced positive outcomes in MNCH. Include measures of institutionalization and sustainability as well as improved service coverage. **(High priority)**
 - Review field activities to determine where the most important new programmatic approaches and outcomes are being tested/achieved in each technical area.
 - Ensure that appropriate data are being collected to establish the evidence of best implementation practices related to outcomes.
 - Describe a process for disseminating this kind of information.
2. Analyze and document the ways that MCHIP is achieving scale up to help USAID design future central projects in ways that strategically position central projects to maximize their potential for catalyzing scale up.
3. Develop MCHIP strategy to raise the profile of child health using the expertise of all partners. For example, identify and champion unfinished agendas in child health such as control of diarrheal diseases, integration of IYCF, healthy timing and spacing of pregnancies, HIV screening in ANC settings, etc.
4. Enhance the current MCHIP website to include more detailed information about ongoing work that may be of interest to global partners. Review all standards, guidelines, and tools currently posted, including those from prior projects, and indicate whether they are still state of the art.

Meeting Mission and Bureau Needs

1. Clarify roles and responsibilities of MCHIP headquarters, field office, and USAID Missions for better teamwork and problem solving.
2. Assist MCHIP COPs in developing a unified MCHIP identity within MCHIP staff and a unified MCHIP image with counterparts and USAID Missions without regard to the institutional affiliations of various staff.

Integration

1. Develop field-based operations research to establish the evidence base for the cost effectiveness or cost-benefit of integration strategies in circumstances where they appear to be advantageous and as funding permits. **(High priority)**
2. Use information generated from the above recommendation to generate a global dialogue about the benefits and costs of integration to help all partners understand when and in what form it is appropriate.

PVO/NGO Program

1. To clear up any misconceptions, issue clear information to U.S. PVOs involved in the CSHGP grants about the role of MCHIP in providing technical support, as well as lack of involvement in the grants-selection process.
2. Find more opportunities to involve CORE in global discussions on technical issues beyond the community health focus.
3. Increase awareness among MCHIP country program staff as well as headquarters about the substantial numbers of people reached globally by PVO/NGO programs (beyond CSHGP grants), with the goal of thinking more broadly about how these organizations can play a role in amplifying best practices and lessons emerging from MCHIP’s work. Develop more

explicit strategies for increasing the three-way learning among MCHIP, CORE and the PVO community.

Monitoring, Evaluation and SBM-R

1. Develop selected global-level performance indicators based on scale-up road maps; develop clear indicators for country ownership and uptake. As part of this effort, improve the methodology for presenting global-level information on program implementation progress to help stakeholders put achievements into a context (see recommendation #1).
2. Include in the M&E plan milestones related to advancing global agendas that MCHIP is actively working on with other global partners.
3. Ensure that strengthening data quality and use are a part of all interventions at the country level.
4. Improve documentation and dissemination of the SBM-R process and lessons learned that have contributed to the current methodology, with the goal of preventing reinvention of the wheel by people who might want to use it “with adaptations”; this will also provide information that can contribute to flexibility (e.g., stages where the methodology might not be based on evidence). Document the spill-over effect on facilities when SBM-R is used by preceptors (service providers) for monitoring clinical training for trainees in their facilities.
5. Develop plans for how to institutionalize SBM-R or adapted forms of SBM-R in country programs to ensure these quality improvement systems live beyond the life of MCHIP. Experiences of other agencies using SBM-R should be included when developing plans. Develop an evidence base for best practices related to institutionalizing these systems.

Global Health Initiative

1. To further strengthen MCHIP’s contribution to GHI, develop and implement credible equity strategies to identify and reach marginalized and vulnerable populations within country programs. Involve PVOs and NGOs in operationalizing these strategies, as appropriate.
2. Include PVOs as feasible in country-level discussions with USAID and other development partners on harmonization of technical approaches to broaden the group of stakeholders involved in supporting national health care systems.

MANAGEMENT AND ADMINISTRATION

1. Develop more unified personnel and management systems among the main implementing MCHIP partners to improve team cohesion and reduce friction. Ensure the line authority and responsibility of the COP for program oversight and supervision of staff, with clear delegations of authority as appropriate for the circumstances in that program.
2. Consolidate in-country activity budgets under the lead partner in each country to enable the COP to have direct control over the budget and reduce the fragmentation caused by several partners operating from separate budgets.
3. Develop with USAID a procedure for quarterly financial reporting that enables USAID Missions to routinely receive reports showing pipelines on both core and field support funding.
4. Track and respond promptly to delays and problems related to interacting with USAID Missions to reduce bottlenecks and management-related frustrations. MCHIP and USAID/HIDN should work together to solve these field problems.

VI. RECOMMENDATIONS FOR USAID

CURRENT PROGRAM

1. Work proactively with MCHIP to help identify the most important and promising new programmatic approaches and outcomes in each technical area as input for a strategy for global knowledge creation. Provide core funding as needed for the costs associated with analyzing and disseminating the findings from this work. **(High priority)**
2. Support MCHIP with communications and timely problem solving with respect to problems that develop with field Missions on management issues.

ADVICE FOR THE FUTURE

1. Use the global learning generated by MCHIP on the best programmatic approaches to scale up to institutionalize and sustain high-impact interventions to guide the design of follow-on central programs.
2. Use lessons from MCHIP regarding positioning of central project activities at the country level to maximize potential for scale up of key interventions to help guide strategies for future central projects.
3. Design future projects that meet the needs of USAID Missions by including a variety of MNCH programs within one vehicle rather than a larger number of more specialized projects.
4. If considering another comprehensive MNCH flagship mechanism, include a PVO/NGO component that provides technical leadership and assistance, and fosters inter-organizational learning and collaboration at the global and country levels.
5. In future RFAs and RFPs, require details in the implementation and management plans that explain how any consortium or multipartner group will consolidate and harmonize management systems at the country level.

ANNEX A. SCOPE OF WORK

Global Health Technical Assistance Project GH Tech

Contract No. GHS-I-00-05-00005-00

Mid-term Evaluation of the Maternal and Child Health Integrated Project (MCHIP): (Final: 4-7-11)

I. TITLE

Activity: GH/HIDN: Mid-term Evaluation of the Maternal and Child Health Integrated Project (MCHIP)

Contract: Global Health Technical Assistance Project (GH Tech), Task Order No. 01

II. PERFORMANCE PERIOD

Five weeks; during late April- May 2011 (depending on availability of key team members)

III. FUNDING SOURCE

USAID/GH/HIDN- MCH

IV. OBJECTIVES AND PURPOSE OF THE ASSIGNMENT

Objectives: The USAID Global Health Bureau's Office of Health, Infectious Disease, and Nutrition (HIDN) requests technical assistance from the Global Health Technical Assistance Project (GH Tech) to carry out a mid-term evaluation of the Maternal and Child Health Integrated Program (MCHIP), HIDN's flagship maternal and child health project. The evaluation findings will be used to inform implementation in Years 4 and 5 of the project, design of the follow-on award, and ensure alignment with new US Government initiatives, such as the Global Health Initiative.

Project Title: Maternal and Child Health Integrated Program

Leader with Associates (LWA)

Cooperative Agreement No. GHS-A-00-08-00002-00

Start and end dates: September 30, 2008 to September 29, 2013

Total estimated cost: \$600,000,000.00

Through analysis of MCHIP's progress and achievements at the mid-point of the project, this performance evaluation will make recommendations to improve implementation during the Years 4 and 5 of the project and will be used to guide USAID on the design of follow-on awards beyond the MCHIP life of project. The evaluation will address whether MCHIP's design is in fact achieving its objectives of addressing GH's and Mission's needs for a wide range of technical areas covered by one project compared to the previous stand-alone projects with focused technical objectives.

The overall goals of this evaluation are to:

- 1. Assess whether MCHIP is achieving its objectives and planned outputs as stated in the MCHIP agreement's project description and in approved implementation plans.** The evaluation will determine quantitatively and qualitatively whether MCHIP is on target to achieve the sub-objectives of the project:
 - Assist USAID Missions, governments, and collaborating partners in country-level scale-up of high impact MNCH interventions.
 - Create a new platform to advance USAID's global leadership, experience, and investments in MNCH.
 - Support PVO/NGOs and PVO/NGO networks in advancing, measuring, and documenting state-of-the-art public health programming.
- 2. Make recommendations to improve implementation of the current project and to inform follow-on projects.**
 - The evaluation will assess whether MCHIP is proactively supporting USAID's objective to scale up MNCH interventions as defined by the Office of Health, Infectious Diseases, and Nutrition (HIDN) - Results Pathways.¹¹ It will also identify opportunities for MCHIP to better align with key priorities of the Global Health Initiative (GHI) and promote the most recent advances in MNCH interventions during the remaining period of the project.
 - The evaluation will make recommendations on the project design that USAID will consider for follow-on awards.

Key evaluation questions (To the extent it is meaningful to do so, the team should specifically consider each of the program's main technical areas – maternal health, newborn health, child health, and family planning – as they address the questions below):

- 1. Country impact:** To what extent, in what ways, and with what challenges has MCHIP acted to increase the coverage of high-impact interventions, considering both settings in which MCHIP has directly invested significant field and/or core resources and settings in which MCHIP's role has been highly leveraged against other in-country activities supported by USAID? Specifically, what approaches to achieving increased coverage were chosen by the program, such as leveraging resources, engaging other partners, collaborating with USAID bilateral programs, developing evidence to guide improved programming, etc? Do these appear to have been the most effective choices, or were opportunities missed?
- 2. Global leadership:** To what extent and in what ways has MCHIP made a difference in contributing to new program and/or policy direction and to scaling-up high-impact interventions* beyond its direct impact in the countries in which it working? What have been missed opportunities, if any?
- 3. Meeting Mission and Bureau needs:** To what extent and in what ways has MCHIP met the needs of USAID Missions and Bureaus other than Global Health? In what ways, if any, have MCHIP activities been detrimental to Mission or Bureau objectives? To what extent have activities required by missions/bureaus in their programs offered, and been used as, opportunities to pursue the program's objectives of increasing coverage of key interventions and informing broader program and policy direction; and to what extent have these country/bureau demands distracted the program's efforts and capacity from those objectives?

¹¹ High impact interventions as defined by HIDN results pathways: skilled birth attendance, prevention of post-partum hemorrhage, eclampsia, newborn care, immunization, polio, community ARI, ORT, zinc, nutrition/anemia, HIV/PMTCT/MNCH integration, water supply, sanitation and hygiene (WASH), urban health.

4. **Integration:** In what ways has MCHIP developed or contributed to models of successful integration within MCH, as well as between MCH and family planning, nutrition, malaria, HIV/AIDS, or water? To what extent has MCHIP effectively documented successes and challenges with these approaches?
5. **Management:** To what extent has MCHIP made the best use of the project's financial, human, and institutional resources to achieve its objectives? What administrative, management and organizational problems has MCHIP faced at headquarters and field levels, and to what extent, and how, has the program overcome these?
6. **Adapting to GHI:** Although MCHIP was designed and awarded before the GHI was announced; how are MCHIP activities aligning to GHI priorities and contributing to its core principles?

Audience: The USAID AOTR team, and USAID MCH staff and MCHIP staff and partners will be the primary users of this report. Mission Health teams, host country governments, in-country beneficiaries of MCHIP activities, and other offices in the USAID Global Health Bureau are also target audiences.

Intended Uses: The evaluation report will be available publicly in the Development Experience Clearinghouse (DEC) and will be shared with participants in the evaluation and other missions who are currently buying into the MCHIP project. The recommendations from this evaluation will be used to inform implementation plans for Years 4 and 5 of the MCHIP project and the design of follow on project(s). Any lessons learned or best practices in support of the Results Pathway or GHI may be shared with other offices in USAID's Global Health Bureau and Mission Health Teams for possible adoption or adaptation to other health programming. Mission teams will be encouraged to share lessons learned and best practices with their in country partners and governments. USAID may also use the report to demonstrate and advocate for best practices with other donors, U.S. and UN sister agencies, and other international stakeholders.

V. BACKGROUND

Maternal mortality worldwide, first estimated in the mid-1980s, remained high and essentially unchanged for several decades with a maternal mortality rate (MMR) of 400/100,000 live births, or more than 500,000 deaths each year. Recent UN published estimates for MMR showed a decline of 34% worldwide during 1990-2008; the estimated number of annual maternal deaths is still very high and is about 358,000 per year. The lifetime risk of maternal death in sub-Saharan Africa is more than 135 times greater than in the developed world. The major causes of maternal mortality are postpartum hemorrhage, pre-eclampsia/eclampsia, puerperal infection, obstructed labor and complications of abortion. Anemia and infections such as HIV also contribute to maternal mortality.

For every maternal death, there are 8 newborn deaths and another 6 stillbirths – many of these are related to the mother's health and nutrition status before and during pregnancy and her care during pregnancy and birth. The 3.9 million newborn deaths and 3.3 million stillbirths annually lead to parental grief and often serious economic repercussions for the family. Many of the newborn survivors of serious complications are afflicted with birth-related physical and mental injuries or with low birth weight, leaving them vulnerable to illness, slow growth and development, and mental retardation.

Global and regional figures mask the true variation of the problems and, in some countries, the significant progress that has been made. For example, promising evidence shows maternal mortality reductions of 20-50% over a decade with sustained government commitment and donor support in countries such as Bangladesh, Indonesia, Egypt, Ethiopia, Kenya, Bolivia, and Guatemala. Furthermore, stagnant maternal mortality ratios hide the reality that without increased family planning, a growing number of maternal deaths each year would have occurred—

in the past 20 years increased contraceptive use has averted almost 4 million maternal deaths. Substantial declines in the neonatal mortality rate have been recorded in Egypt and El Salvador, and promising community approaches at district level have recorded declines in neonatal mortality in Bangladesh and India.

Since the 1980s, the annual number of under-five deaths has declined from an estimated 13.5-15 million (levels that would be almost 15 per cent higher now, taking into account the increased numbers of births each year) to less than 10 million. A substantial number of USAID-assisted countries, including Afghanistan, Bangladesh, Cambodia, Ethiopia, Malawi, Madagascar, Nepal, and Tanzania, have demonstrated that 20 to 40 percent reductions in under-five mortality can be accomplished in periods of five to eight years, despite continued or even worsening poverty and in some cases internal conflict (such as Nepal).

This progress, however, has been uneven. Least progress has been made in sub-Saharan Africa, where some countries (such as Kenya and Nigeria) have actually seen worsening of infant and child mortality. Many countries of southern Asia also continue to have large numbers of newborn, infant, and child deaths. In all regions, inequity in access and use of essential health services is a major issue, with poor and marginalized segments of the population significantly underserved.

Despite the increasing contribution of HIV/AIDS as a direct cause of under-five mortality in some sub-Saharan African countries, this contribution still remains well under 10% in even the highest prevalence settings. The major causes of under-five mortality continue to be diarrheal diseases, pneumonia, vaccine-preventable diseases, peri- and neonatal diseases and conditions, and (in Africa) malaria, with malnutrition being the underlying cause of more than half of these deaths. Unintended pregnancy and close birth intervals also are important contributors to maternal and child mortality.

Burden of maternal and child illness and mortality: Maternal, neonatal and child mortality and morbidity place enormous burdens on families, some of whom experience catastrophic expense and fall into poverty or sink further economically as a result of a serious complication or death. In addition, maternal and child illness and disabilities, many of which are preventable with affordable low cost interventions, place an enormous burden on health care systems and the financial and human resources of developing countries. The greatest burden is on the poor. Although progress continues in many countries, innovative, cost-effective and sustained approaches must be identified and implemented to reach the most vulnerable.

To highlight the importance of maternal and child health to the well-being of populations, the United Nations (UN) and governments have rallied around the MDGs to accelerate and track progress. MDG 4 (reduce under-5 mortality by 2/3) and MDG 5 (reduce the maternal mortality ratio by 3/4) set forth the results expected by 2015 for child and maternal survival. While some countries are on a trajectory to meet the goals, many others are not, and still others are losing ground.

USAID Programming: The USAID Bureau for Global Health (USAID/GH) has been funding maternal health operations research and programs since the 1980s. Through the Mother Care project in the 1990s, USAID/GH became a leader in developing models and testing the feasibility and cost-effectiveness of interventions to reduce maternal and neonatal mortality in the context of the well-being and status of women in the community. USAID/GH continued to support maternal and newborn health programming in the late 1990s, and 2000s through the Access to Clinical and Community Maternal, Neonatal and Women's Health Services Program (ACCESS) and the Prevention of Postpartum Hemorrhage Initiative (POPPHI).

USAID's Child Survival program began in 1982. It marked a shift away from support for primary health care systems toward support for focused preventive and curative health interventions, aimed at the main causes of mortality and morbidity in less developed countries. Several central projects provided technical assistance for implementation of child survival activities. These were followed by The Basic Support for Institutionalizing Child Survival (BASICS) Project, BASICS II, and BASICS III.

In addition, USAID/GH has had a long history of supporting private voluntary organizations (PVOs) and non-governmental organizations (NGOs) and their in-country partners to reduce infant, child, maternal and infectious disease-related morbidity and mortality and to prevent and control malaria. One such effort was the Child Survival Technical Support Plus (CSTS+), a technical support project that provided technical assistance in program design, information on the most recent advances in technology, and technical resources to NGO/PVOs.

MCHIP Development Objective: Support the introduction, scale-up and further development of high impact MCH interventions, including the program approaches to effectively deliver those interventions, to achieve measurable reductions in under-five and maternal mortality and morbidity. In the context of its objective and at the request of USAID Mission staff, MCHIP merged the functions of the following USAID/GH programs, upon their completion, to improve programmatic and administrative efficiency and effectiveness and to respond to the evolving USAID MCH strategy: ACCESS (www.accesstohealth.org), BASICS III (www.basics.org), Immunization BASICS (www.immunizationbasics.jsi.com), POPPHI (www.pphprevention.org), and CSTS+ (www.childsurvival.com).

MCHIP is a centrally-managed project that strives to deliver a full range of high-impact, evidence-based maternal, neonatal, and child health (MNCH) interventions through an integrated approach as appropriate. MCHIP will contribute to substantial reduction in maternal, neonatal, and child mortality in 30 countries by:

- Implementing high-impact, effective interventions at scale, based on global and local data;
- Building global consensus and sustained government commitment to support results-oriented, evidence-based MNCH programs, including mobilizing resources for effective interventions;
- Influencing local programs to incorporate effective, feasible, high-impact interventions and approaches based on global evidence; and
- Strategically integrating critical interventions into existing services and wrap-around programs, emphasizing close-to-client contact and ensuring “no missed opportunities.”

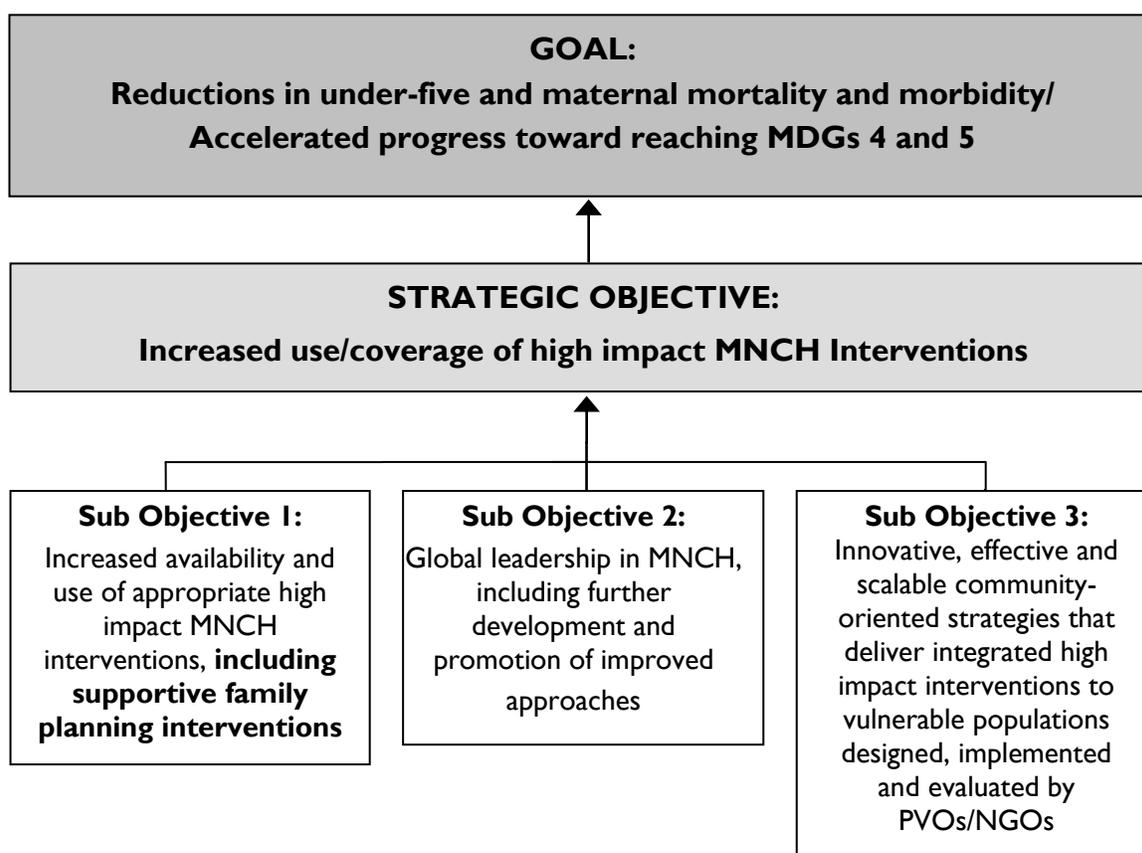
As USAID's flagship MNCH project, MCHIP's platform strives to support countries to scale up high impact MNCH interventions. MCHIP's integrated design offers an opportunity for Missions to tap into a diverse range of technical expertise from one project to address specific technical gaps or to offer an integrated program covering MNCH and also malaria and HIV/AIDS to achieve greater efficiency and less management burden. MCHIP's leadership at global level is also expected to raise global interest, form alliances and partnership to advance MNCH programming, innovations and learning agenda.

MCHIP brings together a partnership of organizations with demonstrated experience in addressing maternal, newborn, child health, malaria and HIV/AIDS issues. Each partner takes the lead in developing programs around specific technical areas: Jhpiego, as the Prime, will lead maternal health, family planning/reproductive health, and prevention of mother-to-child transmission of HIV (PMTCT); JSI—child health, immunization, and pediatric AIDS; Save the Children—newborn health, community interventions for MNCH, and community mobilization; PATH—nutrition and health technology; JHU/IIP—research and evaluation; Broad Branch—

health financing; and PSI—social marketing. Macro International continues support for the Child Survival and Health Grants Program (CSHGP) and the Malaria Communities Program (MCP).

Interventions supported under MCHIP respond to all the MCH sub-elements from the Foreign Assistance program structure hierarchy, focusing on the following: Birth preparedness and maternity services; Treatment of obstetric complications and disabilities; Newborn care and treatment; Immunization; Maternal and young child nutrition, including micronutrients; Treatment of child illness; Household level water, sanitation, hygiene and environment; Building host-country information capacity; Program design and learning. MCHIP also contributes to several sub-elements of the Family Planning/Reproductive Health, Malaria, and HIV/AIDS Elements.

Figure 1: MCHIP Results Framework



Expected project outputs include:

- Contribute to reductions in maternal and under five child mortality in 20 countries
- Contribute to an estimated 118,000 mothers and 7.2 million children under-five saved in 20 high burden mortality countries
- 20 countries demonstrating improved coverage in use of MNCH services, with 5 of these benefiting from an integrated package of high impact MNCH interventions
- 5 countries demonstrating greater equity in coverage of MNCH services
- All 68 MDG Countdown countries benefitting from MCHIP-promoted learning tools and approaches

Significant Changes: Updates on progress towards the Millennium Development Goals (MDGs) and changes in US Government priorities have occurred since MCHIP's inception in 2008. This mid-term evaluation provides an opportunity to maximize MCHIP's contribution towards the MDGs and to identify opportunities to better align with new USG initiatives.

MCHIP was designed to contribute to progress towards MDGs 4 and 5. In 2010 the World Bank revealed that many countries in the developing world were not on track to meet this MDG. While significant progress has already been made, the World Bank projects that under five mortality could reach between 68.1 and 69.5 deaths per 1,000, well above the target of 33.7 deaths per 1,000. Recent maternal mortality estimates have shown that maternal mortality decreased by over 34 percent from 1990 to 2008 and the average annual rate of decline in maternal mortality ratio has been 1.3 percent since 1990. Currently 23 countries are on track to meet MDG 5. However some countries in Sub-Saharan Africa have shown increases in their maternal mortality ratio.¹² With five years left to reach the MDG goals, it is critical to ensure that MCHIP is maximizing its efforts and leveraging the work of other donors towards the MDGs.

Another key development has been the launch of President Obama's **Global Health Initiative (GHI)**. Under the GHI, USG health programming will support partner countries to strengthen health systems for improved, sustainable health impact with a focus on improving the health of women, newborns, and children. The principles underlying the foundation of GHI are the following:

- Focus on women, girls, and gender equality
- Increase impact through strategic coordination and integration
- Strengthen and leverage key multilateral organizations, global health partnerships and private sector engagement
- Encourage country ownership and invest in country-led plans
- Build sustainability through health systems strengthening
- Improve metrics, monitoring and evaluation
- Promote research and innovation

USAID is currently reviewing its programs in MNCH, FP, and Nutrition to ensure that the best practices in these areas are being implemented and support GHI principles. As an integrated project that leverages the work of other donors, strengthens host country governments leadership and plans, and targets the key populations in the GHI, it is critical to evaluate how well the MCHIP structure is working in these areas and opportunities to further support the GHI principles.

VI. SCOPE OF WORK AND METHODOLOGY

Prior to convening the evaluation team, USAID/AOTR team, in consultation with MCHIP Executive Management Team (EMT), will agree on a list of countries for site visits. Four countries will be selected for site visits (the team will split to two groups and each group will visit two countries); all the team will reconvene in Washington, DC. The AOTR team will share rationale used for the selected countries with the evaluation team and will be opened for any modifications. Suggested criteria for countries selection include:

¹²<http://web.worldbank.org/WBSITE/EXTERNAL/EXTDEC/EXTGLOBALMONITOR/EXTGLOMONREP2010/0,,contentMDK:22523483~pagePK:64168445~piPK:64168309~theSitePK:6911226,00.html#>

- Countries in which significant amounts of field support funds have been invested in the MCHIP project, both recent and for longer durations.
- Countries where seed core funds were catalytic to initiate a larger program.
- Countries which have an integrated program (MNH-CH-FP)
- Countries which had previously bought into some of the expired five vertical projects for technical assistance before transitioning to the MCHIP project.
- Countries where MCHIP is working with bilateral projects and/or coordinating with the Child Survival Health Grant programs (CSHGP); if applicable.
- Countries where the program transitioned from field support to Associate Award
- Countries in which Missions have reported challenges to the MCHIP AOTR.

The countries tentatively selected for site visits are: India, Indonesia, Malawi, and Mozambique (TBC with the Missions). Additional countries identified for phone interviews include: Bangladesh, Kenya, Zimbabwe, Rwanda, Paraguay, DRC, and Ghana.

Document Review

The evaluation team will review background documents provided by USAID.

Team Planning Meeting

The evaluation team will convene in Washington, DC for a 2 day team planning meeting. During this meeting, the team will prepare a draft evaluation framework including evaluation tools and schedules for in-country evaluation activities to be reviewed by USAID/AOTR team.

In-briefing with GH/HIDN; Washington, DC-based Data Collection

The evaluation team will meet with USAID AOTR Team and the MCHIP to discuss the methodology, the countries selected for assessment, and data collection tools. Data collection tools must be reviewed and approved by USAID/AOTR prior to data collection activities. The team will also meet with MCHIP EMT members, technical team leaders, and partners to discuss the documentation provided by the project and overall management of the project. The team may also conduct key informant interviews with USAID AOTR Team, USAID MCH and FP staff, USAID mission staff (via phone), and other global partners while in Washington.

Site Visits and Key Informant Interviews

The team leader will divide the team into two sub-teams of two team members for site visits. Each sub-team will visit two countries selected by USAID during the planning phase. During each site visit, the evaluation sub-team will meet with the USAID mission leadership and technical team; meet with the host country government, and other key stakeholders. Suggested evaluation activities include, but are not limited to: review of country-specific work plans; verification of achievements to date; key informant interviews; focus group discussions with clients.

At the end of each country visit, the sub-team will debrief with USAID mission staff to present preliminary findings and get mission feedback before preparing the evaluation report.

Data analysis should include but is not limited to:

- As available, quantitative comparison of achievements against targets for key output indicators to date, such as percent of countries demonstrating improved coverage in use of MNCH services, number of countries demonstrating greater equity in coverage of MNCH services (MCHIP output indicators).

- Assessment of specific tools being introduced such as Standard Based Management and Response (SBM_R) and its impact on improved quality of MNH services and health outcomes at the facilities where it is implemented.
- Qualitative analysis of the timeliness, quality, and completion of MCHIP's technical assistance to USAID Missions, host governments, and other partners compared with missions' expectations. Disaggregate by large and small programs.
- Analysis of the MCHIP management structure including the roles of partners and the extent to which coordination is occurring among partners.

GH/HIDN Debriefing

Upon completing in-country work and re-convening in Washington, DC, the evaluation team will present preliminary findings to GH/HIDN and get final inputs before preparing the evaluation report.

VII. TEAM COMPOSITION, SKILLS AND LEVEL OF EFFORT

The evaluation team will be composed of four individuals. All team members should have the following characteristics:

- Master's degree or higher level of education in a relevant technical area;
- Knowledge, skills, and experience with USAID contracting and reporting requirements; policies and initiatives; and tools, such as performance monitoring plans(PMPs) and results frameworks;
- Advanced written and oral communication skills in English, French language is a plus;
- Expertise working in developing countries;
- Experience working in the international donor environment especially with other development agencies (e.g. UN agencies, WHO, or other USG agency);
- Strong quantitative and qualitative analytical skills.

Additionally, the team members should together include the following individual levels of expertise:

- At least one person with strong knowledge, skills, and minimum of 10 years of experience in evaluation tools and methods;
- At least two people with minimum of 15 years of experience in public health with extensive technical knowledge and experience with interventions, policies and programs in maternal health, newborn health, child health, and family planning ;
- At least one person with a minimum of 5 years' experience in organizational management;
- At least two people with 10 years of experience in designing, implementing, managing, and evaluating international health programs;

The team leader will be identified by USAID prior to the start of evaluation activities. The team leader will be responsible for (1) managing the team's activities, (2) ensuring that all deliverables are met in a timely manner, (3) serving as the primary liaison with the AOTR and Mission teams, and (4) leading briefings and presentations. In addition the team leader must have these characteristics:

- Excellent skills in planning, facilitation, and consensus building;
- Demonstrated experience leading an evaluation team;
- Excellent interpersonal skills;

- Excellent organizational skills and ability to keep to a timeline.

An illustrative table of level of effort (LOE) is as follows:

Task/Deliverable	Duration/LOE	
	Team Leader	Technical Specialists
Review background documents	2 days	2 days
Travel to DC (for non DC-based consultants)	1 day	1 day
Team planning meeting; prepare evaluation framework and data collection tools for USAID review	2 days	2 days
In-briefing and meetings with USAID/W	1 day	1 day
Interviews with MCHIP headquarters staff. Conference calls with 4-6 additional missions.	3 days	3 days
Travel: Team splits into two groups and each group travels to <u>first set</u> of selected countries.	2 days	2 days
Country visits: Information and data collection, including interviews with key informants, field visits and verification of reported project outputs.	6 days	6 days
Travel: Sub-evaluation teams travel to <u>second set</u> of selected countries.	2 days	2 days
Country visits: Information and data collection, including interviews with key informants and verification of reported project outputs.	6 days	6 days
All evaluators travel to DC.	2 days	3 days
Team meeting to analyze data and discuss findings and debriefing with MCHIP management and USAID.	4 days	4 days
Team drafts report and submits to USAID	5 days	4 days
Travel home (for non DC-based consultants)	2 days	2 days
Draft report is circulated to USAID/W staff, MCHIP staff, and Mission teams for comment. (5 working days)	--	--
USAID completes final review (10 working days)	--	--
Team incorporates input into final report	3 days	2 days

Task/Deliverable	Duration/LOE	
	Team Leader	Technical Specialists
USAID approves final report	--	--
GH Tech edits/formats final report for publication	--	--
Total Estimated LOE	41 days	39 days (each specialist)

A six day work week is approved when the team is in the field.

VIII. LOGISTICS

GH Tech is responsible for all logistical arrangements, including travel and transportation, country travel clearance, lodging, communications. USAID country missions from countries selected by GH/HIDN will provide logistical guidance during the evaluation team's site visits, including, where applicable: guidance on recommended hotels and methods of in-country travel

USAID country Mission staff and MCHIP country teams will provide guidance and assistance in the following areas to facilitate and ensure timely completion of the site visits:

- Arrange in-briefing and debriefing at the USAID country mission
- Identify in-country key informants and relevant contact information
- Introduce consultant team to project partners, local government and other stakeholders, as appropriate
- Arrange appointments with relevant government officials and accompany the consultant team on these interviews, as appropriate

IX. DELIVERABLES AND PRODUCTS

- 1. Evaluation Framework:** The consultant team will prepare an evaluation framework which will include includes methodology for evaluation activities; a timeline for these activities; roles and responsibilities of evaluation team members; and data analysis plan. The evaluation framework will be submitted for discussion and approval during the team's in-briefing with GH/HIDN.
- 2. Data Collection Tools:** includes questionnaires for key informant interviews; templates for collection and analysis of MCHIP achievements, other quantitative performance data, and cost data, as determined in the evaluation framework. The data collection tools will be submitted for review and approval prior to the team's country visits.
- 3. Debriefing with GH/HIDN:** After completion of in-country work, the evaluation team will reconvene in Washington, DC to collate the sub-team findings and discuss recommendations for the evaluation report. The team will present the major findings of the data collection and fieldwork to GH/HIDN/MCH staff and MCHIP partners through a PowerPoint presentation.

The debriefing will include a discussion of the findings, conclusions, recommendations for next steps and outline of the evaluation report. The evaluation team will consider USAID and MCHIP partner comments and incorporate those comments and changes into the draft report, as appropriate, prior to submission to USAID.

1. Draft Evaluation Report: A draft report of the findings and recommendations will be submitted to GH/HIDN five business days after the debrief. The evaluation team leader will coordinate and lead draft report writing. He/she will share copies of the report with USAID/MCH and mission staff for comment. GH/HIDN will circulate the draft to Mission staff and MCHIP partners for review and will collect and collate comments, as appropriate. GH/HIDN will provide comments within 10 business days of receiving the draft report.

The report will be submitted by the evaluation team in English, electronically. The written report should clearly describe findings, conclusions and recommendations including next steps. The report should not exceed 30 pages, not including annexes. A suggested outline for this report includes the following:

- Executive Summary;
- Introduction: evaluation purpose, audience, summary of the statement of work;
- Background: brief overview the global and country contexts in MNCH and FP and trends in coverage of high impact interventions in these areas; overview of MCHIP’s structure and design;
- Methodology: clear description of the evaluation questions and the methods used to address each question;
- Findings/Conclusions: MCHIP’s achievements and outcomes to date; projections for end of project achievements compared with targets and expected outcomes; challenges, successes, innovations, and lessons learned during MCHIP’s implementation; project gaps and missed opportunities; strengths and weaknesses of MCHIP’s design and structure; current alignment with GHI principles.
- Recommendations: should specifically address opportunities to incorporate the most recent advances in science and technology into MCHIP’s interventions; recommendations for the structure and management of a follow-on project.

2. Final Report: The evaluation team will submit a final report that incorporates responses to USAID comments and suggestions five business days after USAID/W provides written comments on the draft evaluation report.

GH Tech will provide the edited and formatted final document approximately 30 business days after USAID provides final approval of the report. GH Tech will provide hard copies (20) along with an electronic final copy. The final draft of the report may be used for planning purposes during the editing/formatting process. The final report will be a public document and will be submitted to the DEC and USAID evaluation registry in USAID/Washington.

X. RELATIONSHIPS AND RESPONSIBILITIES

With USAID/HIDN approval, GH Tech will provide the consultants and all administrative and secretarial support to the team during the evaluation performance period. USAID/HIDN will review and approve the evaluation team’s work plan and will select countries in collaboration with mission teams and MCHIP management.

XI. MISSION AND/OR WASHINGTON CONTACT PEOPLE/PERSON

Technical direction will be provided by:

Nahed Matta, AOTR for MCHIP

NMatta@usaid.gov

Tel: 202-712-4564

Additional support will be provided by:

Linda Banda, Alternative AOTR for MCHIP

LBanda@usaid.gov

Tel: 202-712-5428

Betsy Hendrickson, program analyst

EHendrickson@usaid.gov

XII. COST ESTIMATE

GH Tech will provide a cost estimate for this activity.

XIII. REFERENCES

USAID/HIDN will provide the background and reference materials to GH Tech in advance of the performance period. Documentation will include:

- The MCHIP Request for Applications (RFA);
- MCHIP Award and relevant Modifications;
- Implementation Plans for Years 1-3;
- Annual and Semi-Annual Reports to date;
- The USAID Global Health Bureau's Results Pathways;
- The Global Health Initiative consultation document;
- An updated table of the countries in which it is working including the amount of money expended (disaggregated by field support and central funding) and activities carried out;
- List of resources (e.g. financial, goods, and services) leveraged from other sources;
- Tools, implementation guidelines, policies, and/or training curricula developed.
- Country work plans and reports

ANNEX B. INTERVIEWS/CONSULTATIONS FOR MCHIP EVALUATION

INTERVIEWS WITH USAID/WASHINGTON

Elizabeth Fox, Deputy Director, HIDN Office, GH Bureau

Richard Greene, Director, HIDN Office, GH Bureau

Africa Bureau

Karen Fogg

George Greer

Mary Harvey

GHI Task Force

Lily Kak

MCH Division

John Borrazzo

Debbie Armbruster

Linda Banda

Al Bartlett,

Diaa Hammamy

Troy Jacobs

Trish MacDonald

Nahed Matta

Mary Ellen Stanton

Nutrition Division

Neal Brandes

Nazo Kureshy

INTERVIEWS WITH USAID MISSIONS

Bangladesh

Meena Umme

Ghana

Felix Osei-Sarpong and Susan Wright

Kenya

Lilian Mutea-Muthui, Jerusha Kamithing, Washington Omwomo, Lisa Godwin, and Sheila Macharia

India

Kerry Pelzman, James Browder, Stephen Solat, Shweta Verma, Ky Lam, Sheena Chabra, Loveleen Johri, Elizabeth Callendar, Ramesh Babu and select program staff

Indonesia

Irene Koek, Mildred Pantouw, Rachel Cintron and Antoinette Tomasek

USAID/Madagascar

Jocelyne Andriamiadana, Barabara Hughes, Theresa Outlaw

Malawi

Melanie Luick-Martins, Lilly Banda, and Chimwemwe Chitsulo

Nepal

Anne Peniston, Han Kang, and Deepak Paudel

Paraguay

Graciela Avila

Zimbabwe

Jo Keatinge

INTERVIEWS WITH MCHIP HQ STAFF

Koki Agarwal

David Cantor

Anita Gibson

Steve Hodgins

Jennifer Luna

Barbara Rawlins

Leo Ryan

Pat Taylor

INTERVIEWS WITH MCHIP PARTNERS AT HQ LEVEL

Broad Band: Reena Eichler and Alex Ergo

CORE: Shannon Downey, Ann Hendrix-Jenkins and Karen LeBan

JSI: Marge Koblinsky

PSI: Cecilia Kwak

Save the Children: David Oot

CORE MEMBER FOCUS GROUP

Luis Benavente, MCDI

Emmanuel d'Harcourt, IRC

Judy Lewis, Haitian Health Foundation

Jennifer Nielsen, Helen Keller International

Alan Talens, CRWRC

INTERVIEWS WITH GLOBAL PARTNERS

Bill and Melinda Gates Foundation: France Donnay

FCI: Ann Starrs

Maternal Health Task Force: Ann Blanc and Ana Langer

UNICEF: Mark Young

WHO: Mathews Mathai and Cathy Wolfheim

Women Deliver: Jill Sheffield

INTERVIEWS IN INDONESIA

MOH Maternal and Child Health Division: Dr. Erna, Dr. Lukas, and select staff from child health department

MCHIP/Jakarta: Anne Hyre, Asmuyeni Muchtar, Dr. Wita Sari, Endang Iradati, Jennifer Rosenzweig

MCHIP/Bireuen: Dr. Ratih Rakhmawati and select MCHIP Bireuen staff

MCHIP/Serang: Titien Irawati,

Bireun Bupati (District Governor): Mr. Noreen Abdul Rahman

Bireuen District Health Office: Dr. Amir Addani

Blang Guron Village Midwife: Ibu Ehartati

Budi Kemulian Hospital: Dr. Baharrudin

Dr. Fauziah Hospital: Chief Midwife Marhani and other staff

Gandapura Puskesmas: Darma Wati

Jeumpa Puskesmas: Mr. Zakaria and other staff

Mercy Corps: Fransiska Mardiananingsih,

Perinasia: Dr. Hadi Pratomo and Dr. Rulina Suradi,

Serang District Hospital: Dr. Sri Lestari

UNICEF: Dr. Endang Widiastuti, Dr. Budhi Setiawan, Dr. Lukman Hendro

WHO: Dr. Martin Weber,

World Bank: Claudia Rokx, Puti Marzoeki, Wendy Savasdyani

INTERVIEWS IN INDIA

MOHFW/India

Dr. Kiran Ambwani, Deputy Commissioner, Family Planning;

Dr. Ajay Khera, Deputy Commissioner, Child Health and Immunization;

Mr. Dileep Kumar, President, Indian Nursing Council

MCHIP/New Delhi

Dr. Karan Singh Sagar, Dr. Bulbul Sood, Dr. Somesh Kumar, Dr. Anju Puri, Dr. Vijay Kiran, Pearl Abra, Dr. Rasmi Asif, Dr. Vineet Srivastav, Dr. Siddarth Saha

MCHIP/Jamtara

Dr. Gungjan Taneja

MCHIP/Ranchi

Dr. Sumant Mishra, Dr. Kamlesh, Dr. Dinesh, Dr. Pavan Pathak,
Dr. Jaya Mohanti

MCHIP/Simdega

Dr. Koustav

PSI

Dana Ward and Dr. Amit Bhanot

Ranchi

Dr. Kiran Trivedi and staff at Rajendra Institute of Medical Science

Jamtara District:

Mr. K. N. Jha, Deputy Commissioner/District Magistrate

Dr. L.N. Sherma, Civil Surgeon

Dr. Aradhena Patnayak, Managing Director, NHRM

Dr. Praveen Chandra, Director of Health, NRHM

Dr. Ajit Kumar Prasad, SEPIO/Director State Institute for Child Health

Dr. Nelish, Medical officer

WHO: Dr. Debashish Roy and Dr. Rahul Kapset

Simdega District:

Dr. Vijay Khanna, Civil Surgeon/Chief Medical Officer

Dr. Christ Anand Xaxa in charge of Reproductive and Child Health

ANM Faculty at Training Center: Agnes Xaxa, Nelam Suren, and Lily Grace Shaw

Dr. A. K. Ghosh, Deputy Reproductive and Child Health Officer

Dr. Arun Kumar, Pabia Additional Primary Health Centre

INTERVIEWS IN KENYA

MOH

Dr. Migiro, Division Child and Adolescent Health (DCAH); Dr. T Kamau, Division of Vaccines and Immunization (DVI); Dr. Sarah Ousase, Division of Nutrition (DoN); Dr. Tabilla Mwaga, Division of Reproductive Health (DRH); Dr. Annah Wamae, Department of Family Health (DFH)

MCHIP/Nairobi

Peter Kaimenyi, Dr. Isaac Maloza, Dr. Alowa, Nancy Koskei, Joygrace Muthoni, Dr. Lynn Kanyuuru, Dr. Evans Mokaya, Walter Mukhwana

UNICEF

Josephine Odanga

WHO

Dr. Kibet Sergon

Nyanza Province

Provincial Public Health and Sanitation Department: Dr. J.K. Kioko, Provincial Director Public Health and Sanitation: John W Odera, Provincial EPI Logistician

Bondo District

District Health Management Team (DHMT)

Dr. Julius Oliech, District Medical Officer of Health; Charles Mbeya, District Clinical Officer; Duncan Monianyi, Public Health Officer; Nelly Irangi, District Nutrition Officer; Samson Oando, District Health Administration Officer; Joel Milambo, Community Strategy Focal Person; Grace A Orawanda, District Health Records and Information; Anne A. Okoth, District Public Health Nurse

Staff at Uyawi Dispensary

Staff at Gobei Dispensary

CHW (Floris) at Liunda Beach Community

Chris Barasa, Senior Program Officer, ICAP (CDC)

Western Province

Evelynn Shapala, Moi University based HBB master trainer

Mary Wekesa, Bokoli Sub District based HBB master trainer

Maternity Staff at Sirisia Sub-District Hospital (Clinical Officer in-charge, Felicitas, HPP: Solomon, Nursing in charge: Kathrin); CHWs (2) and TBA from catchment area

Maternity staff at Bukoli Sub-District Hospital

INTERVIEWS IN MALAWI

MOH

Nanzeen Kaphagawani, MCHS Zomba Campus Director; Michael T Eliya, National PMTCT Coordinator, HIV/AIDS Department; Amon Nkhata STI/Male Circumcision Program officer, HIV/AIDS Department; Doreen Ali, Director National Malaria Control Program; Mrs. Fannie Kachale, Deputy Director of Reproductive Health; Stella Kamphinda, Nursing Officer-Education Programmes, Nurses and Midwives Council of Malawi; Martha Mondwa, Registrar and Chief Executive Officer, Nurses and Midwives Council of Malawi; Dr. Abigail Kazembe, Lecturer, Head MNH Department, Kamuzu College of Nursing; Dr. Ann Phoya, Chairperson, National Quality Assurance Committee

MCHIP/Lilongwe

Tambudzai Rashidi, Anna Chinombo, Aleisha Rozario, Charles Yuma, Joby George

MCHIP/Nkhotakota: Charlene Chisem

MCHIP/Machinga: Veronica Lwasha

GIZ: Julia Ilse Human

MSH: Rudi Thetar, Mexon Nyirongo

PSI: Ricki Orford

Royal Norwegian Embassy: Anne Liv Evensen

UNFPA: Juliana Lunguzi and Grace Hiwa

UNICEF: Grace Flora Mlava

WHO: Harriet Chanza

Nkhotakota District

M Linley Chewere, District Nursing Officer

Dr. Chisenga, District Health Officer

Ntosa HC: Staff and HSAs, Members of Community Action Group (CAG), Community women in catchment area village (Suruwi)

Malowa Health Center: Staff, Members CAG, women in catchment area village

Machinga District

Henry Banda, Chief Clinical Officer, DHMT

Datherine Malenga, Senior Registered Nurse (FP Trainer), DHMT

Chikweo HC staff and HSAs, women from catchment area village (Masaka)

Nyambi HC staff and HSAs

Ntaja HC staff and HSAs, members of Community Action Group

ANNEX C. DOCUMENTS REVIEWED FOR MCHIP MIDTERM EVALUATION

Child Survival Health Grants Program

Innovation links to MCHIP Ares of Focus

Program portfolio

Community Case Management essentials: *Treating Common Childhood Illnesses in the Community: A Guide for Program Managers*, Washington, DC. CORE Group, Save the Children, BASICS, and MCHIP (2010)

GHI Results Pathways

Maternal GHI Pathway (2011)

Child GHI Pathway (2011)

Global Health Initiative Consultation Document, *Implementation of the Global Health Initiative* (Jan 2010)

Integrated Community Case Management of Childhood Illnesses. *Documentation of Best Practices and Bottlenecks to Program Implementation in the Democratic Republic of the Congo (DRC)*. Summary Report (Draft, March 7, 2011)

Integrated Community Case Management of Childhood Illnesses. *Documentation of Best Practices and Bottlenecks to Program Implementation in Senegal*. Summary Report (Draft, Feb 28, 2011)

Interventions for Impact in Essential Obstetric and Newborn Care, Africa Regional Meeting, Addis Ababa (Feb 2011)

Malaria in Pregnancy Country Case Study: Malawi's Successes and Remaining Challenges for Malaria in Pregnancy Programming (April 2011)

Malaria in Pregnancy Country Case Study: Zambia's Successes and Remaining Challenges for Malaria in Pregnancy Programming (January 2010)

MCHIP Annual Implementation Plans for Years 1, 2, 3

MCHIP Annual and Semi-annual Reports

Year 1 Annual Report (final revision Dec 22, 2009)

Year 2 Annual Report (final resubmission Dec 21, 2010)

MCHIP Semi-Annual Report Oct 2009-March 2010

MCHIP Contract (Fully Executed/Modified, June 8, 2009)

MCHI Country Investment Table (April 23, 2011)

MCHIP Country Summaries (May 2011): Bangladesh, Burkina Faso, Dominican Republic, DRC, Ethiopia, Ghana, Guinea, Guyana, India, Indonesia, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mozambique, Nepal, Nigeria, Paraguay, Rwanda, Tanzania, Timor-Leste, Zimbabwe

MCHIP Democratic Republic of Congo (DRC) Transition Report. (1 April 2009–30 September 2010)

MCHIP Regional Briefs

Highlights in Newborn Health, LAC Region Q1-Q2 (FY 2011)

MCHIP Monitoring, Evaluation and Research, *Summary for MCHIP Program Years: 2008-2011*

MCHIP Pipeline Summary (2011)

MCHIP, *The quality of maternal and neonatal care in Kenya: Findings from a national survey - Are services provided according to internationally agreed performance standards?* (Draft, April 25, 2011)

MCHIP Request for Applications (April 23, 2008)

MCHIP Workplan Narratives

Year 1 (March 27, 2009)

Year 2 (October 23, 2009) (+ Response, October 13, 2009)

Year 3 (October 21, 2010)

MNH List Analyses (final, August 18, 2010)

National Programs for Prevention and Management of Postpartum Hemorrhage and Pre-Eclampsia/Eclampsia in Selected USAID Program-Supported Countries: Status Report., Fujioka, A. and Smith, J. (March 2011)

Performance Monitoring Plan (original, August 2009; proposed revisions April 2011)

Report to USAID on Highlights from MCHIP Internal Mid-term Review (by Mark Leach)

Sante Maternelle et Neonatale au Senegal, Succes et Defis. (Draft Juin 2010)

Scale up road maps:

Country Scale-up Maps on PPH Prevention and Management at Scale and Pre-eclampsia/Eclampsia at Scale (Afghanistan, Angola, Bolivia, DRC, Equatorial Guinea, Ethiopia, Ghana, Guinea, India, Indonesia, Kenya, Liberia, Madagascar, Malawi, Mali, Mozambique, Nepal, Nigeria, Paraguay, Rwanda, Senegal, South Sudan, Tanzania, Uganda, Zambia, Zanzibar, Zimbabwe)

Pathway to Implementation of Diarrheal Disease Management with Zinc at Scale

Pathway to Implementation of Priority Newborn Interventions At Scale

Selected Articles:

“Family planning and reproductive health: Why the US should care,” working paper for the Council on Foreign Relations, April 2011, Agarwal

“Men key to reducing maternal deaths in developing countries” *Front Lines*, May 2010

“Why we need men to save lives” in *Global Health Magazine*, winter 2011, Agarwal

Selected Reports, Press Clippings, Workplans, Quarterly Reports and Program Overviews

For countries visited: India, Indonesia, Kenya, and Malawi

For countries interviewed: Bangladesh, Ghana, Madagascar, Nepal, Paraguay, Zimbabwe

Strengthening Health Systems to Improve Maternal, Neonatal and Child Health Outcomes: A Framework ‘How to’ guide. Alex Ergo and Rena Eichler (2011)

Technical Briefs:

MCHIP Technical Brief on Child Health
MCHIP Technical Brief on Family Planning
MCHIP Technical Brief on Health Systems Strengthening
MCHIP Technical Brief on HIV
MCHIP Technical Brief on Immunization
MCHIP Technical Brief on Malaria
MCHIP Technical Brief on Maternal Health
MCHIP Technical Brief on Monitoring, Evaluation, and Research
MCHIP Technical Brief on Newborn Health
MCHIP Technical Brief on PVO/NGO Support

“Testing innovations to improve and scale-up high impact maternal, newborn, and child health interventions in vulnerable communities: USAID’s partnership with 14 International Non-Governmental Organizations (INGOs) through the Child Survival & Health Grants Program in 16 countries,” USAID and MCHIP (2011)

Understanding Community Components of a Health System, CORE Group and MCHIP (Draft, 5/1/2011)

USAID Evaluation Policy (Bureau for Policy, Planning, and Learning, Jan 19, 2011)

Peer Reviewed Articles:

- Glenton, C., Lewin, S., Scheel, I., Pradhan, S., Hodgins, S., Shrestha, V. Stakeholder views of volunteerism, payment and other incentives in the Female Community Health Volunteer Programme in Nepal: A qualitative study. *Social Science & Medicine* 2010, 70(12); 1920-1927
- Hodgins, S., McPherson, R., Suvedi, B.K., Shrestha, R.B., Silwal, R.C., Ban, B., Neupane, S., Baqui, A.H. Testing a scalable community-based approach to improve maternal and neonatal health in rural Nepal. *J Perinatol.* 2010 Jun;30(6): 388-95
- Hodgins, S., Thapa, K., Khanal, L., Aryal, S., Suvedi, BK., Baidya, U., Mullany, LC. “Chlorhexidine Lotion vs. Aqueous for Preventive Use on Umbilical Stump: a Randomized Non-Inferiority Trial,” *Pediatr Infect Dis J.* 2010 Nov; 29(11):999-1003
- McPherson, R., Tamang, J., Hodgins, S., Pathak, L.R., Silwal, R.C., Baqui, A.H., Winch, P.J. Process evaluation of a community-based intervention promoting multiple maternal and neonatal care practices in rural Nepal. *BMC Pregnancy and Childbirth* 2010 Jun 7;10(1):31
- Rajbhandari, S., Hodgins, S., Sanghvi, H., McPherson, R., Pradhan, Y.V., Baqui, A.H., Misoprostol Study Group. Expanding uterotonic protection following childbirth through community-based distribution of misoprostol: Operations research study in Nepal. *Int J Gynaecol Obstet.* 2010 Mar;108 (3):282-8
- Ricca, J., Prosnitz, D., Perry, H., Edward, A. Morrow, M., Ernst, P., and Ryan, L. “Comparing estimates of child mortality reduction modelled in LiST with pregnancy history survey data for a community-based NGO project in Mozambique.” *BMC Public Health* 2011, 11(Suppl 3): S35)
- Steinglass et al, “Development and use of Lives Saved Tool as a model to estimate the impact of scaling up proven interventions of maternal, neonatal, and child mortality” in *Int J of Epidemiology*, Oct 2010

ANNEX D- MONITORING AND EVALUATION

OBSERVATIONS AND SUGGESTIONS

Observations and suggestions for monitoring country progress in introducing/scaling up high-impact interventions among the MCHIP countries and for measuring the activities with which MCHIP is actively involved:

Assumption: The types of services for which MCHIP partners bring expertise were pulled together in part because it is assumed that the package of defined high-impact interventions available to women and children, will result in greater improvement in MNCH mortality and morbidity than would occur if only some intervention are offered.

It is recognized that some interventions have more impact than others, because they affect more people (e.g., immunization) than others (e.g., PMTCT). However, this does not mean that those interventions that are relevant to fewer persons are any less important—equity demands that minority populations having need are served—particularly when the outcome without service can be death. So although the MCHIP Program and countries may prioritize interventions, not addressing some, it is still important to know the overall status—what is missing and what is present and at what scale. Whether the results are evaluated as sufficient or not is a judgment call that will be shaped by narratives that explain the reasons for the findings.

The objective of this type of monitoring and measuring tool is to allow MCHIP to show changes in status of high-impact interventions where MCHIP influence is expected to be effective. Criteria for whether the tool should be used for an individual country might be 1) MCHIP country presence; 2) activities for at least one year (or it could be two years). It is not suggested that the scope of the work be a criteria. The principle is that MCHIP should be proactive in advocating for high-impact interventions, not simply reactive. If MCHIP sponsors study tours or meetings where others pick up on the interventions, then MCHIP advocacy can be attributed and the change should be documented. If MCHIP has a country presence for a single activity (e.g., male circumcision) and does not advocate for other MNCH activities while in country, then MCHIP may be effectively carrying out a task for a country, and meeting the Mission needs, but not effectively carrying out their Program mandate of advocating for high impact MNCH interventions. It may be that MCHIP does not advocate but, by chance, there are advocates and projects that result in improvement in high-impact intervention status. The objective **of this methodology** is NOT attribution, it is to monitor status and change—regardless of who is responsible for change—and by doing this to help MCHIP to stay focused on its Program objectives and to help stakeholders better understand the needs within countries.

It is recognized that some countries have limited portfolios and timeframes and also that countries start and end at different points in time so further discussion will be needed to decide the most useful way to aggregate information to provide a global picture of MCHIP and changes in status for high-impact interventions. One suggestion is that at the end of the project, several groupings of countries be developed to show change separately in countries where MCHIP worked one year, two years, three years. Another suggestion is that one or two cohorts of countries that started Year 1 and started Year 2 be followed, with the cohorts being countries where MCHIP activities continued for at least 3 years.

Recommendation 1: The global MCHIP Program should present an annual picture of the status of defined high-impact interventions, for each country where they have a presence and have worked for at least one year. (This can also be done for specific interventions). Note: This process has been carried out for PPH, pre-eclampsia/ eclampsia by country, and for CCM for some countries.

Recommendation 2: The country-level pictures should be aggregated and followed as a cohort (cohort of countries where work started Year 1; work started Year 2; etc.) to provide a picture of the global MCHIP influence on introduction of new interventions, and scale up.

The annual pictures should:

Present a picture of status—if scale up is occurring without MCHIP influence, this is still scale-up and means the country does not need help (or is receiving it elsewhere) for a particular intervention.

- Not be expected to evaluate quality (e.g., the pictures are measuring steps in implementation and scale up, not how effectively the intervention is carried out)
- Reflect generally held understanding by stakeholders on status of interventions—they do not require validation, but should be based on information the Country Program feels is reasonably accurate (e.g., if PPIUD is being scaled up by the country and the MOH Family Planning divisions states this is occurring in all provinces and all districts, this is a sufficient level of information. If the MCHIP staff feel this is not true, a rough look at HMIS statistics on IUD insertions, or a quick call to the partner working on the intervention can be used to provide a more accurate picture of the current status, and to provide some evidence for whether additional help is needed or not for the intervention. Scale-up definitions may be loose for the purposes of this monitoring. It may be sufficient to know that a country is in the “process of scaling up” and to quantify scale up (e.g., as per MCHIP definitions in the PMP) using a different methodology. The purpose of this is to provide a relatively quick overview for planning and monitoring purposes. The more rigorous each data item becomes, the more difficult it will be to get the overview. For illustrative purposes we simply asked MCHIP country offices if an activity was in the process of being scaled up, and if yes, if it was by MCHIP or by others.

Recommendation 3: The profiles should present a baseline (before MCHIP started activities in the country, and then (maybe annually or every 2 years) the status at the time the profile is completed.

DEFINITIONS

Denominator: Number of intervention applicable to the country (e.g., if malaria is only relevant to a few geographic areas and MCHIP is not working with those area it can be defined as applicable or not, depending on whether it is of sufficient concern or not)

- I. Status of intervention presence in country:
 - Not in country
 - Advocacy-no activity
 - Pilot testing
 - Scaling-up nationally (or in relevant districts, for malaria)

2. Status of health system support for interventions

- Accepted as national policy
- National policy
- Included in pre-service curricula
- Included in in-service curricula
 - It is assumed that if it is in pre and/or in-service training it is already policy).
 - Some interventions (e.g., implementation policies such as RED) might not require inclusion in pre-service curricula.

3. MCHIP activity related to high-impact interventions

Following are samples of a reporting spreadsheet and graphs showing how the information might be presented.

1. The Excel file is a template for a spreadsheet for reporting baseline and current information on indicator status in the country. The template is NOT a final suggestion for MCHIP—rather, it is a model that MCHIP can use as a starting point. Interventions to be included, definitions, and the measures of status (across the top of the spread sheet) need to be revised depending on internal assessments of what seems most reasonable given the objective.
2. The table on page 72 is information derived from the template spreadsheet. NOTE: The information presented in the table is for illustrative purposes only. There may be some errors in the numbers as there was not time to clarify some of the information.
3. The graphs on pages 74–76 are illustrative of ways to present the global project progress in introducing and scaling up high-impact interventions.

The Evaluation Team presents these only as basis for starting if this proposal is accepted. The specific interventions to be included and the components to be monitored for global progress require more in-depth discussion.

Category being assessed	Status within each country for the indicated category of implementation for interventions									
	Kenya		Malawi		Indonesia		India		Summary	
	Baseline	Current	Baseline	Current	Baseline	Current	Baseline	Current	Baseline	Current
System support for scale-up and sustainability										
National policy/updated policies	8	13	16	21	10	10	11	14	45	58
Updated pre-service curriculum	4	4	11	12	5	5	8	11	28	32
Updated in-service curriculum	5	5	12	13	8	8	12	17	37	43
Interventions being addressed **	17	24	16	21	16	16	21	23	70	84
Implementation status										
National scale up led by others	7	11	13	11	9	11	7	10	36	43
National scale up led by MCHIP support		1		5		6		3	0	15
Pilot by others	8	0	3	0	0	0	3	0	14	0
MCHIP Pilot/scale up in focus areas only		5		3		1		2	0	11
Advocacy but no	2	7	0	1	6	0	6	6	14	14

Category being assessed	Status within each country for the indicated category of implementation for interventions									
	Kenya		Malawi		Indonesia		India		Summary	
	Baseline	Current	Baseline	Current	Baseline	Current	Baseline	Current	Baseline	Current
activity yet										
MCHIP Program activities to support implementation and scale-up										
MCHIP Advocacy but no activity yet		7		1		0		5		
MCHIP scaling-up in focus areas		8		5		14		12		
MCHIP helping others scale up outside focus area		0		6		13		7		
Activity being scaled up without MCHIP involvement (no MCHIP activity for topic)		7		11		4		4		
Notes:	1) For this example, total possible for each category is 27 for each country and 4 countries, thus the total possible for the Program is 4*27=108 interventions. This assumes that all categories apply to all interventions. This might not be true (e.g., pre-service curricula might not be applicable for RED strategy for EPI)									
	2) Categories are not mutually exclusive. MCHIP may be scaling up in focus areas and helping others to scale up.									
	3) Persons other than MCHIP may be scaling up activities in some geographic areas and MCHIP scaling up in other geographic areas.									

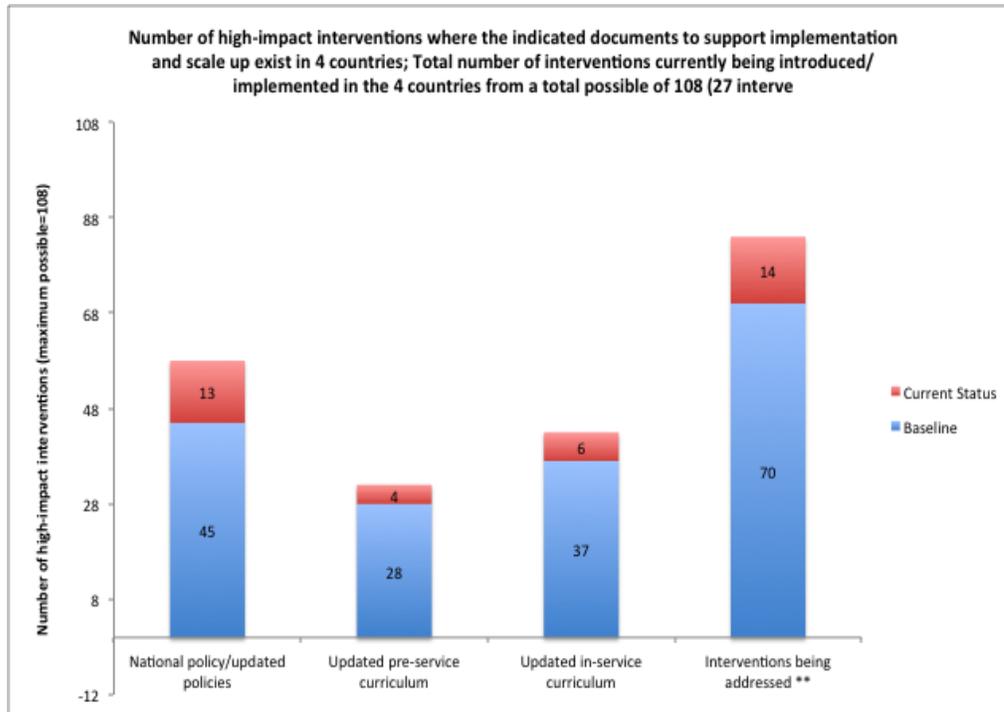


Figure D-I. Number of High-impact Interventions where the Indicated Documents to Support Implementation and Scale-up Exists in Four Countries

**Some interventions are being advocated or have been accepted as policy but documents have not been updated to reflect this.

Definitions National policy/updated policies: Assuming that if intervention has been added to pre or in-service training, it is policy. Some interventions being addressed are being advocated, or have been accepted as policy but have not been formalized. Total number of eligible high-impact interventions (27 interventions * 4 countries=108).

Updated pre-service curriculum: Total number of eligible high-impact interventions for which pre-service training curricula have been updated to reflect correct practices. Assuming for this model that pre-service is applicable for all topics, so the total possible is 108.

Updated in-service curriculum: Assuming for this model that in-service is applicable for all topics.

Interventions being addressed: Total number of eligible high-impact interventions where the topic is being discussed at any level from advocacy to scale-up.

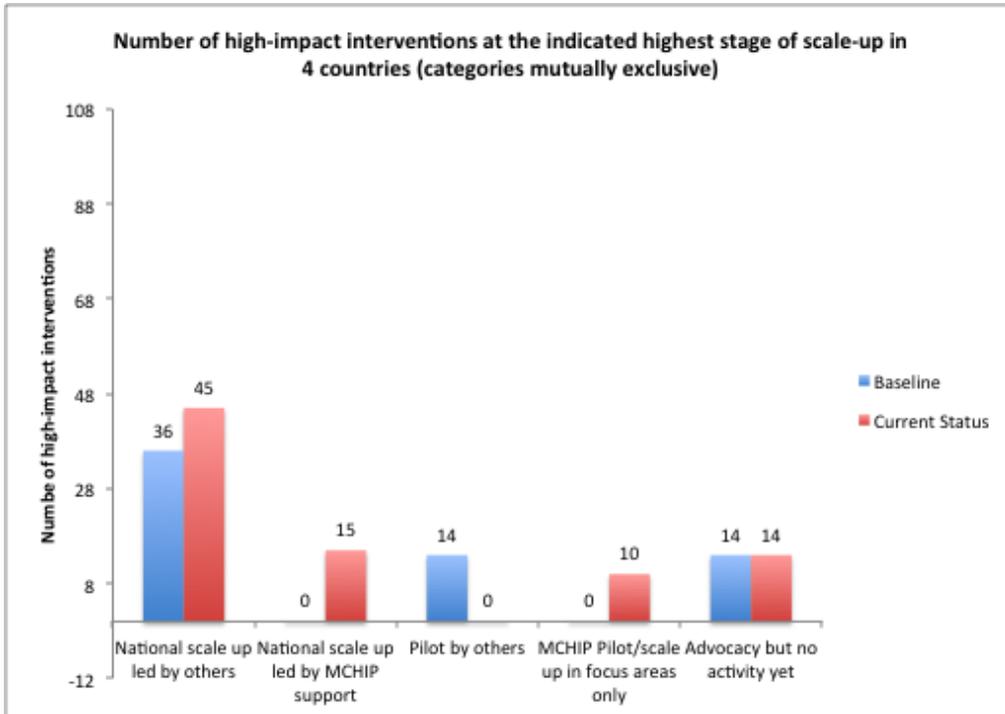


Figure D-2. Number of High-impact Interventions at the Indicated High Stage of Scale-up in Four Countries

National scale up led by others: MCHIP may be helping to scale up interventions, but they are not the leaders, they are implementing to contribute to national scale up.

National scale up led by MCHIP Support: MCHIP assistance (training; TA; etc.) is required for the scale up.

Pilot by others: Interventions at pilot stage when MCHIP first started.

MCHIP pilot/scale up in focus areas only: MCHIP is piloting/scaling up in focus areas but scale up is not taking place elsewhere in country.

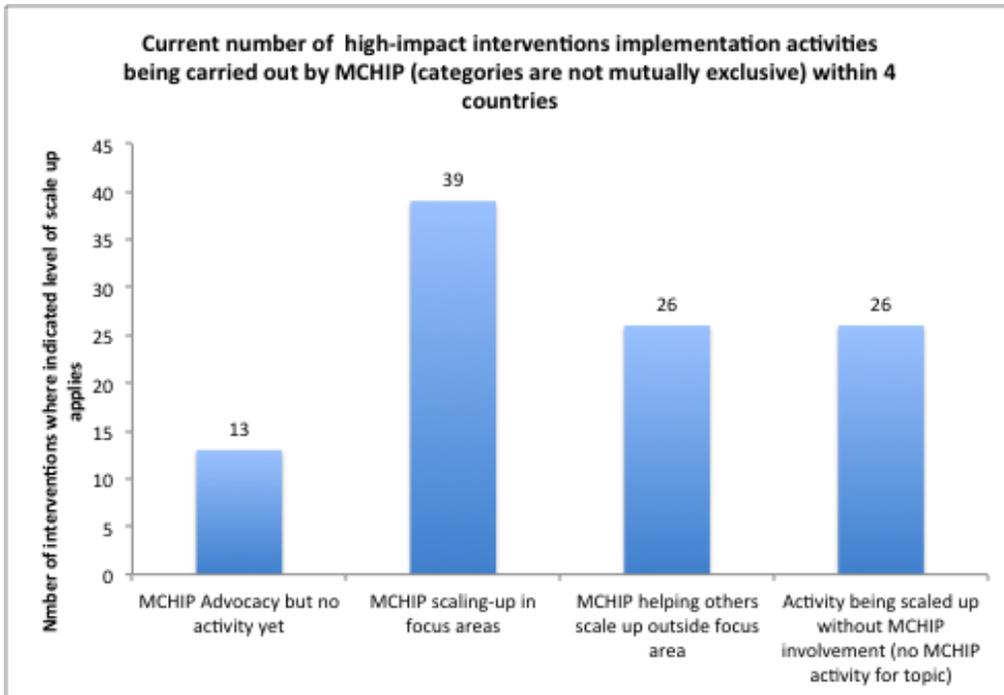


Figure D-3. Current Number of High-impact Interventions Implementation Activities being Carried Out by MCHIP

			Policy status-mark 'I' in column most reflective of status prior to MCHIP				Implementation status: Mark 'I' in each relevant column					Level of implementation									
			(1a)	(1b)	(1c)	(1d)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	
Topic		High Impact Intervention	Predessor project addressing this issue	Not being addressed	Stakeholders advocating for policy/pilot for evidence for advocacy	Accepted as national policy but policy/guideline documents not updated	National policy with update policy/guideline documents	integrated into preservice training curricula	Integrated into inservice training curricula	Pilot testing	Scale up nationally	Advocacy	MCHIP pilot/supported pilot	Scale up in MCHIP focus areas	Scaling up with MCHIP support to MOH/partners outside focus areas	Scaling up without MCHIP support to MOH/partners outside focus areas	New/ revised curriculum pre-service curriculum	New revised curriculum in-service curriculum	Piloting revised supervision tools/data collection for this intervention	New information included in national supervision/H MIS reporting forms	
Maternal	1	AMTSL-traction, oxytocin, massage	ACCESS			I		I	I	I						I					
	2	PPH	ACCESS			I		I	I	I						I					
	3	PE/E use of MgSo4	ACCESS			I		I	I	0	I					I		0	I		
	4	PE/E use of calcium		I				0	0			0									
	5	Post-abortion care	ACCESS			I		0	0	0	0					I	0	0	0	0	
	6	Community Misoprostyl		I				0	0			I	0	0	0	0	0	0	0	0	
	7	Malaria in Pregnancy (MIP):IPT and bednets	ACCESS			I		I	I	I						I					
HIV	8	PMTCT strategy for community follow up of HIV+ mother/baby (REDS; Pairs)		I				na	0	0	0	X		I			I	0	0	I	
	9	Integration PMTCT and ANC				I		0	0	I	I	X		X		I		0	0	I	
FP	10	PP IUD (with PNC)	ACCESS			I		0	0	I	0					I					

			Policy status-mark 'I' in column most reflective of status prior to MCHIP				Implementation status: Mark 'I' in each relevant column					Level of implementation									
			(1a)	(1b)	(1c)	(1d)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	
Topic			Predessor project addressing this issue	Not being addressed	Stakeholders advocating for policy/pilot for evidence for advocacy	Accepted as national policy but policy/guideline documents not updated	National policy with update policy/guidelines documents	integrated into preservice training curricula	Integrated into inservice training curricula	Pilot testing	Sale up nationally	Advocacy	MCHIP pilot/supported pilot	Scale up in MCHIP focus areas	Scaling up with MCHIP support to MOH/partners outside focus areas	Scaling up without MCHIP support to MOH/partners outside focus areas	New/ revised policy/guidelines	New/ revised curriculum pre-service curriculum	New revised curriculum in-service curriculum	Piloting revised supervision tools/data collection for this intervention	New information included in national supervision/H MIS reporting forms
	11	integration MCH other than PP IUD w/ PNC+C35		I						0	0	I	0	0	0	0	0	0	0	0	0
Newborn	12	Neonatal resuscitation	Moi University		I					I	0	0	0	I	0	0	I	0	0	0	0
	13	Community hand-washing for neonatal sepsis	MCHIP/U NILEVER	I						0	0	I	0	0	0	0	0	0	0	0	0
	14	Chlorhexidine on cord for NB sepsis		I						0	0	0									
	15	KMC (facility or community)			X	I				0	0	0	0								
	16	Other emergency NB Care (if applicable)	ACCESS	I												I					
Child	17	CCM malaria			I							I								I	
	18	CCM pneumonia		I						0	0	I									
	19	CCM diarrhea ORS + zinc		I						0	0	I									

			Policy status-mark 'I' in column most reflective of status prior to MCHIP				Implementation status: Mark 'I' in each relevant column					Level of implementation							(14)	(15)
			(1a)	(1b)	(1c)	(1d)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)		
Topic		Predessor project addressing this issue	Not being addressed	Stakeholders advocating for policy/pilot for evidence for advocacy	Accepted as national policy but policy/guideline documents not updated	National policy with update policy/guidelines documents	integrated into preservice training curricula	Integrated into inservice training curricula	Pilot testing	Sale up nationally	Advocacy	MCHIP pilot/supported pilot	Scale up in MCHIP focus areas	Scaling up with MCHIP support to MOH/partners outside focus areas	Scaling up without MCHIP support to MOH/partners outside focus areas	New/ revised policy/guidelines	New/ revised curriculum pre-service curriculum	New revised curriculum in-service curriculum	Piloting revised supervision tools/data collection for this intervention	New information included in national supervision/H MIS reporting forms
IYCF	20	IYCF as own issue	PATH-IYCN																	
		community support BF; Baby Friendly Community Initiative monitoring tool		X	I	0	0	0			I			I	I	0	I	I	0	
	21	Diarrea treatment ORS+zinc (national guideline for facility treatment)	Basics	X	I		0	0		X		x		I	I			I		I
	22	Facility ORT corner	UNICEF		I		I	0		I		x		I	I			0	I	0
	23	EPI strategy to reach dropouts (e.g., RED)	UNICEF				I	0	0		I		x		I	I		0	I	I
	24	Pneumococcal vaccine		I				0	0				x		I					
	25	Rotavirus vaccine		X	I		0	0			I									
Systems	26	Hospital SBM-R/QOC	ACCESS	X	I		0			I		0x			I				I	0
	27	Health Center Level SBM-R	ACCESS		I	0		0		I		0	I							

ANNEX E. ATTACHMENTS

Comments on global MCHIP project indicators

For the global program monitoring it seems that measuring progress in introducing and scaling up interventions, and in ensuring system support for sustainable activities are better reflections of whether the overall project has achieved its objectives (or sufficient progress to be considered as success). Reporting on numbers of people receiving specific services or interventions may help to monitor if a country program is making sufficient progress, but are less meaningful in the global context, where the numbers are out of context.

Following are comments on the current global project indicators and suggestions for the types of indicators that might better reflect whether the MCHIP Program has made sufficient progress toward its objectives.

When measuring scale-up and interventions at the country level, it is suggested that national level changes (e.g., introduction of the package of EmOC services) be counted, even if MCHIP is not specifically focusing on the interventions. For example, when MCHIP sponsors “best practices” or related types of meetings/workshops, or participates in global or national level working groups related to the interventions, others may be influenced to introduce or expand these interventions. A baseline should be estimated and any changes should be accepted as indicators of MCHIP influence, even if it is indirect.

The evaluation team is well aware that the program is already more than half completed, so introducing new ideas about program monitoring and evaluation may not be desirable. If MCHIP and USAID decide to review the indicators, however, the suggestions below (and their definitions) might provide some ideas for the final evaluation.

SUGGESTIONS ON INDICATORS FOR GLOBAL MCHIP MONITORING AND EVALUATION			
#	TOPIC	INDICATOR FROM PMP APRIL 2011	COMMENTS
1	Impact/ coverage	Number o MCHIP countries demonstrating reductions in maternal mortality since the last survey.	Survey every 3-5 years, as per PMP. Good
2		Number of MCHIP countries demonstrating reductions in newborn and under-five mortality	Survey every 2-5 years, as per PMP. Good
3		Estimated number of lives saved among children under five in USID MNCH countries as a result of MCHIP-supported interventions, including CSHGP and MCP supported grants in these countries.	LiST tool as per PMP every 2-5 years. Good. Suggest deleting the “as a result of MCHIP-supported interventions...” and rather consider all changes as relevant to MCHIP support, since a large part of MCHIP work is advocacy for others to scale-up or introduce
8	MAT	% women 4x ANC any provider	These indicators are in the PMP and rely on survey methods every 2-5 years for measurements.
9		% IPT	
16		% women iron/folate during pregnancy	
10		% SBA (nationally)	
17		% SBA in USG assisted programs	
			Suggest: All programs that have a focused working area should be reporting on the number of births by skilled birth attendants. Rationale: Percentages only make sense in the survey (as per PMP) however, tracking numbers should be carried out even if the intervention is not specific to SBA (e.g., if intervention is community mobilization to increase use of SBA or is HBB—both interventions should be motivational for use of SBA services)
11		% live births delivered by C-section	Survey every 2-5 years, as per PMP. Good
			Suggest all programs with a focused working area should be reporting on number of C-sections in relation to number of births by skilled birth attendants. This may require advocating that a referring facility follow-up on outcome of referral.
10		% SBA who know how to manage PE/E	Exclude for Global indicator. Keep if needed for other reason.
18		# women receiving AMTSL through USG supported programs	Exclude for Global indicator. Keep if needed for other reason (IIP/OP indicator).
19		% women uterotonic immediately PP	Exclude for Global indicator. Keep if needed for other reason.

SUGGESTIONS ON INDICATORS FOR GLOBAL MCHIP MONITORING AND EVALUATION			
#	TOPIC	INDICATOR FROM PMP APRIL 2011	COMMENTS
21	NEWBORN	% babies not breathing/crying success resuscitated	Exclude for Global indicator. Keep if needed for other reason.
		ENC: clean cord; thermal; dry and wrap	Exclude for Global indicator. MCHIP indicates this indicator is being dropped
12		% NB put to breast within 1 hour of birth	Survey every 2-5 years, as per PMP. Good
14	PNC	% babies born outside facility with PN visit within 2 days of birth	Survey every 2-5 years, as per PMP. Good
22		# PP/NB visits within 2 days of birth in USG support	Exclude for Global indicator. Keep if needed for other reason.
13		% mothers receive PNC within 2 days of childbirth	Survey every 2-5 years, as per PMP. Good
15	FP	% mothers with <24m using FP	Survey every 2-5 years, as per PMP. Good
16		# clients attending MNCH services with integrated FP at MCHIP supported facilities who receive FP counseling	Exclude for Global indicator. Keep if needed for other reason.
20		# NB receive antibiotic tx for infection from appropriate HW through USG programs	Exclude for Global indicator. Keep if needed for other reason (IIP/OP indicator).
4	EPI	% 12-23m DPTx3	Survey every 2-5 years, as per PMP. Good
23		# <12m receive DPT3 (USG)	Exclude for Global indicator. Keep if needed for other reason (IIP/OP indicator).
5	CHILD	% 0-59 w/ diarrhea receive ORT + continued feeding	Survey every 2-5 years, as per PMP. Good
24		# cases diarrhea treated (USG)	Exclude for Global indicator. Keep if needed for other reason (IIP/OP indicator).
15		# countries with strategies to revitalize ORT	Exclude for Global indicator. Keep if needed for other reason.
6		% 0-59 pneumonia taken to appropriate provider	Survey every 2-5 years, as per PMP. Good
7		% 0-59 w/ pneumonia receive antibiotics	Survey every 2-5 years, as per PMP. Good
25		# cases pneumonia treated with antibiotics (USG)	Exclude for Global indicator. Keep if needed for other reason.

SUGGESTIONS ON INDICATORS FOR GLOBAL MCHIP MONITORING AND EVALUATION			
#	TOPIC	INDICATOR FROM PMP APRIL 2011	COMMENTS
17	HSS	# national policies drafted with USG support	Suggest: Where feasible, rather than counting each different policy that is affected, group policies that, together, reflect a set of agreed practices to achieve an objective. EmOC, ENC, CCM are three strategies that encompass a number of different, individual practices that together should achieve an objective (e.g., EmOC: the country has accepted the key interventions to reduce mortality directly related to delivery. For example, # countries with national policies and/or updated pre and in-service curricula (depending on what is relevant. Assume if in curricula it is policy) that include Key EmOC practices of 1) AMTSL; MgSo4 for eclampsia; neonatal resuscitation with suction; (Uncertain if managing PPH with misoprostyl belongs here or not).
18		# MCHIP countries innovative health financing w/ MCHIP support	Suggest: Broaden this to health finance or incentives mechanisms either related to provider or client practices? This would not include the recognition part of SBM unless it is something innovative. It could include the mother-baby packs; P4P; etc.
9		# people trained through USG supported programs	Must keep
11		# countries pre-service strengthened to improve SBA	GOOD
	HIS		Suggest: # countries piloting new maternity or postpartum program/quality of care indicators
			Suggest: # countries accepting any new maternity or postpartum program/quality of care indicators for national collection and routine reporting
			Suggest: # countries piloting new CCM indicators
			Suggest: # countries accepting any new CCM indicators for national collection and routine reporting
	Scale-up		Suggest: # countries where key EmOC practices (define a package such as AMTSL, misoprostyl, <u>and</u> MgSo4) are accepted practices (by policy or incorporation into training curriculum) for all facilities below District Hospital level conducting deliveries, and in-service training/refresher training is being rolled out (by MOH or by NGO partners—with or without MCHIP support). Note: Possibly define roll out as having occurred in at least x districts.

SUGGESTIONS ON INDICATORS FOR GLOBAL MCHIP MONITORING AND EVALUATION			
#	TOPIC	INDICATOR FROM PMP APRIL 2011	COMMENTS
			Suggest: # countries where CCM for all 3 relevant treatments have been included in national policies and/or updated in-service curricula for persons responsible for supervising CCM providers
			Suggest: # Districts where has CCM been introduced (for catchment area of at least 20% of facilities?)
			Suggest: # districts where key EmOC practices have been introduced (in at least 20% of facilities?)
12		# MCHIP supported facilities demonstrating increased compliance with clinical standards over baseline	Exclude for Global indicator. Keep if MCHIP needs for monitoring countries
			Suggest: % of hospitals (district or higher level) where SBM-R has been introduced
			Suggest: # districts where SBM-R has been introduced for facilities below district hospital level
			Suggest: Within districts where SBM-R has been introduced for facilities below Hospital level, # and % of facilities
13		# countries with introduction of high impact MNCH interventions through MCHIP supported activities and CSHGP grants in MCHIP supported countries	GOOD
14		# countries with expanded hi impact MNCH interventions	GOOD
	LEARNING		Suggest: Number of regional workshops/training meetings that focus on sharing best practices in implementation of high-impact interventions
			Suggest: Number of cross-country study tours that focus on sharing best practices in implementation of high-impact interventions
			Suggest: Number of documents shared (publication; monograph on website) that provide information on implementation strategies, problems encountered, and how these were overcome (or strategies that did not work) for adding to knowledge on “best practices in implementation”

SUGGESTIONS ON INDICATORS FOR GLOBAL MCHIP MONITORING AND EVALUATION			
#	TOPIC	INDICATOR FROM PMP APRIL 2011	COMMENTS
			Suggest: Number of documents of the type mentioned above, that bring together information from several countries to add to the strength of the lessons learned.

For more information, please visit:
<http://resources.ghitechproject.net>

Global Health Technical Assistance Project

1250 Eye St., NW, Suite 1100

Washington, DC 20005

Tel: (202) 521-1900

Fax: (202) 521-1901

www.ghtechproject.com