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MCHIP Maternal and Child Health Integrated Program

MCHIP YEAR THREE ANNUAL REPORT

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Abbreviations and Acronyms

AAP	American Association of Pediatrics
ACCESS	Access to Clinical and Community Maternal, Neonatal and Women's Health Services Program
AEFI	Adverse Events Following Immunization
AFR/SD	USAID Africa Bureau, Office of Sustainable Development
AFRO	WHO Africa Regional Office
AIDS	Acquired Immune Deficiency Syndrome
AMTSL	Active management of the third stage of labor
ANC	Antenatal care
ANMTC	Auxiliary Nurse Midwife Training Center
ARI	Acute respiratory infection
BASICS	Basic Support for Institutionalizing Child Survival
BCC	Behavior change communication
BEmONC	Basic emergency obstetric and newborn care
CA	Community agent
CAG	Community action group
CBDA	Community-Based Distribution Agent
CBMNH	Community-based maternal and newborn health
CCM	Community case management
CDC	U.S. Centers for Disease Control and Prevention
CECAP	Cervical Cancer Prevention Program
CHW	Community health worker
CKMC	Community Kangaroo Mother Care
CM	Community mobilization
cMYP	Comprehensive Multi Year Plan
CPR	Contraceptive prevalence rate
CSHGP	Child Survival and Health Grants Program
CSO	Civil society organization
CYP	Couple Years Protection
DCTC	Divisional Clinical Training Center
DRC	Democratic Republic of the Congo
ECSACON	East Central and Southern Africa College of Nursing
EMA	Ethiopian Midwifery Association
EmONC	Emergency obstetric and newborn care
EMRO	WHO Eastern Mediterranean Regional Office
ENA	Essential Nutrition Action
ENC	Essential newborn care
EPI	Expanded Program on Immunization
FMOH	Federal Ministry of Health

FP	Family planning
FWA	Family Welfare Assistant
FWC	Family Welfare Clinic
FWV	Family Welfare Visitor
GAIA	Global AIDS Interfaith Alliance
GAVI	GAVI Alliance (formerly the Global Alliance for Vaccines and Immunization)
GDA	Global Development Alliance
GHI	Global Health Initiative
HA	Health Assistant
HBB	Helping Babies Breathe
HEW	Health Extension Worker
HIDN	Health Infectious Disease and Nutrition
HIV	Human Immunodeficiency Virus
HSA	Health Surveillance Assistant
HSMB	Hospital Services Management Board
HSS	Health systems strengthening
HWWS	Handwashing with soap
iCCM	Integrated community case management
ICM	International Confederation of Midwives
IEC	Information, education and communication
IIP	Institute of International Programs
IMNCI	Integrated Management of Neonatal and Childhood Illness
INC	India Nursing Council
IP	Infection prevention
IPC	Infection prevention and control
IPTp	Intermittent preventive treatment during pregnancy
ISEqH	International Society of Equity in Health
IYCF	Infant and Young Child Feeding
IYCN	Infant Young Child Nutrition
JHU	Johns Hopkins University
JSI	John Snow, Inc.
KAPP	Kenya Action Plan for Pneumonia
KMC	Kangaroo Mother Care
L&D	Labor and delivery
LAC	Latin America and the Caribbean
LAM	Lactational Amenorrhea Method
LiST	Lives Saved Tool
LLIN	Long lasting insecticide-treated nets
LRP	Learning resource package
LSHTM	London School of Tropical Medicine

M&E	Monitoring and evaluation
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
MCTS	Mother and Child Tracking System
MDG	Millennium Development Goal
MIP	Malaria in pregnancy
MIYCN	Maternal, infant and young child nutrition
MMC	Medical male circumcision
MMI	Model Maternities Initiative
MNC	Maternal and newborn care
MNCH	Maternal, newborn and child health
MNH	Maternal and newborn health
MOH	Ministry of Health
MOHFW	Ministry of Health and Family Welfare
MOHSW	Ministry of Health and Social Welfare
MOPHS	Ministry of Public Health and Sanitation
NGO	Nongovernmental organization
NNC	National Nodal Center
NRHM	National Rural Health Mission
NSSK	Navjaat Shishu Suraksha Yojna
NUVI	New and Under-Utilized Vaccines Implementation
OiU	Oxytocin in Uniject
ORS	Oral rehydration salts
ORT	Oral rehydration therapy
PAC	Postabortion care
PATH	Program for Appropriate Technology in Health
PE/E	Pre-eclampsia/eclampsia
PHC	Primary health care
PIP	Program implementation plan
PMI	U.S. President's Malaria Initiative
PMTCT	Prevention of mother-to-child transmission of HIV
PPFP	Postpartum family planning
PPH	Postpartum hemorrhage
PPIUCD	Postpartum intrauterine contraceptive device
PPIUD	Postpartum intrauterine device
PQI	Performance and quality improvement
PSE	Pre-service education

PSI	Population Services International
PVO	Private voluntary organization
QoC	Quality of care
RAB	Rwanda Agriculture Board
RCQHC	Regional Center for Quality Health Care at Makerere University
RDT	Rapid diagnostic testing
RED	Reach Every District
RH	Reproductive health
RI	Routine Immunization
RISE	Results Information System for Excellence
SBA	Skilled birth attendant
SBM-R	Standards-Based Management and Recognition
SC	Save the Children
SIFPSA	State Innovations in Family Planning Services Agency
SMOH	State Ministry of Health
SNL	Saving Newborn Lives
SPHCDA	State Primary Health Care Development Agency
STI	Sexually transmitted infection
TA	Technical assistance
TAG	Technical advisory group
TBA	Traditional birth attendant
TEN	Track Every Newborn
TIMS	Training Information Monitoring System
TOR	Terms of Reference
TOT	Training of trainers
TWG	Technical working group
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VIA	Visual inspection of the cervix with acetic acid
VMMC	Voluntary Medical Male Circumcision
VPD	Vaccine-preventable diseases
WASH	Water, Sanitation, and Hygiene
WHO	World Health Organization
WHO/AFRO	World Health Organization/Regional Office for Africa
WRA	White Ribbon Alliance

Introduction and Summary of Major Achievements

The Maternal and Child Health Integrated Program (MCHIP),[1] funded by the U.S. Agency for International Development (USAID), contributes to reductions in maternal, newborn and child mortality through increased coverage of key, high-impact interventions. MCHIP's global leadership role and mandate, the strong working relationships and dissemination channels established with regional partners and, perhaps most importantly, the direct reach to over 35 country programs worldwide allow MCHIP to not only influence policies that support improved health outcomes, but also to support countries in achieving their goals and stimulate discussion and support across countries. MCHIP is uniquely positioned to contribute to achieving the Millennium Development Goals (MDGs)—Goals 4 and 5 in particular. MCHIP's country reach also allows its contributions at the regional and global levels to be grounded in current field realities and provides a strong platform for multi-directional program learning.

During Program Year 3, MCHIP's work spanned all of the Global Health Initiative (GHI) Plus Countries,[2] as well as the majority of USAID's priority MCH countries. MCHIP contributed to work in these countries through direct technical assistance, and country and regional level programming. As described in this report, MCHIP's reach goes beyond these countries through a variety of means including convening communities of practice and organizing key meetings and conferences, creating opportunities for policymakers, researchers and program planners to come together to review the latest evidence, share program experience and discuss how implementation challenges could be or have been overcome.

To date, MCHIP has received $40 million in total core/Bureau obligations and $81.6 million in field obligations for Program Years 1 through 3 (see **Annex A** for a financial summary). Since it began in October 2008, the proportion of field funding to core funding has grown tremendously. This field funding represents support to 27 countries—an increase of 23% from the previous program year.

As the number of MCHIP country programs increased in Year 3, there was also a broadening of program content and greater integration of activities in most countries. Several large integrated country programs got underway early in the year in Zimbabwe, Ethiopia, Rwanda and Mali, contributing to MCHIP's extremely rapid growth. MCHIP also welcomed the ACCESS-FP programs in India, Guinea and Bangladesh. In Bangladesh, the Health Fertility Study was added to MCHIP's ongoing maternal and newborn program. In India, ACCESS-FP's postpartum family planning activities were merged with ongoing MCHIP pre-service education, newborn and immunization activities, and expanded to a third USAID focus state. In Guinea, the situation was reversed, with the USAID/Guinea mission requesting that MCHIP add newborn, child health and malaria interventions to an earlier ACCESS-FP platform.

Another factor in the growth of MCHIP's country programs was the rapid expansion of its immunization portfolio. During the second half of the year, USAID launched a new initiative to support the introduction of new and underused vaccines in up to 10 countries through MCHIP. In addition to expanded work in Kenya, Zimbabwe, DRC and elsewhere, this initiative spurred planning for new immunization activities in Tanzania, Malawi and Senegal. MCHIP also started work under the Millennium Challenge Corporation (MCC) threshold grant to improve immunization coverage in Timor Leste in Year 3, and the Central Asia program in Kyrgyzstan and Tajikistan, which is focusing on coverage improvement and polio eradication, also got underway.

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

In other technical areas, earlier work in South Sudan was expanded to include family planning support late in the year, and the team began planning for an exciting new program in Egypt that will begin in Year 4.

Only two country programs closed during the year: MCHIP's PEPFAR-funded activities in South Africa came to a close and its MNCH activities in DRC were transitioned to a new USAID bilateral project in July.

The mid-term evaluation of MCHIP, conducted in April–May 2011, highlighted the value country mission programs place on MCHIP's ability to effectively support national Ministries of Health (MOHs), the quality and effectiveness of MCHIP personnel and the program's contributions to health systems strengthening. The evaluation further affirms the value of a central project with the technical breadth of MCHIP to meet the needs of USAID missions and highlighted MCHIP's work in reinforcing and operationalizing the GHI's as well as USAID's Best Action Plans.[3].

The main section of this report presents MCHIP program results and activities, organized by the USAID Health Infectious Disease and Nutrition (HIDN) Results Pathways and other technical areas, from October 1, 2010 to September 30, 2011. Annexes provide additional information on program finances (Annex A); AFR/SD (Annex B) and Latin America and Caribbean Bureau (LAC) results (Annex C), scale-up of key maternal and newborn health (MNH) interventions (Annex D); success stories (Annex E); communication events held throughout the year (Annex F); and the revised global MCHIP monitoring and evaluation (M&E) framework with results data for Year 3 (Annex G).

GLOBAL LEADERSHIP

This year, MCHIP has contributed both to *articulating principles* for appropriate *service delivery integration* and to further development and dissemination of *specific guidance* on integration. One example, is taking better advantage of contacts over the first weeks and months postpartum to link immunization, nutrition and family planning (FP) counseling and service delivery. We have been helping to ensure a less compartmentalized approach to MNH work, for example, developing guidance on labor and delivery care practices that reduce the risk of neonatal asphyxia. The "Africa Regional Meeting on Interventions for Impact in Essential Obstetric and Newborn Care," convened in Addis Ababa from February 21–25, 2011, also helped in breaking down such compartmentalization, bringing together MNH program managers from 36 countries, exposing them to current best practices in MNH and working together on formulating country plans.

A central focus for MCHIP is that we effectively contribute to lasting impact *at scale*. Achieving and sustaining implementation of effective programs and services at full national scale is clearly a big challenge. MCHIP is fortunate to have strong field staff who know their country contexts well and have a good sense of what it takes to move services forward and establish durable gains within their health systems. During Year 3, MCHIP headquarters developed a tool to assist in country-level planning, management and monitoring of scale-up efforts—with both project staff and in collaboration with host country MOHs and other key partners. These "scale-up maps" also played a very useful role for MCHIP headquarters this year in allowing us to characterize scale-up efforts and status across countries where MCHIP is working, with regard to postpartum hemorrhage (PPH) and pre-eclampsia/eclampsia (PE/E) best practices.

[3] MCHIP Mid Term Evaluation Report – page ix

The scale-up maps (and other closely related frameworks) have now been used in MCHIP across a range of technical areas. This tool has also been shared with other USAID implementers.

When used descriptively, i.e., for monitoring, scale-up maps are a characterization of a process, where certain strategic tasks have already been adequately addressed and where others remain to be seriously engaged in the future. However, even programs or services that have been "fully scaled up" may not be achieving real population impact. For that to be achieved, the right technical interventions or household practices have to be taken up at high, effective coverage. And effective coverage is itself a function not just of having reached beneficiaries, but also of having delivered key interventions, with appropriate quality.

During Year 3, in its global and country-level work, MCHIP has given serious attention to supporting improvement in service *quality*. MCHIP has collaborated with the Health Care Improvement Project (HCIP) in documenting and reviewing the range of quality improvement approaches used across USAID-funded projects, and elaborated recommendations on how best to support such work in the future. MCHIP has also developed an inventory of quality improvement work in MCHIP countries. We will continue not only to support quality improvement efforts, notably, using Standards-Based Management and Recognition (SBM-R), but also to critically assess quality improvement efforts with regard to effectiveness, scalability and sustainability.

Measurement of content and quality of care (QoC) has been an important priority for the project during Year 3. We have implemented additional maternal and newborn QoC facility assessments and have disseminated results at country and regional levels. These surveys mark a step forward from earlier service delivery assessment approaches, in that they include actual observations and cover a broader technical range than the earlier PPH surveys. The observation component has been particularly useful with regard to routine labor and delivery (L&D) care. The surveys have also included observations of management of complications; however, because of the small number of cases observed, results from this component are necessarily more impressionistic. Not surprisingly, the surveys have demonstrated important performance gaps, and have pointed not only to *skill deficits,* but also to important *systems factors* that will need to be addressed to improve QoC. Conducting such surveys can provide a powerful impetus to key stakeholders in country to take more concerted action to improve quality. However, implementing such a survey is necessarily complex, challenging and costly. It should be understood that they provide a snapshot of the state of MCH services at a single point in time, not as a solution to the need for monitoring service delivery content and quality.

MCHIP has been addressing the need for more adequate *monitoring*, working together with counterparts from the World Health Organization (WHO) and other key maternal health measurement experts, to elaborate a small set of new indicators for routine monitoring of maternal health service quality to be recommended to MOHs. In Year 3, with the main initiative coming from MCHIP, a face-to-face meeting was held in Geneva and working groups have been collaborating remotely to further develop this guidance. We are hopeful that definitive new WHO guidance in this area will be released in the first half of Year 4. MCHIP was further very active in working with global partners to identify and promote routine indicators for monitoring community case management (CCM) and newborn resuscitation, contributing to the development of the Helping Babies Breather (HBB) Implementation Guide's M&E section.

In addition to its work supporting improved quality and coverage of health facility-based services, MCHIP's efforts in Year 3 have included an important focus on *household* and *community* levels. Across virtually all of MCHIP's technical areas, there have been community elements and, in some cases (e.g., CCM), the community component has been the most

important aspect of our efforts. Our work has included better characterization of community health systems (by CORE group) and key performance factors for successful service delivery through community health workers (CHWs). This work continues, with close collaboration with other USAID implementers and other global partners involved in work with CHWs. MCHIP has been providing global-level technical leadership in CCM, particularly with regard to key issues to be taken into account in ensuring sound implementation. MCHIP has continued to promote and support—at global, regional and country levels—community-based service delivery approaches for MNH, including new misoprostol pilots and incorporation of early postnatal home visits into the work of CHWs.

MCHIP has elaborated equity guidance over the past year, with the key audience including Child Survival and Health Grants Program (CSHGP) grantees and MCHIP field programs. We have also engaged global-level thought leaders in health equity, contributing to moving the substantive discussion in this area forward.

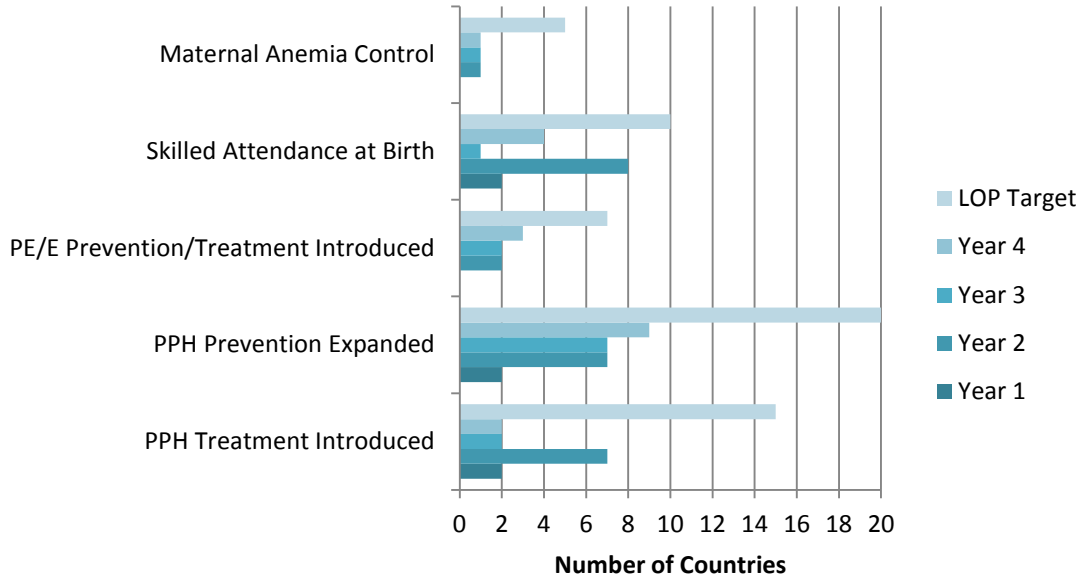
Having crossed the midpoint of this five-year award, as noted by the external evaluation, MCHIP has been accumulating considerable program experience and insights into sound implementation practice. Recognizing this, from Year 3, we have been devoting more attention to program learning. For example, this year there was multi-country documentation of several areas of our work, including CCM and malaria in pregnancy. Over the second half of the year, project leadership both at headquarters and the field began to more systematically review and reflect on the range of our work, seeking to identify issues of particular interest that could warrant more rigorous documentation, to bring insights and learning to the broader global health community. These efforts will be carried forward into Year 4 as a major area of focus.

Detailed Year 3 Achievements by Results Pathways and Program Areas

MATERNAL HEALTH OVERVIEW

In Year 3, MCHIP built on the platforms established in Years 1 and 2 to direct attention toward the two major killers of women during pregnancy, PPH and PE/E, while also focusing efforts on skilled birth attendants (SBAs), maternal anemia, malaria in pregnancy, QoC and health systems strengthening (HSS) for maternal health. Key interventions included: strengthening PSE systems; improving the quality of maternal health services through facility-based quality improvement approaches, such as Standards-Based Management and Recognition (SBM-R) (in countries as diverse as Ethiopia, Mozambique, Zimbabwe, India, Indonesia, Bolivia and Paraguay) and competency-based clinical training in almost all the countries where MCHIP is working; and creating demand for services through community outreach, especially in Bangladesh, Bolivia, Ethiopia, Rwanda, Liberia, Mozambique and Guinea. At the country level, MCHIP advocated for strengthening antenatal care (ANC) and labor and delivery programs including use of oxytocin and/or misoprostol for the prevention of PPH and use of magnesium sulfate for PE/E management. Progress made in high-impact maternal health interventions is illustrated in Figure 1.

Figure 1. Progress for High Impact Maternal Health Interventions



As reflected in the MCHIP mid-term evaluation, MCHIP is well recognized in maternal health. MCHIP continues to be seen by global partners, such as WHO and UNFPA, as a technical and programmatic leader in PSE and PPH and PE/E prevention and management. MCHIP support helped set the stage for the adoption of a sustainable national PPH prevention strategy in Madagascar; the development of strategies for PPH prevention in Rwanda, Liberia, Guinea and South Sudan; and the expansion of community-based distribution of misoprostol in Bangladesh through the MaMoni program. The "Africa Regional Meeting on Interventions for Impact in Essential Obstetric and Newborn Care" was a resounding success with more than 300 participants representing 36 countries, discussing prevention and management of PPH, PE/E and newborn asphyxia. This meeting brought together researchers, professionals and policy and program managers to discuss scale-up of key interventions. Numerous country programs have

been stimulated to focus more specifically on maternal health, including South Sudan, Zambia, Liberia, Guinea and Kenya. A multi-country analysis of PPH and PE/E programs was completed and presented at the meeting, which will be used to inform existing and new projects. This analysis—and the scale-up maps used as a tool for program analysis and expansion—has been seen as a useful foundation for monitoring of country program expansion over time. The use of the scale-up maps has helped countries, such as Nigeria and Angola, bring together multiple partners in maternal health around a unified vision for maternal health program strengthening and has driven a more focused agenda. It will be re-applied during Program Years 4 and 5 as a way to mark progress in scaling up lifesaving interventions.

MCHIP made great strides in strengthening PSE through the development and launch of a PSE toolkit and the development of the *State of the World's Midwifery Report*. This toolkit has been viewed by more than 9,335 people in 153 countries and has been requested as a tool for program expansion in Bangladesh, Ghana, Afghanistan and South Sudan. By developing such tools, MCHIP as a global program is seen as a technical resource for partners and governments as they address challenges in human resources for maternal, newborn and reproductive health. MCHIP is working to enhance midwifery and/or nursing education in Ethiopia, Ghana, India, Lesotho and Malawi. MCHIP also developed a variety of guides and provided training to support efforts in MNCH, again, serving as a resource for program efforts in the field in Bolivia, Ethiopia, India, Madagascar, Mozambique and Rwanda.

Prevention and Treatment of Postpartum Hemorrhage

(Note: All results under the Skilled Care at Delivery pathway also contribute to the PPH results pathway.)

Core Funded

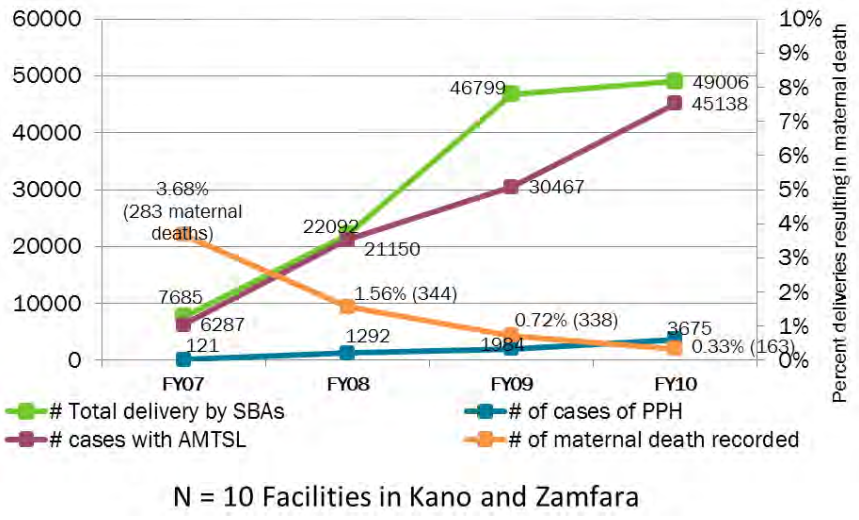
- Ethiopia hosted the MCHIP "Africa Regional Meeting on Interventions for Impact in Essential Obstetric and Newborn Care" in Addis Ababa from February 21–25, 2011. It focused on prevention and management of PPH, pre-eclampsia and newborn asphyxia. The meeting was co-sponsored by the Gates-funded Oxytocin Initiative. More than 300 colleagues/partners received updates on key MNH interventions. As a direct result of this meeting, several MCHIP country programs in Africa initiated activities for implementation of PPH reduction programs.
- The PPH toolkit was finalized, which will assist country programs, donors and governments to develop comprehensive and innovative programs to address hemorrhage, the leading cause of maternal mortality worldwide. This program guidance outlines key steps, identifies available resources and highlights lessons learned from current projects. It will be launched in November 2011 after the PPH taskforce meets in October.

Field Funded

MCHIP is working in 16 countries on prevention and treatment of PPH. Highlights include:

- In **Nigeria**, MCHIP continued to support the strengthening of essential and emergency obstetric and newborn care services at facilities in the three northern states of Kano, Zamfara and Katsina. Figure 2 below shows the percentage of women with vaginal births who received active management of the third stage of labor (AMTSL) at MCHIP-supported facilities (n=27) as well as decreasing maternal case fatality rates. Facilities supported by MCHIP have been able to maintain high coverage of AMTSL since support began under the Access to Clinical and Community Maternal, Neonatal and Women's Health Services (ACCESS) Program (over 90% of vaginal births over the year).

Figure 2. PPH and Use of AMSTL Compared with Maternal Deaths and Deliveries for 10 Hospitals in Nigeria (2007–2010)



- In **Madagascar**, as a result of extensive advocacy efforts, MCHIP helped set the stage for the adoption of a sustainable national PPH prevention strategy through increased uterotonic coverage. MCHIP obtained approval from the Ministry of Health (MOH) to move forward with an introductory PPH prevention program to increase the use of uterotonics at facility and home births. This project will emphasize training of providers in AMTSL using oxytocin as well as misoprostol for prevention of PPH. Its goal is to demonstrate that misoprostol is a viable alternative for PPH prevention when oxytocin is not available at health facilities, and will also test the program effectiveness of distributing misoprostol to women for use at home birth when they are not able to access care at a facility. The project findings will be used to inform scale-up plans.

Midwife Elysabeth Boilette practices aortic compression to stop excessive bleeding after childbirth. She was a participant this past June in MCHIP's Maternal and Neonatal Training in Toliara, in South Western Madagascar. *Photo Taken by Jean Pierre Rakotovao, MCHIP—Madagascar Chief of Party*

- The MaMoni program in **Bangladesh** , an associate award to MCHIP, is distributing misoprostol at the facility and community levels to scale up prevention of postpartum hemorrhage (PPH) for women delivering at home. MaMoni began community-based distribution of misoprostol in all seven upazilas of Sylhet through the Ministry of Health and Family Welfare (MOHFW) and in two upazilas of Habiganj through MaMoni community health workers (CHWs) with technical support and in partnership with EngenderHealth and Venture Strategies Innovations. Distribution in Sylhet started on a pilot basis in two upazilas initially in May 2010 and was expanded to all Upazilas by the month of October 2010. Scale up of this intervention started in Habiganj since February 2011. It is preferred that all third trimester women receive misoprostol from Family Welfare Visitors (FWVs) at Family Welfare Clinics (FWCs) or at satellite clinics during ANC visits. For mothers who do not attend ANC, misoprostol is also made available at community clinics through Health Assistants (HAs). Lastly, for those pregnant women who do not receive misoprostol at the clinic level, Family Welfare Assistants (FWAs) provide misoprostol to women during home visits. During the year, Misoprostol was distributed to 17,720 mothers, among whom 14,522 delivered. 12,280 (85%) mothers consumed misoprostol immediately after delivery and 10,688 (87%) out of those who consumed misoprostol

returned the used catchment covers. FWAs or MaMoni CHWs follow up on usage during postnatal care visits and collect unused misoprostol.

- In **Indonesia**, MCHIP provides inputs to ensure that all midwives in the MCHIP subdistricts are competent in AMTSL. A baseline assessment of AMTSL competency was conducted in the MCHIP target subdistricts to identify the percentage of village midwives competent in AMTSL. The participants included 329 midwives from MCHIP and non-MCHIP districts—midwives who had received basic emergency obstetric and newborn care (BEmONC) training that includes AMTSL as well as those who had not. The results indicated that 40% of village midwives could correctly perform AMTSL in Bireuen, 5% in Kutai Timur and 52% in Serang. As a follow-on, MCHIP is conducting on-the-job training for these midwives on AMTSL, which will be followed by another assessment in the next six months. As other factors such as limited cases may have led to low scores, MCHIP is also working with communities to increase demand for services.

Eclampsia

(Note: All results under the Skilled Care at Delivery results pathway also contribute to the Eclampsia results pathway.)

Core Funded

- MCHIP completed a multi-country review of the progress of PPH and PE/E programs. (also contributing to the PPH results pathway.)The purpose of this analysis was to document progress in national scale-up of PPH and PE/E reduction programs in all MCHIP and MCHIP-affiliated programs around the world. This database will inform existing and new projects and will be useful as a reference for USAID and partners as they address global issues and improve country programs. The multi-country analysis on PPH and PE/E was presented at USAID, the CORE Group meeting and other forums, and was posted on the MCHIP Web site. It was also disseminated to countries, and the country programs were oriented on the best use of the document. The information was used to inform MCHIP core workplanning for Year 4, and discussions have been held with each MCHIP country program to advise them on how to use the information from the matrix in their field workplanning. Technical assistance is also being provided for PE/E programming in Bangladesh, Ethiopia, India and Kenya.
- MCHIP developed a PE/E toolkit with currently existing materials. This program guidance outlines key steps, identifies available resources and highlights lessons learned to help donors, partners and governments to develop comprehensive and innovative programs to address PE/E. This was disseminated at the Africa Regional meeting in Ethiopia in February 2011 in both electronic and print formats. The resources will be uploaded to the K4H Web site. Additional materials are being collected for online toolkit updates semi-annually, and a launch will be held in MCHIP Year 4.
- MCHIP finalized the Ethiopia, Kenya and Tanzania maternal and newborn complications QoC survey reports and disseminated the study findings. MCHIP/Kenya disseminated the findings to the national, provincial and APHIA*plus* teams. Each Provincial Health Management Team is involving partners and other stakeholders to disseminate findings and implement action plans developed. In Ethiopia, a small dissemination meeting was held with the MOH. Tanzania disseminated their report at a national meeting on ANC, organized by the MOH. Findings were used in Ethiopia to design the MCHIP workplan. Other quality of care studies were funded with field support funds, including Madagascar, Rwanda and Mozambique. Planning for the Zimbabwe QoC study also began in FY11 and a small amount of core funds were used for technical assistance.

- At the MCHIP "Africa Regional Meeting on Interventions for Impact in Essential Obstetric and Newborn Care" in Addis Ababa in February, all the PPH and PE/E Task forces met to develop annual action plans, with some task forces more active than others during the year. The Standards, Training and Quality Assurance PE/E task force produced a draft learning resource package entitled, "Prevention, Identification, and Management of Pre-eclampsia/Eclampsia" that will be pretested in Year 4.

Field Funded

- In **Madagascar**, MCHIP completed the QoC facility survey and presented the labor and delivery observational results to the MOH. MCHIP has further sensitized key MNH stakeholders on the importance of assessing QoC, in addition to the accessibility of health services. MCHIP plans to consolidate efforts to improve QoC through dissemination of final results in a "working meeting," where local stakeholders at different levels will determine how to address the identified gaps in health care service delivery.
- **Rwanda** completed a draft of a report summarizing the findings from its MNC QoC study and held a dissemination meeting with the MOH and USAID Mission. Findings have been used to inform the MCHIP activities in country. MCHIP, with the MOH, further strengthened the capacity of providers to effectively deliver an integrated minimum package of MNCH services at the health center level and integrated complementary package at the hospital level, according to national norms and protocols..
  - Planning for the the QOC studies in **Mozambique** and **Zimbabwe** was carried out. Data collection in Mozambique began in October 2011.The survey has been delayed in Zimbabwe (there are many stakeholders involved) and training will begin in November 2011. It will also have a postpartum care component as well as a child health component (supported by UNICEF) and be part of the National Integrated Health Facility Assessment (NIFHA).
- In **Nepal**, MCHIP completed three steps of a proteinuria test study to determine if the new point of care self-test for PE/E detection is comparable to more expensive, lab-based standard tests and if pregnant women are willing and able to use the self-test correctly. Steps 1 and 2 were conducted at the largest tertiary maternity hospital in Nepal, the Paropakar Maternity and Women's Hospital in Kathmandu, beginning in August 2010 and concluding in early FY11. Results were promising and were shared with USAID. Step 3 of the study to examine user acceptability was conducted in August 2011, with 600 pregnant women seeking ANC in two government health facilities in Morang district, Koshi Zonal Hospital and Mangalbare primary health center (PHC). Results from Step 3 will be analyzed in early FY12.

Skilled Care at Delivery

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

Core Funded

- MCHIP developed the PSE toolkit through a collaborative process with WHO, USAID and other partners. The toolkit includes an implementation guide, which highlights the pathway toward sustainable change in the structure and function of PSE programs, as well as an extensive collection of tools and resources for improved education and educational management. The toolkit was launched during MCHIP Year 3 and is being used by MCHIP programs and partners in Bangladesh, Ghana, Liberia and South Sudan. To ensure that the toolkit is both widely used and regularly updated, a process has been put in place to ensure regular engagement with a broad community of practice of technical experts, program managers and end users.

- MCHIP conducted modeling of the past and future impact of investments in PSE on reduced mortality and lives saved. This analysis, presented to USAID, looked at the potential impact of PSE for midwives in 30 countries.
- Global consensus has been achieved regarding the importance of maternal health service content indicators. This consensus will lead to recommendations for MOHs to include new indicators in national health information systems that will provide regular data on coverage of key interventions.

Field Funded

- In **Bolivia**, MCHIP advanced the implementation of SBM-R for quality improvement in maternal health, FP and postabortion care (PAC) at the national level as well as the departmental level. MCHIP received the support of the MOH in implementing SBM-R so that it complements the Short Cycles approach already in use by the MOH. An MCHIP-supported health network was awarded the National Best Practices Award by WHO/PAHO for its efforts to improve service delivery quality using SBM-R. The MOH has requested that MCHIP join the national quality improvement working group and participate actively in the development of guides and accreditation manuals for health facilities, integrating SBM-R with the work the MOH has done to date. Of the 71 participating facilities, 62 have implemented all seven areas of standards developed and introduced by MCHIP and 977 providers have been trained in essential obstetric care.

Photograph taken by Patricia Arana, Jhpiego

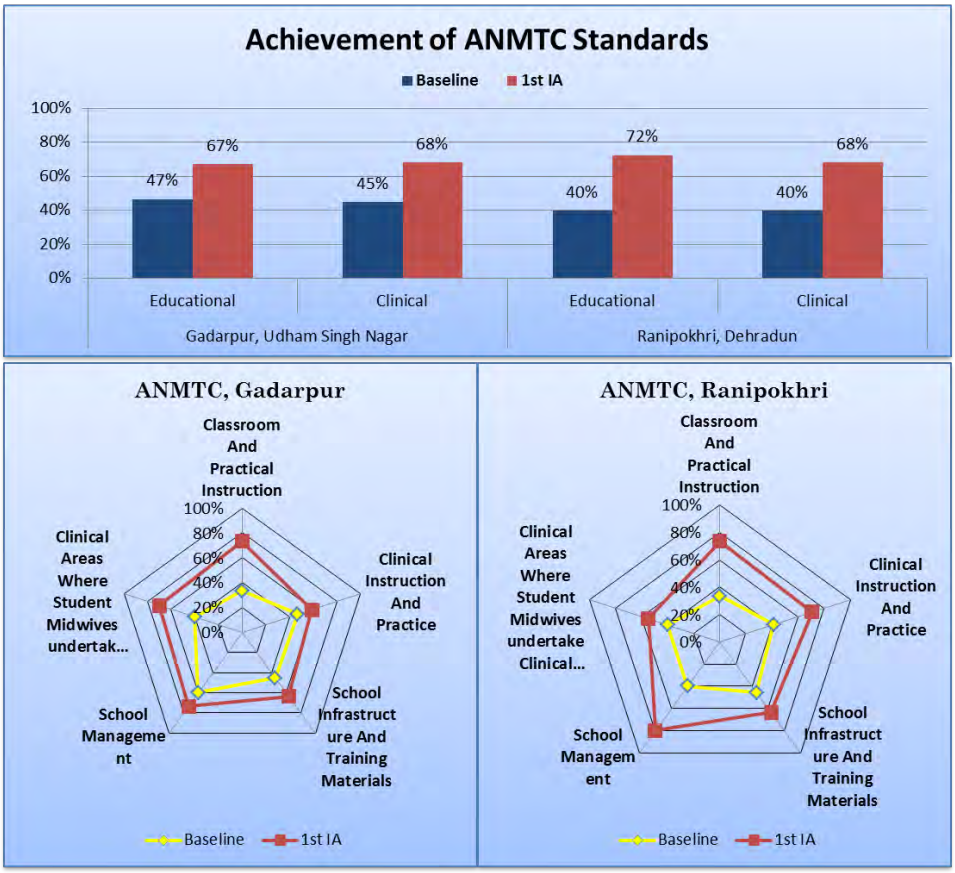
Essential Obstetric Care Training, Bolivia

- In **Ethiopia**,
  - with support from MCHIP, the Ethiopian Midwifery Association (EMA) increased its capacity to manage its operational functions, including development of the EMA's Human Resource and Financial Manual. MCHIP sponsored the EMA to celebrate the International Day of the Midwife on May 5, 2011, which led to its increased visibility in the arena of MNH advocacy. Additionally, more than 300 midwives were oriented to the White Ribbon Alliance (WRA) during the EMA's Annual General Assembly meeting in September 2011. This increased awareness of the need for the WRA for MNH advocacy in the country.
  - MCHIP supported five health science colleges to improve the quality of pre-service midwifery education. A performance and quality improvement (PQI) process was introduced to define standards and identify gaps in midwifery education. Two faculty development workshops were conducted—Classroom Teaching Skills (24 instructors), and Clinical Teaching Skills and Student Performance Assessment (23 instructors) to support them to improve the teaching-learning process.
  - MCHIP provided support to the FMOH to adapt the Accelerated Midwifery (AM) pre-service Education curriculum. The curriculum aims to address the country's huge need for midwives by training diploma-level trained nurses in one year. MCHIP seconded a staff to the FMOH during the adaptation of the curriculum and development of core competencies, and sponsored a national three-day curriculum review workshop. The AM PSE curriculum was finalized (all core competencies per ICM included) and implementation commenced quickly by the FMOH in February /March 2011.
- In **Malawi**, MCHIP provided technical assistance to the Global AIDS Interfaith Alliance (GAIA) in February 2011, to train 12 lecturers from Kamuzu College of Nursing in

BEmONC. MCHIP provided technical assistance on content, training models and logistical support such as preparing the clinical sites for practicals.

- In **Nigeria**, MCHIP improved the education of midwifery students by donating a variety of anatomic models and obstetric equipment to four schools of midwifery in the three MCHIP-supported states (two in Kano, one in Katsina and one in Zamfara). Use of models for clinical practice helps to strengthen competency-based training in the schools so that students graduate with the necessary knowledge and skills.
- In **India**, MCHIP strengthened nursing and midwifery PSE:
  - MCHIP strengthened SBA in-service training sites in Uttarkhand state. MCHIP conducted a needs assessment of the existing 10 SBA training sites to examine the readiness of the sites for quality SBA training and proposed seven additional training sites; conducted refresher training for the trainers from the existing 10 SBA training sites for SBA best practices (AMTSL, ENC, infection prevention [IP], partographs, etc.) based on the gaps identified during the assessment; field tested the Mama Natalie simulator for use during the SBA trainings; and provided materials for strengthening trainings.
  - MCHIP facilitated the establishment of five National Nodal Centers (NNCs) of excellence in nursing and midwifery PSE. MCHIP also strengthened them by implementing educational and clinical standards through the SBM-R process. Two of these NNCs, CMC Vellore and St. Stephen's in Delhi, were acknowledged by the Indian Nursing Council and MCHIP for the attainment of 85% of the educational standards.
  - MCHIP strengthened the Auxiliary Nurse Midwife Training Centers (ANMTCs) in Jharkhand, Uttarakhand and in Uttar Pradesh (UP) to improve the PSE and training of nursing and midwifery students. MCHIP developed and applied a six-week curriculum and learning resource package (LRP) for ANMTC faculty. Figure 3 on the following page illustrates improved compliance with educational standards at two ANMTCs. The standards, which apply the SBM-R approach to preservice education, cover such aspects of preservice education for ANMs as classroom instruction, school infrastructure, clinical instruction, and school management and clinical practice.

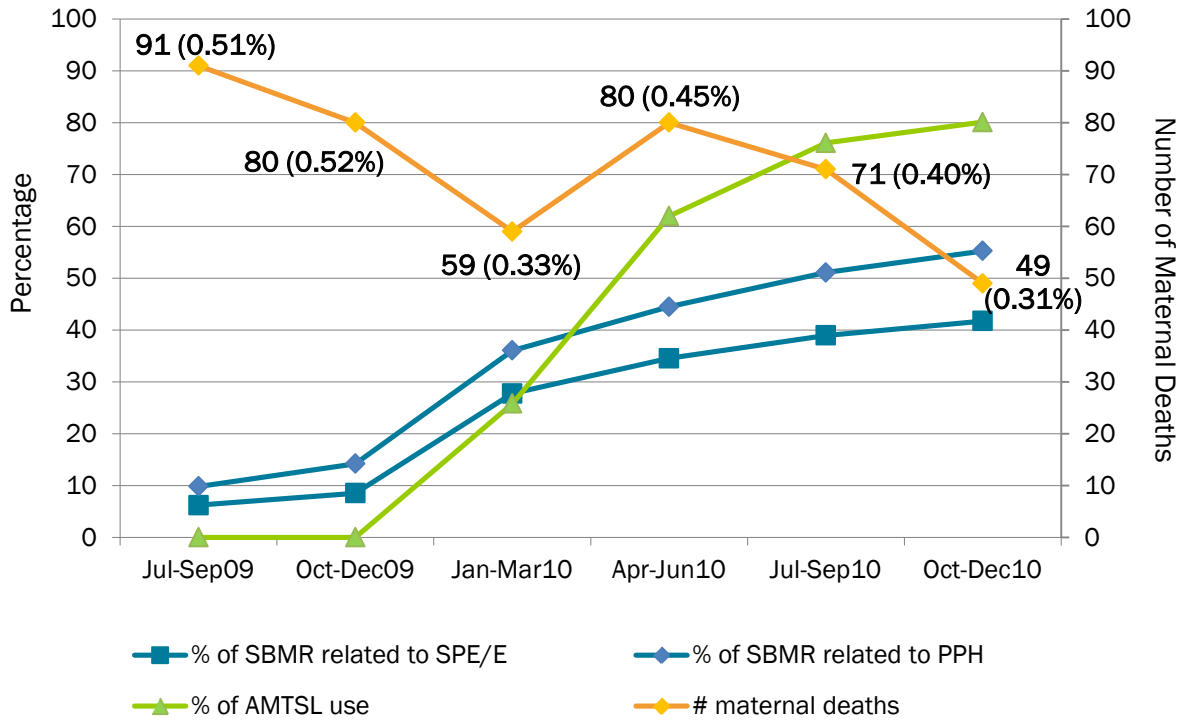
Figure 3. Improved Compliance with Midwifery Preservice Educational Standards at Two ANMTCs in India, Baseline (June 2011) and Follow-up (September 2011)



- In **Madagascar**, MCHIP developed capacity in MNH/BEmONC:
  - MCHIP has developed a cadre of 18 clinical trainers well versed in proven training techniques and in MNH/BEmONC. These trainers and MCHIP increased the capacity of 437 physicians and midwives to provide quality care for women and newborns experiencing complications related to PPH, PE/E, infections and neonatal asphyxia through trainings in targeted MNH knowledge and skills in six provinces throughout Madagascar.
  - Through hands-on two-day supervision workshops, MCHIP clinical trainers ensured that 55 physicians and midwives previously trained on MNH/BEmONC are correctly using newly acquired skills.
- In **Paraguay**, MCHIP strengthened capacity for emergency care:
  - In collaboration with the Ministry of Health and Social Welfare (MOHSW), MCHIP completed updates to the national protocols for emergency newborn care and emergency obstetric care. The dissemination process for the updated policies and norms will take place during the MCHIP Maternal Health Clinical Skills Standardization course.
  - MCHIP improved the capacity of SBAs at two hospitals to provide essential and emergency services during the first round of Technical Update and Clinical Skills Standardization Trainings in essential MNH and BEmONC. This first round included national and regional trainers/providers from each of two targeted regions, with 20 participants from San Pablo Hospital (Región Central) and 14 from the Ciudad del Este Regional Hospital (Alto Paraná).
- In **Mozambique**, MCHIP supported EmONC MNCH data collection and reporting:

- MCHIP supported 34 of the country's largest EmONC facilities, covering 21% of all institutional births nationwide, to continue to implement key high-impact MNH services under the Model Maternities Initiative (MMI). Data continue to show improvement in routine use of AMTSL (78.4% of labors), skin-to-skin contact (76.8% of births) and immediate breastfeeding (77.3% of births).
- MCHIP conducted a national launch of a set of seven new data collection and reporting tools (logbooks and forms) for facility-based MNCH services, adapted to fit the MOH's concept of integrated and evidence-based MNCH service provision. MCHIP rolled out training nationally at the end of 2010 and the system is currently being implemented in 19 of the 34 MMI sites. Throughout the first six quarters of the Model Maternities Initiative, in the 17 health facilities that did follow-up quality evaluations, there was an upward trend in the adherence to quality standards related to PPH and eclampsia; an upward trend in the use of AMTSL; and a downward trend in number of maternal deaths from all causes (% in parentheses in Figure 4 below). Cause-specific mortality is currently not available in the national HMIS.

Figure 4. Increased Compliance with PQI Standards and Declining Maternal Deaths at 17 Model Maternities in Mozambique



- In **Ghana**, MCHIP strengthened PSE for midwives:
  - MCHIP strengthened 12 midwifery schools, one public health nurses school and six clinical sites by providing resource materials including reference manuals, job aids, models and intrauterine contraceptive device models and equipment to improve competency of tutors and students.
  - MCHIP strengthened HIV/AIDS, TB, malaria, newborn resuscitation and FP in 17 midwifery schools, nine community health nursing training schools and one public health nursing school by updating standards, developing and implementing assessment tools and then conducting technical skills training for 80 tutors on HIV, TB, malaria and FP from April 4–15, 2011, which resulted in a 12% increase (64% to 76%) in knowledge

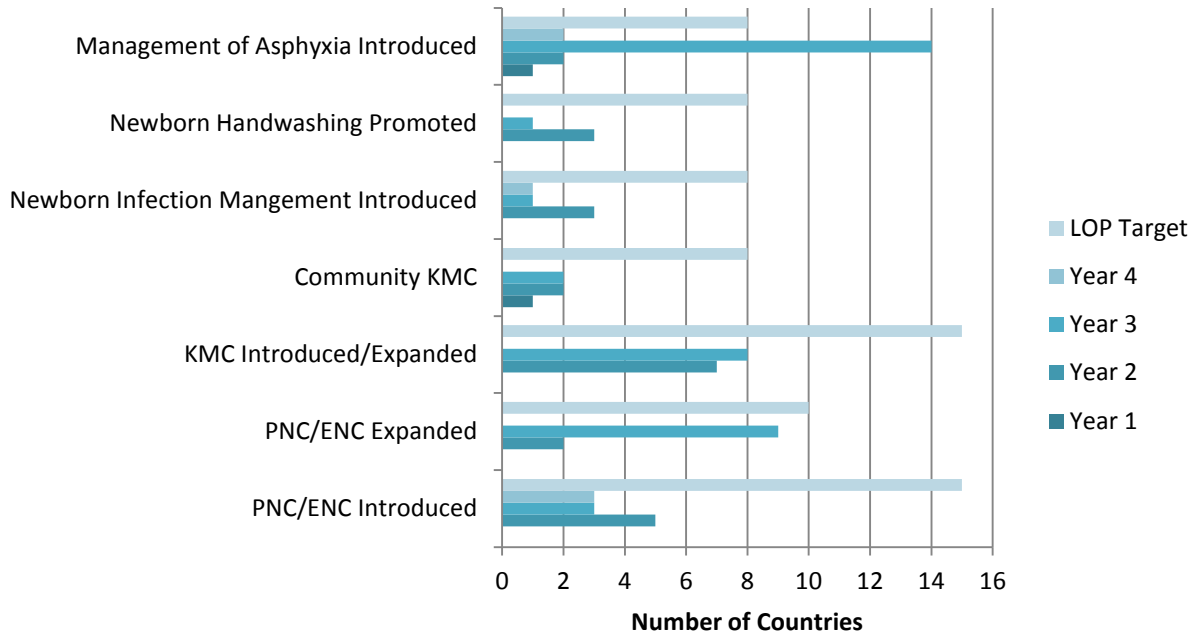
between pre- and post-course questionnaires. In addition, 21 examiners were trained in PPFP from May 16–17, 2011.

- MCHIP trained 20 tutors from 18 midwifery schools in HBB from June 23–24, 2011, in Kumasi, and then the team conducted follow-up of tutors at two nursing and midwifery schools at Cape Coast and Kumasi.

NEWBORN HEALTH OVERVIEW

Throughout Program Year 3 (PY3), MCHIP's newborn health team focused on addressing the three main causes of newborn deaths worldwide—newborn asphyxia, prematurity/low birth weight (LBW) and infection—by supporting the introduction and scale-up of evidence-based prevention and treatment interventions. These include essential newborn care (ENC), inclusive of the prevention and management of birth asphyxia using the Helping Babies Breathe (HBB) approach; prevention and management of preterm and LBW babies through kangaroo mother care (KMC); and prevention and management of newborn sepsis, including handwashing with soap for newborn survival. MCHIP's newborn team has set up relationships with SNL, AAP, WHO, UNICEF and others to advance its global reach. Progress for high-impact newborn health interventions is presented in Figure 5 below.

Figure 5. Progress for High Impact Newborn Health Interventions



In keeping with its mandate to provide global technical leadership in newborn health, MCHIP supported WHO to review the evidence for chlorhexidine application to the umbilical stump to reduce newborn sepsis and continued to support the implementation of the WHO/UNICEF Joint Statement on postnatal home visits to improve coverage and care for newborns in the first hours and days after birth. MCHIP completed a KMC implementation guide that provides tools and "how to" guidance for countries interested in initiating or strengthening KMC services. And to catalyze action on making treatment of newborn infections more readily available and accessible, MCHIP led a technical working group to initiate an implementation guide for newborn infection management at peripheral health facilities and in the community. This guide will be developed in PY4.

MCHIP also worked to introduce and expand newborn health interventions in 23 countries globally. PNC home visit activities were scaled up in Bangladesh, Malawi, Nigeria and Rwanda, and strengthened in Indonesia. A total of 14 MCHIP-supported countries were implementing KMC as of PY3—six more than in PY2—with services scaled up in the Dominican Republic and Malawi. MCHIP strategically invested PY3 core funds in newborn sepsis prevention and management activities in the Dominican Republic and Nigeria, where lessons learned will be documented to inform the global dialogue. In Bangladesh and Indonesia, MCHIP supported formative research on handwashing for newborn survival and initiated program activities in PY3.

The number of countries introducing or expanding ENC/resuscitation programs with MCHIP support increased significantly from two in PY2 to 17 in PY3. One key to this success was MCHIP's regional approach to technical assistance and information sharing. The capacity development of 116 HBB master trainers at the Africa Regional Meeting in Addis and MCHIP's leadership of the LAC region's Neonatal Alliance are two exceptional examples. MCHIP's collaboration with the Regional Center for Quality of Health Care and the East Central and Southern Africa College of Nursing in PY3 sets the stage for regional improvements in ENC/resuscitation pre-service curricula in PYs 4 and 5.

Newborn Resuscitation and Essential Newborn Care

Core Funded

- A core group of HBB trainers was created for the Africa region to facilitate the implementation of neonatal resuscitation in the context of ENC using the HBB training materials and approach across multiple countries. A total of 121 trainers from MOHs and NGOs in 25 sub-Saharan African countries, and two from non-African countries, were trained. Participants at the workshop also discussed how the HBB training would be rolled out in their respective countries and integrated with ongoing maternal and newborn programs. To date, since the Addis Ababa training, participants from Ghana, Malawi, Nigeria, Rwanda and Zimbabwe have co-facilitated training in their respective countries. In Rwanda, HBB has been integrated nationally with the BEmONC trainings. Others from Mozambique and Uganda are members of teams reviewing and revising current MNH training materials to include HBB in preparation for nationwide improvement of newborn care. Furthermore, MCHIP Nigeria trained 208 service providers in 15 health facilities on sepsis management. The MOH in Bangladesh has adopted HBB as a national strategy based on findings of a pilot test of the approach supported by MCHIP, UNICEF and the Laerdal Foundation.

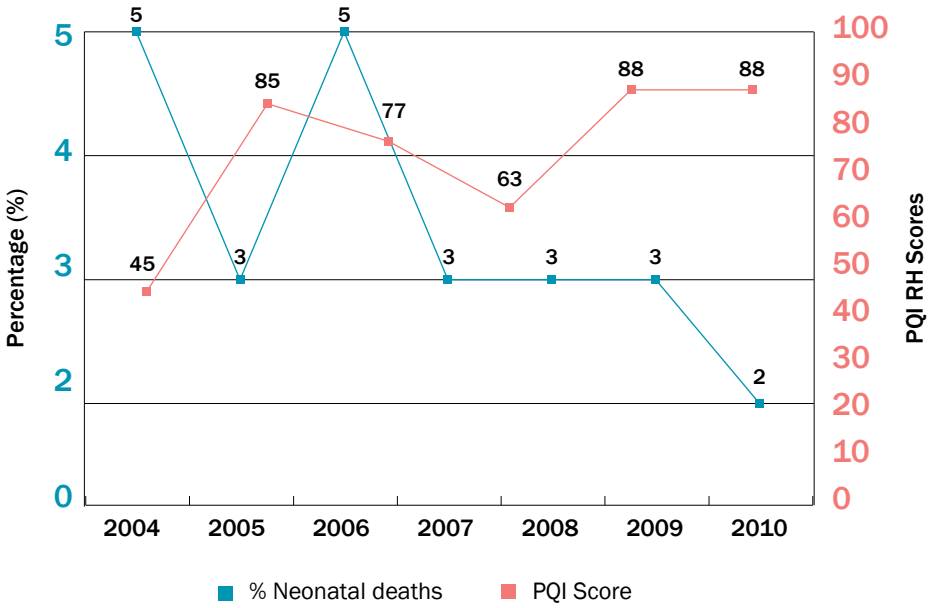
Dr.Wachira demonstrating proper newborn ventilation with bag and mask to a group of students during a pretesting workshop at Machakos District Hospital, Kenya.

Field Funded

- In **Kenya**, MCHIP supported the MOH's Division of Child and Adolescent Health and the national Newborn Technical Working Group to incorporate the HBB curriculum into the ENC clinical training package and pretest the draft package at Machakos District Hospital. The pretest assessed the content, flow and timing, and the feasibility of a facility-based training.

- In **Malawi**, MCHIP contributed to the scale-up of HBB by contributing to Malawi's national HBB rollout plan; training 35 national HBB trainers, bringing the total to 40; and training 224 providers from seven districts in HBB. The HBB trainings and ongoing mentorship will improve newborn resuscitation skills of providers in rural health centers and district hospitals. Trained providers competently using their skills will reduce newborn mortality in support of MDG 4.
  - In **Malawi**, on August 1, 2011, Machinga District Hospital, which has been implementing PQI for RH (including ANC, labor and delivery/newborn care and postnatal care) and IPC with MCHIP support, was awarded a shield of excellence in provision of RH services and maintaining outstanding IPC practices. Figure 6 presents data from the hospital showing a falling trend in the percentage of neonatal deaths from 2004 to 2010.

Figure 6. Neonatal Death Trends at Machinga District Hospital, Malawi, 2004–2010



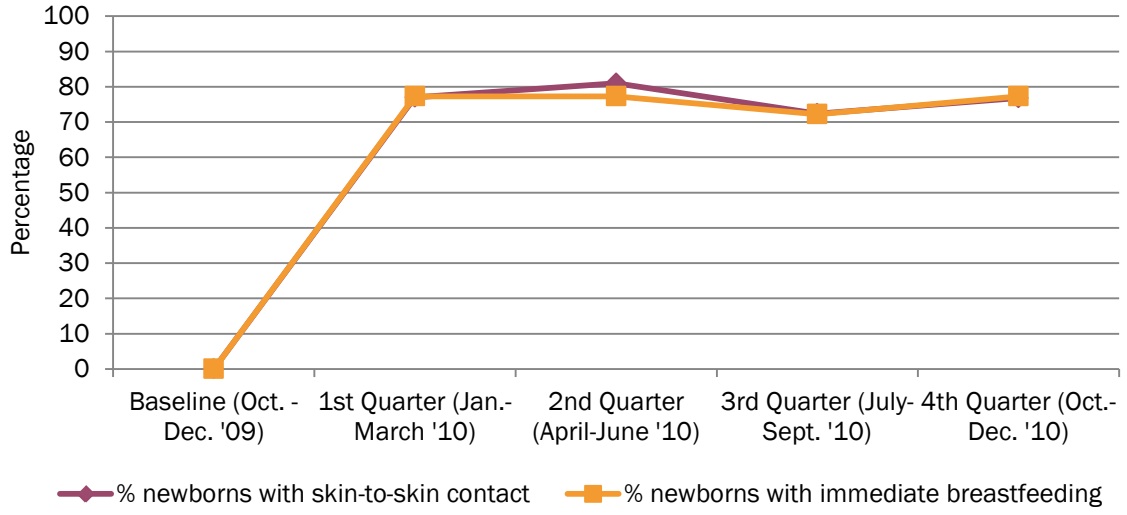
- In **Ethiopia**, MCHIP sponsored 20 Ethiopian participants in the Regional HBB TOT in Addis Ababa, February 24–25, 2011. A discussion on efforts to roll out HBB in Ethiopia was initiated with the Federal Ministry of Health (FMOH) and partners. The integration of HBB with different MNCH training packages by the FMOH and partners is underway. MCHIP supported the FMOH in developing the national HBB implementation plan, which will be an integral part of the National Child Health Program.
- In **Nigeria**, following the MCHIP Regional Meeting on PPH, PE/E and HBB, held in Ethiopia, MCHIP Nigeria conducted a TOT course for 23 HBB trainers followed by a series of clinical trainings in three states, namely Kano, Katsina and Zamfara. A total of 296 frontline health care workers were trained to perform neonatal resuscitation using the HBB learning resource package.
- In **Paraguay**, MCHIP strengthened newborn resuscitation services in two regions:
  - Región Central: MCHIP facilitated two workshops on advanced neonatal resuscitation from March 29–31, for a total of 37 health professionals working in the area of neonatal care at Hospital San Pablo.
  - Alto Paraná: MCHIP conducted a three-day training on newborn resuscitation/care from May 19–21 at the Hospital in Ciudad del Este, targeting nursing and medical staff; 17 participants successfully completed the course.

- MCHIP completed the first SMB-R training with 40 participants from the two targeted regions, and conducted an evaluation at the hospitals in San Pablo and Ciudad del Este. MCHIP worked with the quality committees of San Pablo Hospital and Cuidad del Este Regional Hospital to develop actions plans to address gaps in service delivery.

- In **India**:
  - MCHIP facilitated a national partnership forum at the national level with a focus on ENC and resuscitation.
  - "Newborn and Child Health Strategy 2011–2015" was prepared with MCHIP support as a part of the consultation led by the Government of India with experts, state governments and other stakeholders.
  - MCHIP rolled out Navjaat Shishu Suraksha Yojna (NSSK) in 24 districts of Jharkhand and 37 districts of Uttar Pradesh; 224 health providers trained in NSSK (ENC/resuscitation) at state and district levels this year.
  - MCHIP developed the State Program Implementation Plan (PIP) for 2011–2012, which included funds for training on NSSK.
  - The HBB job aid in Hindi was adopted by the states of Jharkhand and UP. The resuscitation job aid was displayed at 215 centers in UP and Jharkhand. The Government of Jharkhan (GOJ) has gone ahead with printing the same with state funds.
  - MCHIP completed the newborn care facility readiness assessment and disseminated the findings for the focus districts in Jharkhand. MCHIP prepared the facility-wide and district action plan.
  - MCHIP updated the standards on ENC support to be incorporated with the India Nursing Council (INC) pre-service curricula.

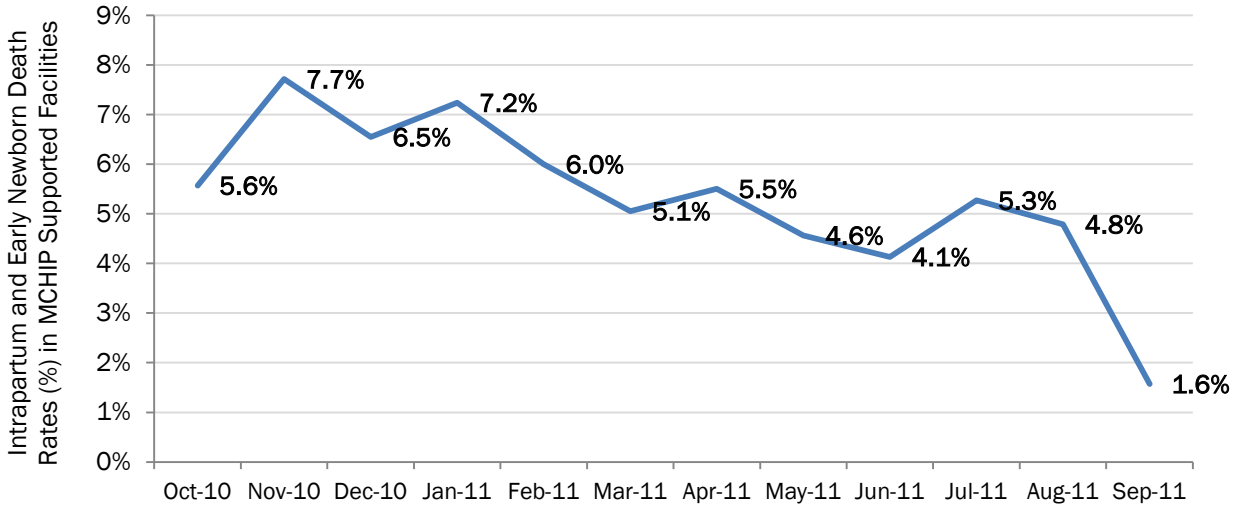
- Model Maternities in **Mozambique** track results-oriented indicators of the quality of service delivery on a monthly basis. This has recently been institutionalized in the MOH's own information system with training on a new set of registers at the end of 2010 that include newborn care indicators. Newborn quality indicators showed dramatic improvement over baseline at intervention facilities and targets were exceeded for such high impact interventions as immediate skin to skin contact between mother and newborn and immediate breastfeeding (within the first hour after birth). See results in Figure 7 below.

Figure 7. Provision of High-impact Newborn Care Interventions at Model Maternities in Mozambique



- MCHIP is currently working in 17 health facilities in the Mutare and Chimanimani districts of **Zimbabwe**, which provide over 80% of the deliveries occurring in these districts, and in which over 90% of the facility-based maternal and newborn deaths taking place in these two districts occur. In FY11 the rate of intrapartum and early newborn deaths decreased in seven of the MCHIP-supported health facilities (Figure 8) that had completed data sets. These facilities benefit from quality improvement activities such as training in ENC and provision of supplies/equipment for newborn resuscitation.

Figure 8. Falling Trend in Intrapartum and Early Newborn Death Rates (%) in Seven MCHIP-supported Facilities in Zimbabwe



Note: the data are from 7 health facilities in Zimbabwe which were able to provide complete data for the entire period.

Kangaroo Mother Care and Low Birth Weight Newborns

Core Funded

- MCHIP completed the KMC Implementation guide. This is a "how to" guide for countries interested in initiating or strengthening KMC implementation and includes tools that can be used in facility-based KMC. These tools are drawn from the program experiences of Saving Newborn Lives, ACCESS and MCHIP in efforts to introduce and expand this intervention in a number of countries. The KMC guide will be launched in MCHIP Year 4 and will assist Program Managers in MOHs and nongovernmental agencies to introduce and/or expand this intervention.

Field Funded

- In **Ethiopia**, MCHIP assessed and selected 18 facilities to implement KMC) in four regions (Amhara, SNNP, Oromia and Tigray regions), and has commenced training providers on KMC as an integral part of the BEmONC training. A study to evaluate the KMC intervention was planned. Additionally, a training module on community KMC (CKMC)for Health Extension Workers (HEWs) was prepared and the necessary equipment and supplies for establishing CKMC are being procured
- In **Paraguay**:
  - MCHIP established a KMC demonstration site at San Pablo Hospital, and is in the process of establishing the second demonstration site at the Hospital in Ciudad del Este.

An additional KMC site is being set up in Coronel Oviedo. This site approached MCHIP with interest and an offer to implement it with their own resources and MHCIP guidance. MCHIP trained them; MCHIP will provide supervision during routine visits for other activities.

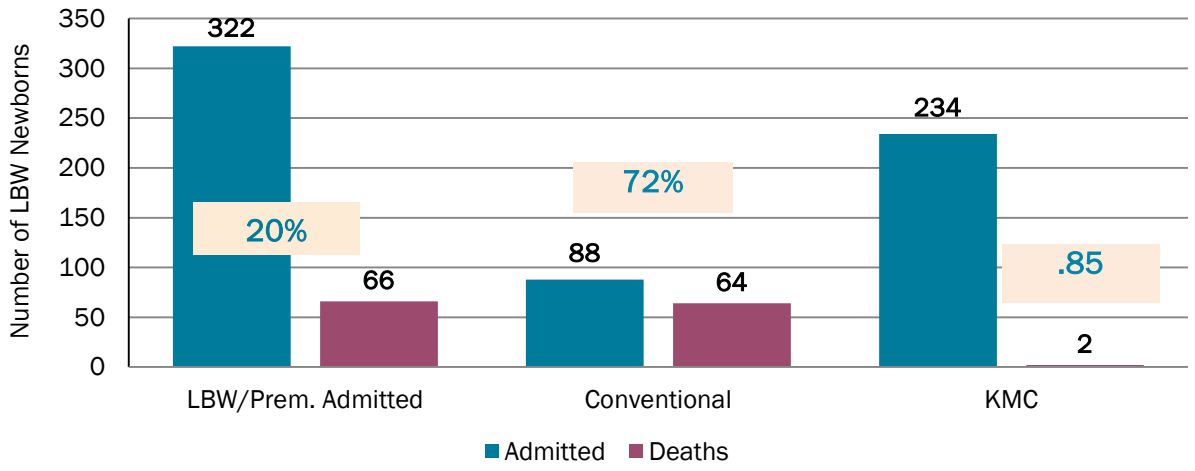
- MCHIP is engaging with the MOHSW, PAHO and UNICEF regarding a national scale-up plan for KMC.
- The head of obstetrics at the nursing school now plans to add KMC to their curriculum after attending the MCHIP KMC workshop. A faculty of school of medicine also attended this workshop, and now wants to include breastfeeding and KMC in their curriculum. MCHIP is following up.

- In **Malawi**, in January and February 2011, MCHIP trained 80 Health Surveillance Assistants (HSAs) in a community-based MNH (CBMNH) package including ambulatory and CKMC, and in March 2011, 40 HSAs were trained in community mobilization (CM) from 16 new, scale-up health facilities in all four of MCHIP's focus districts. Forty service providers based at these scale-up health facilities were oriented on CBMNH and CKMC to enable them to supervise HSAs and ensure adequate continuum of care from the facility level to community level and vice versa.
- In **Rwanda**, MCHIP supported provision of KMC services in seven District Hospitals, training 26 staff at six new hospitals and provided the needed KMC materials. A total of 686 low birth weight babies received KMC care at these facilities during the reporting period.
- In the **Dominican Republic**, the KMC program at San Vicente de Paul hospital, one of three referral facilities serving as a maternal and child health (MCH) Center of Excellence in the country, is in full implementation; 322 premature/low birth weight babies were admitted to the hospital in 2010, and the mortality rate was only 0.85% (two deaths) among those who received KMC treatment (n=234) compared to a much higher mortality 0f 72% (64 deaths) among those who received conventional care (n=88 --see Figure 9 below). In addition, the hospital has seen a reduction in the proportion of newborn deaths represented by premature/low birth weight babies from 90% in 2008 (baseline) to 67% in 2010. San Lorenzo de Los Mina Hospital, serving the poorest area of the capital city of Santo Domingo, is starting training for KMC, which is expected to have a high impact, given that 16% of all live births are premature/low birth weight with high mortality rates (about 2,000 babies per year could benefit from the program in the center).

Photographer: Dr Nieves Rodriguez, MCHIP DR

Celebration of KMC graduates- San Vicente de Paul hospital KMC Program.

Figure 9. Proportion of Deaths of LBW/Premature Babies Treated with KMC vs. Conventional Management at San Vicente de Paul Hospital in Dominican Republic, January through December 2010



- MCHIP, through the Ministry of Health and Child Welfare, is financially and materially supporting the revitalization of KMC in Zimbabwe. KMC is a well-recognized method of improving newborn survival of low birth weight babies, and while almost universally practiced in Zimbabwe's district and provincial hospitals in the 1990s, very few facilities continue to provide this method of care. In FY11, four KMC units were established in Sakubva, Chimanimani, Rusitu and Mutambara hospitals.

Newborn Sepsis

Core Funded

- MCHIP completed an assessment of newborn sepsis management by non-physician health providers in selected health facilities in three states in Northern **Nigeria**, Katsina, Kano and Zamfara. The findings were used to inform program design and training. Providers at PHCs were trained to identify and manage sick newborns with possible severe bacterial infection, using an adapted WHO Integrated Management of Neonatal and Childhood Illness (IMNCI) protocol. This activity will contribute to program learning, and will better inform and facilitate dialogue in working together with government and professional bodies on how to move treatment of newborn infections closer to the community. An evaluation is planned for MCHIP Year 4.
- In **Nigeria**, MCHIP introduced the concept of community-based management of neonatal sepsis to health facilities in MCHIP-supported sites in three states (Kano, Zamfara and Katsina) following a needs assessment conducted by MCHIP. More than 200 health care workers in the three states were subsequently trained to provide this service. (This activity was co-funded with field support.)
- In the **Dominican Republic**, MCHIP expanded the quality improvement of prevention and treatment of newborn sepsis to an additional MCH Center of Excellence as part of the regional strategy to reduce newborn mortality. This brings the total number of centers to three. All three are referral hospitals, which attend approximately 18,000 deliveries per year. The Antonio Musa Hospital has sustained the package of changes for prevention of infection for over four years (initiated with BASICS), resulting in a sustained reduction of the proportion of newborns admitted to the nursery for suspected hospital-acquired infections (from 42% at baseline in 2007, to currently less than 5% from 2008 onwards). MCHIP planned and initiated a baseline assessment of quality of treatment of newborn sepsis in the three hospitals.

Postnatal Care

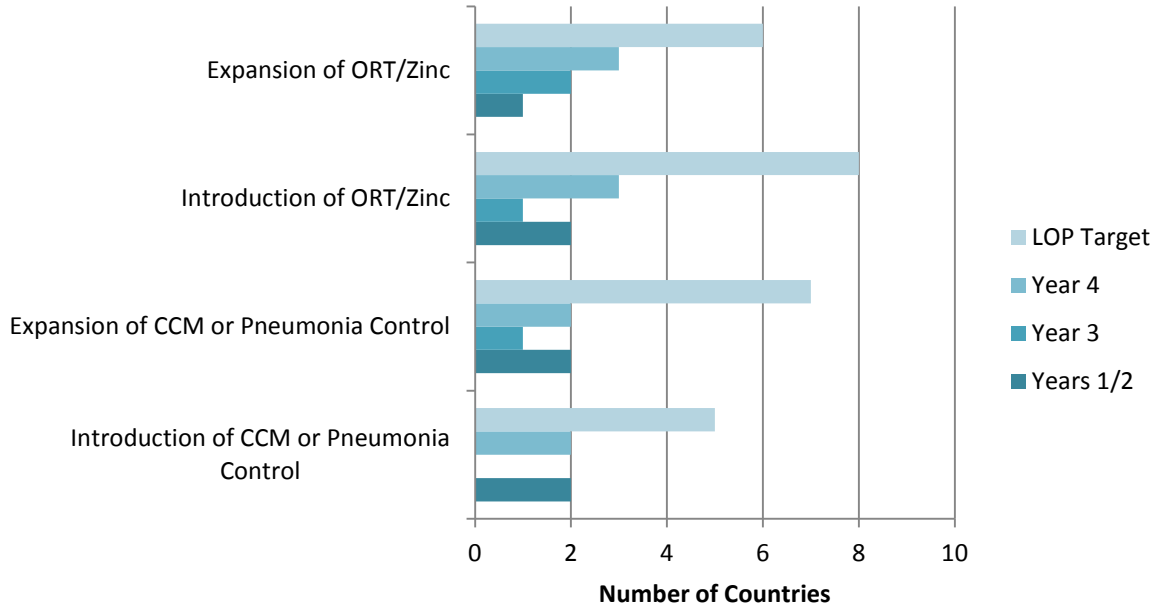
Field Funded

- In **Malawi**, MCHIP procured 5,704 hygiene kits for 16 program-supported health facilities in three districts. The kits are intended to incentivize facility deliveries and subsequent postnatal care visits at one week, six weeks, 12 weeks and six months postpartum. The full hygiene kit, including a bucket with tap, Waterguard, ORS *Thanzi* and soap, will be given to all women who deliver in a facility and receive postnatal care; refills of Waterguard, ORS *Thanzi* and soap will be provided at each follow-up visit. (This contributes to the SBA results pathway as well.)
- In **Nepal**, MCHIP contributed to a national evaluation and supported capacity building:
  - MCHIP facilitated national dialogue among key government officials (including from the Family Health Division, Child Health Division and the National Health Training Center) on integration of key community-based maternal, child and newborn health activities. This led to MCHIP being asked to contribute to a national evaluation of the community-based newborn care package, which was initiated with the full support and ownership of the Government of Nepal and key stakeholders.
- In **Rwanda**, MCHIP increased access to community-based MNH counseling and postpartum/postnatal services. A total of 211 community-based MNH trainers and 3,903 community-based MNH providers (Agents de Santé Maternelle) in five districts were trained, and post-training follow-up of the providers that were trained last year was conducted in one other district.

CHILD HEALTH OVERVIEW

In Year 3, the child health team continued to develop strategies and shape policies with partners at the global, national and sub-national levels to expand access to case management and preventive interventions aimed at the three main causes of death among children under five: pneumonia, diarrhea and malaria. Progress for high-impact child health interventions is illustrated in Figure 10 below.

Figure10. Progress for High Impact Child Health Interventions



MCHIP focused in particular on documenting and promoting best practices for CCM to ensure reduction in child mortality, including development of indicators to measure CCM. MCHIP worked to increase the number of countries introducing and achieving full-scale CCM programs. Under this umbrella, MCHIP, through its role as the secretariat for the Global CCM Task Force, strengthened global leadership by ensuring the adoption of the CCM indicators, and promoting their use at the country level. In addition, MCHIP was instrumental in developing a global CCM toolkit, which includes tools that support introduction, expansion and implementation of full-scale programs. To make these tools globally available, improve communication with CCM partners, and to allow countries easy access to these tools, MCHIP launched a global online CCM resource center (www.CCMCentral.com), making the tools available for strong program management at the country level.

In country programs, MCHIP addressed bottlenecks, helping Rwanda and DRC to achieve impact at greater scale. After years of advocacy in Mali, MCHIP played a key role in changing the policy on cadre of CHWs, which enabled the government and partners to expand the CCM program.

A critical issue related to diarrheal disease is the lack of attention and focus on the global, country and household levels. MCHIP supported oral rehydration therapy (ORT)/Zinc revitalization in Kenya, DRC, Mali and Rwanda.

In Kenya, MCHIP has supported the development of comprehensive Infant and Young Child Nutrition (IYCN) guidelines. In Mali, MCHIP has provided technical support to the MOH in the review and revision of training curriculum for a community-based package of essential care to be delivered by CHWs; and was instrumental in Rwanda for nutrition training for CHWs, community IYCF behavior change communication (BCC) and growth monitoring and promotion.

Acute Respiratory Infection/Pneumonia/iCCM [4]

Core Funded

- Global leadership: With USAID, MCHIP functions as Global CCM Task Force Secretariat, and facilitated the development of a program of work among Task Force members to advance the global child health agenda. Through this forum, MCHIP built consensus on the iCCM scale-up benchmarks and indicators. Support materials for indicators and reference sheets are in the final stages of development. MCHIP also facilitated a review of a sample of tools among Task Force Members, which led to the compilation of a Tool Kit of program management guidelines including training and supervision. Through this process, gaps were identified and tools were developed, most notably in the area of logistics. All are posted on www.CCMCentral.com, launched in September 2011. The website serves as the global CCM resource center, and provides the latest updates, key links, meeting updates and outcome reports, in addition to a rangeof tools to improve management of and access to program materials, for managers implementing country-level programs.

Field Funded

- In **Rwanda**:
  - MCHIP improved access to quality CCM services in five districts, where 203 CCM trainers were trained and 3,265 CHWs were trained in CCM (C-IMCI). All CHWs trained were equipped with a CCM kit. MCHIP provided the wooden boxes, padlocks, boots, jerry cans, cups, and spoons, while the MOH provides medical supplies. Currently,

[4] Because MCHIP works on all three diseases (pneumonia, diarrheal disease and malaria) simultaneously at the country level, all CCM work is integrated. As such, all iCCM achievements under ARI/Pneumonia are considered to be achievements under ORT/Zinc and Malaria as well.

all CHWs are implementing the complete package of CCM (using rapid diagnostic tests [RDTs], treating malaria by referring to the protocol, providing care of diarrhea and pneumonia, and ensuring appropriate referrals to higher levels.)

- In collaboration with the MOH, the Rwanda Health Communication Center and development partners, MCHIP conducted a workshop to discuss the development of the BCC sub-strategy for MNCH. The sub-strategy is in line with the national health sector BCC policy enacted in 2006. As a result of this workshop, a consensus was reached on the key behaviors to promote to improve MNCH and the strategic framework for the development of the sub-strategy. Currently, their framework has been proposed for approval by the Rwanda Biomedical Center/ Health Communication Center and MOH.

Validation workshop of IMCI revised tools in Rubavu district: Senior officials from the Rwanda Ministry of Health, universties and peditricians, District Medical Officers and development partners.

- MCHIP supported the MOH, UNICEF and WHO to update and streamline the national IMNCI training course, reducing it from 12 to six days. This important contribution has already resulted in cost savings by cutting theoretical exercises while maintaining time-tested IMNCI video and hands-on practical sessions. Trainers and providers spend less time away from their duty stations without compromising the quality of training. By cutting training time by 50%, national rollout of new IMNCI is accelerating. By September 2011, 186 health facility personnel have been trained by MCHIP in IMCI in its seven intervention districts. An additional 61 health personnel were trained by other partners. With these trainings there are now approximately three trained staff per health center in each of these seven intervention districts, covering both health centers and referral hospitals (the national objective is to train two care providers per health facility).

Oral Rehydration Therapy/ZINC

Please also see iCCM/acute respiratory infection (ARI)/pneumonia core-funded results and AFR/SD results.

Core Funded

- Technical assistance for ORT/zinc revitalization: MCHIP supported revitalization of ORT/zinc efforts in Kenya, including harmonization of health and water, sanitation, and hygiene (WASH) BCC messages. Activities included assisting the MOH to develop a national strategy along with training and implementation guidelines for facility staff and CHWs. In Zimbabwe, MCHIP supported a child health needs assessment in two districts to identify key gaps in QoC for childhood illness and to use the findings to plan interventions; MCHIP supported ORT/zinc through CCM programs in DRC, Mali and Rwanda including a national mass media campaign for zinc use in DRC. MCHIP also supported updating of facility-level IMNCI guidelines for malaria case management and ORS/zinc in Rwanda. In India, MCHIP is conducting a study to assess the efficacy of Aquatabs NaDCC tablets to prevent diarrheal disease. The study is ongoing and results will be available by December 2011.

Field Funded

- In Kenya:

- MCHIP supported and facilitated the Division of Child and Adolescent Health (DCAH) in finalizing the ORT Corner operational guidelines. This is an outcome of the rapid assessment and situational analysis of ORT Corners in Nyanza and Western provinces done together with DCAH. MCHIP supported identification and initial process of revitalizing four ORT Corners in Western province. These ORT corners will be equipped and staffed to function as models or centers of excellence for diarrhea management in FY'12. The centers of excellence will provide demonstration and mentorship to health center staff who will, in turn, improve the ORT corners in their own health centers.
- MCHIP facilitated a zinc advocacy meeting. Through this meeting, the team outlined the main steps for zinc inclusion as an over-the-counter drug by the Pharmacy and Poisons Board, formed a task force to define the details and created a rapid ORS and zinc scale-up plan.
- MCHIP helped facilitate the GAPP Conference in Nairobi, Kenya, and provided assistance with the development of the Terms of References TORs for the Kenya Action Plan for Pneumonia (KAPP) TWG and the national action plans. MCHIP participated in the GAPP follow-up meetings with WHO, UNICEF and MCHIP/W for KAPP advocacy to key policy gatekeepers, namely the Director of Medical Services, Director of Public Health and Sanitation and the Chief Nursing Officer, with resultant buy-in of the latter two.

- In **Malawi**, MCHIP received and warehoused 600,000 sachets of ORS Thanzi. MCHIP distributed 210,000 sachets nationally through the commercial sector. Distribution of ORS Thanzi was coupled with 200 community education sessions through community educators promoting point-of-use water treatment and prompt treatment of dehydration using ORS Thanzi.
- In the **Democratic Republic of Congo (DRC)**, MCHIP worked in collaboration with UNICEF, the MOH and other partners to launch a multimedia campaign to promote diarrheal disease treatment. This campaign consisted of a series of half-day, scientific sessions to share information and generate support for diarrheal disease treatment in five major cities. A total of nearly 450 health professionals participated, and the sessions were covered widely in country through 22 television stations, 29 radio channels and seven newspapers. This campaign increased awareness among both health providers and the general public about new recommendations to combat diarrhea and create a demand for the use of zinc to treat diarrhea in children.

IMMUNIZATION OVERVIEW

Immunization has received unprecedented attention over the past year, including planning for the Decade of Vaccine in light of the commitment of Bill Gates of $10 billion; replenishment of GAVI funds with involvement of heads of state; approval of 50 country applications to GAVI to introduce pneumococcal, rotavirus, pentavalent and meningitis A conjugate vaccines (with conditional approval of another 21 applications); and numerous high-visibility presentations on Capitol Hill about the power of vaccines. With all the focus on vaccines—their power, value, supply and financing—there has not been corresponding focus on what it actually takes to vaccinate children. The focus has been on increasing *access* to vaccines. But there has been inadequate focus on the *availability* of the means to deliver the vaccines, *awareness* by communities, *acceptability* of vaccination, *affordability* of the program, *affability* of health workers and *accountability* of governments to their populations.

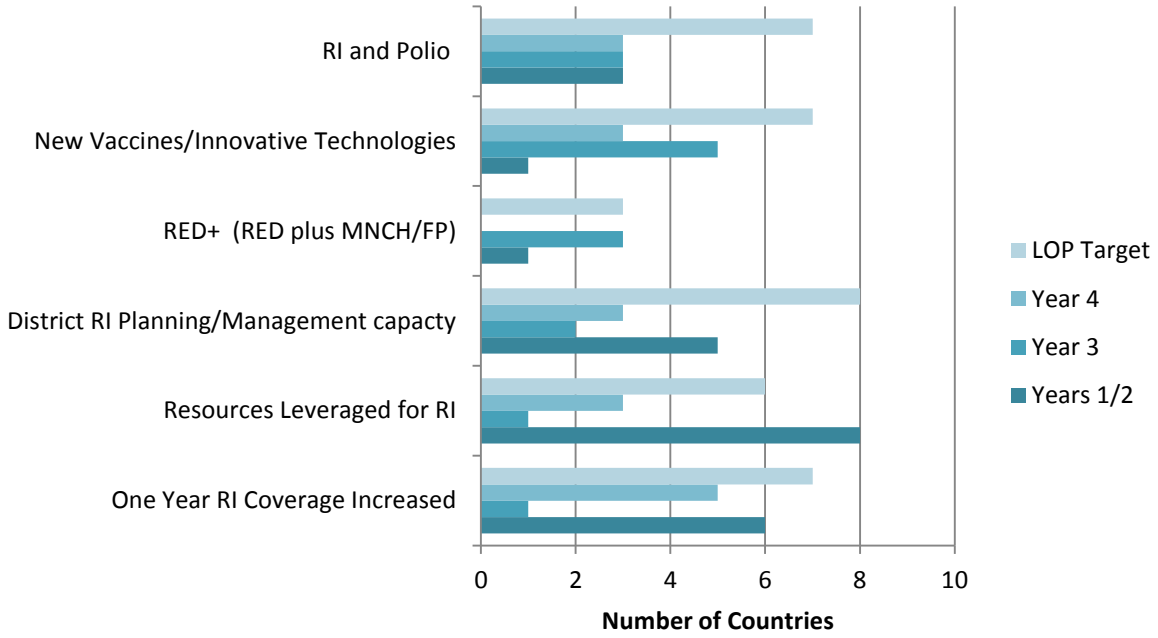
Strengthening immunization, as an integral part of the functioning health system, is the foundation to achieve and sustain coverage targets, sustainably reduce disease and mortality, and successfully introduce new vaccines. Yet, despite their relative maturity, immunization

programs in many countries have become fragile even as they face new challenges. Programs require policies, staff, supplies, logistics, management, monitoring and surveillance, community engagement, political ownership, financial support, communications, advocacy and coordination. Constant attention, maintenance and repair are needed for sustained, effective and efficient performance. Past high accomplishment in immunization efforts does not guarantee success in the future.

USAID understands that building capacity at scale to strengthen immunization programs for the long-term is a developmental challenge and that support for vaccine procurement through GAVI and support for disease-specific initiatives like polio eradication, however important, is inadequate to strengthen routine immunization programs for sustained mortality reduction. Many countries require the sort of technical support that MCHIP has been designed to provide.

Working with global, regional, national and sub-national partners, MCHIP continued to provide technical assistance on immunization and share information and best practices with countries and partners. In addition, MCHIP provided global leadership on immunization policymaking, practice, research and learning through membership on many global and regional advisory groups and task forces convened by WHO, UNICEF, CDC and others. MCHIP also contributed to learning through lectures, presentations and publications. Progress for MCHIP support for high-impact immunization interventions is presented in Figure 11 below.

Figure 11. Progress for High Impact Immunization Interventions



MCHIP technical support resulted in GAVI funding for the introduction of new vaccines in Benin, DRC, Kenya, Rwanda, Tanzania and Zimbabwe. MCHIP assisted countries to smoothly introduce new vaccines and/or to strengthen their routine immunization systems in 13 countries: DRC, India, Kenya, Kyrgyzstan, Liberia, Nigeria, Rwanda, South Sudan, Tajikistan, Tanzania, Timor-Leste, Ukraine and Zimbabwe. Building on immunization as an effective service delivery platform, MCHIP in Liberia designed a program and supporting materials and messages to integrate postpartum family planning counseling and services with routine child immunization visits.

MCHIP completed its work this year in providing complementary technical leadership support to the WHO response to pandemic influenza A (H1N1), both at the global level and throughout the Africa region. Polio eradication activities were carried out at the global level through consistent support to a multi-agency indicator working group, as well as through targeted assistance to the WHO Eastern Mediterranean Regional Office (EMRO), Afghanistan and Pakistan. At the country level, MCHIP provided technical support to improve polio linkages with routine immunization in the DRC, India, Kenya and Nigeria.

Routine Immunization and New Vaccines

Core Funded

- MCHIP collaborated with USAID and other partners at the global and country levels to support the effective and sustainable introduction of safe, high-quality, lifesaving new vaccines. In **Benin, the DRC, Kenya, Rwanda, Malawi, Tanzania and Zimbabwe**, MCHIP supported the introduction of new vaccines by working with the MOHs and other stakeholders on national implementation plans and GAVI applications, strengthening routine immunization systems, adaptation of training materials and building the capacity of health workers and managers, assessing the readiness of the cold chain and logistics system. and revising recording, reporting and monitoring tools and monitoring and evaluating the introduction process (Table X). On September 27, 2011, GAVI announced that it will provide funding for vaccine introductions in each of these six countries. USAID has committed approximately $2 million to MCHIP to expand their technical support for New and Under Utilized Vaccines Implementation (NUVI) in the upcoming fiscal year.

Table 1. New Vaccine Introduction Progress by Country

COUNTY		PNEUMOCOCCAL VACCINE (PCV)	ROTAVIRUS VACCINE INTRODUCTION
1	Kenya	Introduced **February 2011**	planned and conditionally approved for introduction in **January 2013**
2	Rwanda	Introduced **April 2009**	Planned and approved to introduce in **Q2 2012**
3	Tanzania	Planned to introduce in **Jan 2013**	Planned and approved for introduction in **Jan 2013**
4	Zimbabwe	Planned to introduce in **July 2012**	Planned and conditionally approved for **Jan 2013**
5	Malawi	Introduced in **November 2011**	Planned to introduce for **October 2012**
6	Benin	Introduced in **August 2011**	
7	DRC	Introduced using a provincial phased approach starting in **April 2011**, Up to now, 4 out of 11 provinces have introduced the vaccine.	Not yet planned
8	Senegal	Planned for **2012**	Planned for **2013**

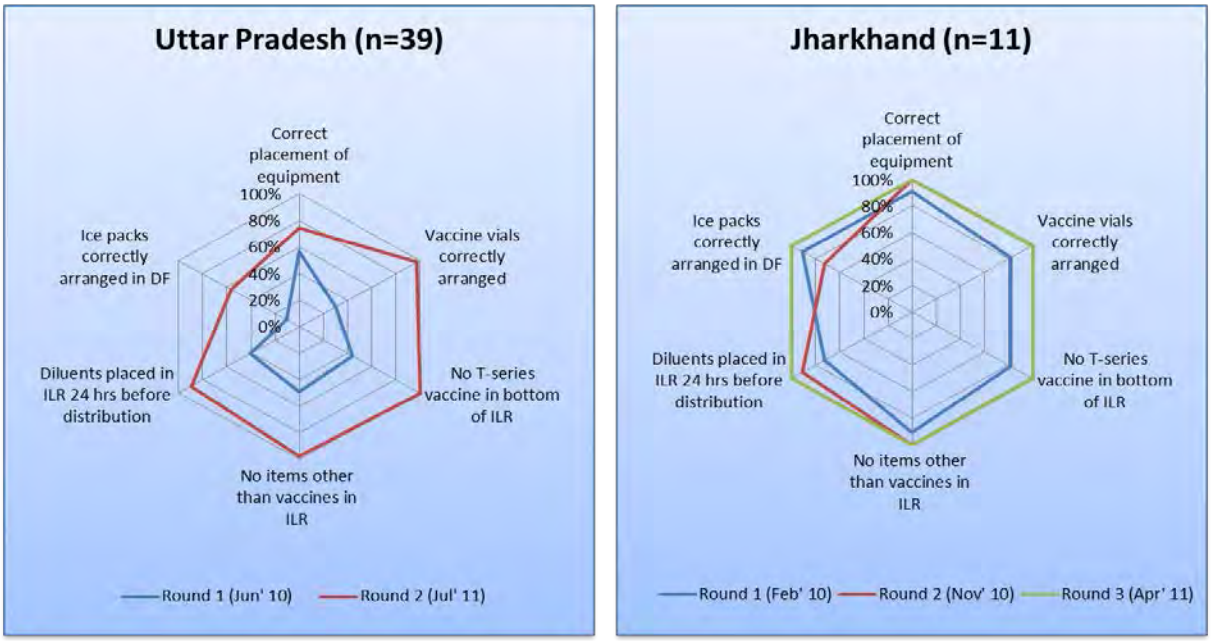
Field Funded

- In **Kenya,** MCHIP made progress in vaccines and immunization services:
  - MCHIP helped the MOH introduce the pneumococcal conjugate vaccine (PCV 10) into the childhood vaccination program in Kenya to prevent the leading cause of mortality among children under five. The introduction of this vaccine was well received in the community and has created a renewed interest in vaccination both in the community and among leaders.
  - MCHIP increased the capacity of 35 mid-level Expanded Program on Immunization (EPI) managers on planning and management of immunization services to improve

service delivery. Situation assessments conducted in the first year of the project in Nyanza and Western provinces identified the lack of experience on the part of district managers as one of the contributing factors for the suboptimal immunization coverage. After the successful introduction of PCV 10, Kenya is planning to introduce the rotavirus vaccine in January 2013. In order to secure GAVI funding for the introduction, MCHIP, working with other partners, assisted the Division of Vaccines and Immunization to create an introduction plan, revise the Comprehensive Multi Year Plan (cMYP) and submit an application for consideration to GAVI.

- In **India**, MCHIP identified immunization demonstration blocks in five districts of UP and Jharkhand following an immunization readiness assessment of all sub-district-level facilities. Demonstration sites were developed for two thematic areas (cold chain management and recording reporting practices) in each of the districts, MCHIP supported the Government of India in the introduction of new vaccines and promotion of underutilized ones, which will result in the protection of more children against life-threatening vaccine-preventable diseases (VPDs):
  - The identified blocks per district. The objective of these demonstration sites is to facilitate cross learning visits and knowledge sharing with other facility and supervisory staff. All the selected sites are now ready for cross visits and learning by other block staff, as per readiness scoring. Baseline and follow-up assessment scores for cold chain/storage performance at facilities in the five districts are provided in Figure 12 below (n refers to the sample size of facilities).

Figure 12. Progress for Vaccine Storage Practices at Facilities in Uttar Pradesh and Jharkhand States, India, Baseline and Follow-Up



  - MCHIP developed the following national guidelines with support: cMYP for year 2010–17; revised guidelines for RI PIP (also reviewed routine immunization (RI) PIP from five states); Revised Adverse Events Following Immunization (AEFI) guidelines; operational guidelines for second dose of measles (for all states)and catch-up campaigns (for 14 states); introduction of Hepatitis B vaccine (all states); revised guidelines for JE vaccination for endemic districts and states; introduction of Liquid Pentavalent Vaccine in Tamil Nadu and Kera.

- Participation and co-facilitation during national-level meetings and forums for detailed program review and strategic plans for improving immunization coverage in the low-performing states through monitoring and supportive supervision, and communication strategies. MCHIP team chaired important sessions during these meetings.
- MCHIP developed a concept of Track Every Newborn (TEN) in October 2010 to promote increased immunization coverage. After six months, the government announced its Mother and Child Tracking System (MCTS), which has a similar approach to that of TEN. MCHIP rolled out TEN MCTS initiative in one identified block of each focus district.
- MCHIP conducted scale-up of RAPID ***(Regular Appraisal of Performance of Immunization at District level, using supportive supervision)*** activity in all 24 districts of Jharkhand (formally approved under National Rural Health Mission [NRHM] PIP); and 32 districts of UP (through UNICEF and government medical colleges). Recently, funds for conducting RAPID have also been approved in PIPs of the states of Haryana and Punjab

- In **Tanzania**, MCHIP assisted the Tanzania and Zanzibar teams in April 2011 to revise their cMYPs and compile their application and introduction plans for GAVI new vaccine support for both PCV13 and rotavirus vaccine introductions. Both applications were approved, and introduction will begin with PCV13 in 2012 and RotaRix in 2013.
- In **Rwanda**, MCHIP supported the introduction of the rotavirus vaccine through a proposal approved for GAVI funding. Training materials have been adapted at the national level with MCHIP support in order to prepare the providers for implementation of the new vaccine.
- MCHIP provided technical assistance for the development of **Zimbabwe's** successful applications to GAVI for the introduction of pneumococcal and rotavirus vaccines. Zimbabwe was approved to introduce pneumococcal vaccine in 2012 and the application for rotavirus was approved with conditions for possible introduction in 2013.
- In **Liberia**, MCHIP is implementing an innovative approach to integrate FP counseling and services with routine child immunization visits, in response to the MOHSW's call for integration of MCH and FP services and in the effort to bring FP services closer to the client. To date, an initial program design focused on tailoring FP messages to be delivered individually by vaccinators to all women bringing their infants for routine immunization visits was developed; messages and materials including job aids, leaflets and posters were created based on an EPI/FP assessment consisting of interviews and focus group discussions with vaccinators, FP providers, officers in charge and mothers of infants under one year; and a TOT was conducted. These trainers will be involved in the further EPI/FP integration activities planned in MCHIP Year4.
- In **DRC**, MCHIP provided technical support to EPI in preparation for the PCV-13 vaccine introduction, supporting the training of 48 provincial and health zone teams, and 36 health providers in Bas Congo to help them plan for the arrival of the vaccine, and to identify and address any potential issues with its distribution, storage, acceptance and use.

Polio Eradication

Core Funded

- MCHIP provided leadership for polio eradication efforts, providing input on use and tracking of communication indicators at the global level and in polio priority countries, as well as participating in polio technical advisory groups (e.g., India and Pakistan, regionally to EMRO). Technical support for polio activities was also provided in DRC and Kenya, and for improving the tracking of newborn and pregnant women in India.

H1N1

Core Funded

- MCHIP completed its work this year in providing complementary technical leadership support to the WHO response to pandemic influenza A (H1N1), both at the global level and throughout the Africa region. MCHIP finalized a report summarizing its work and recommendations on the pandemic response and participated in a WHO-sponsored workshop on the main operational lessons learned from the H1N1 vaccine deployment initiative.

MALARIA OVERVIEW

MCHIP continued to provide leadership at the global, regional and country levels as described below, through technical and programmatic guidance, to ensure malaria: 1) programming is **effectively integrated** as a core component of maternal and child health services; 2) best practices and lessons learned are disseminated to advance **program learning**; and 3) reproductive health and malaria control managers, as well as child health and malaria control managers, continue to work together to roll back malaria on an integrated platform of MNCH—to accelerate **scale-up for impact**. MCHIP targets: 1) malaria in pregnancy (MIP); 2) integrated-community case management (iCCM); and 3) malaria comprehensively at the community level through the "Malaria Communities Program."
Malaria in Pregnancy—MCHIP plays a critical role in the global Roll Back Malaria (RBM) MIP Working Group with MCHIP's Director, Dr. Koki Agarwal, serving as Co-Chair and MCHIP's Malaria Team Leader providing technical and programmatic support. Through the working group, MCHIP fosters dialogue through technical meetings, among global and country level leaders, to advance knowledge and understanding of MIP programming at the country level. In Year 3, MCHIP's leadership at the global level in the MIP working group resulted in advancing: a) the understanding of MIP in low malaria transmission settings through a literature review; b) recognition among the RBM Board about the importance of revitalizing MIP programming to ensure sustained outcomes; and c) partnerships among RH and malaria control teams from eight countries.[5]

Because of MCHIP's breadth of experiencing in supporting MIP programming, MCHIP is counted on to drive the dialogue forward and develop/co-develop effective tools to advance MIP programming to the next level. In addition to MCHIP's role in the MIP working group, MCHIP also participated in a number of meetings to highlight the critical importance of and support for MIP programming. MCHIP provided both technical and programmatic input to the WHO Global Fund Policy Brief targeting countries developing Global Fund proposals. MCHIP also highlighted successes and challenges countries are facing through participation in a panel titled "Changing Faces of Malaria in Maternal Health."

Recognizing that MIP programming is at a crossroads—although most high malaria transmission countries have adopted intermittent preventive treatment and applied proven malaria approaches—many countries have still not achieved RBM, PMI and country-level targets for MIP, such as IPTp uptake and use of insecticide-treated bed nets/long-lasting insecticide treated bed nets among pregnant women. To better understand MIP programming country-level successes, challenges and lessons learned, MCHIP conducted MIP program reviews in both Malawi and Senegal in Year 3. These documentations directly lend to not only the acceleration of program learning among country-level stakeholders, but also provide the insight to help countries apply successful strategies and accelerate MIP programming.

[5] Cambodia, India, Indonesia, Senegal, Solomon Islands, Zambia, Zanzibar

MCHIP's global-level leadership combined with its documentation of MIP best practices, challenges and lessons learned position it well as a global program to **support countries to apply proven approaches, accelerate implementation and scale up for impact.** Some examples of how MCHIP's global leadership in MIP is helping countries accelerate MIP implementation, with field support funds, include:

- **Burkina Faso**—MCHIP is supporting comprehensive approaches (e.g., in-service training, PSE) that build on lessons learned from other high-performing malaria countries.
- **Ghana**—MCHIP is supporting strengthening PSE for comprehensive MNH services including malaria.
- **Rwanda**—MCHIP is supporting a comprehensive community-to-clinic approach to address MIP. MCHIP also supported the MOH in developing a study protocol for MIP surveillance, which will lead to study implementation in MCHIP Year 4.

Integrated Community Case Management (Note: Information on iCCM is repeated in the Child Health section of this report)—MCHIP plays a key technical leadership role at global and country levels. MCHIP, as part of the global CCM Task Force, plays a strategic role in developing tools to standardize approaches for planning, implementing and monitoring iCCM programs at both the introduction and expansion stages. In addition, MCHIP is driving the lesson learning agenda to identify best practices and promising solutions to challenges of implementing full-scale iCCM programs.
MCHIP focused in particular on documenting and promoting best practices for CCM to ensure programs are effective in increasing access to and use of effective interventions for diarrhea, malaria and pneumonia, including development of indicators to measure CCM performance. MCHIP strengthened global leadership by ensuring the adaption of the CCM indicators, and promoting their use at the country level. In addition, MCHIP supported the development of a global CCM toolkit, which includes tools that support introduction, expansion and implementation of full-scale programs. To make these tools globally available, improve communication with CCM partners, and to allow countries easy access these tools, MCHIP launched a global CCM resource center (www.CCMCentral.com), making the tools available for strong program management at the country level.

By providing global leadership in development of tools for CCM planning and implementation, MCHIP made progress supporting global and national partners to increase access to and use of lifesaving interventions for children suffering from diarrhea, malaria and pneumonia.

Malaria Communities Program—MCHIP provides technical guidance and support to 18[6] grantees of PMI's Malaria Communities Program, to improve their capacity to deliver effective malaria interventions and enhance their contributions to accelerating malaria prevention and control efforts. Targeted technical assistance provided to grantees in Year 3 included reviewing and providing technical and programmatic input on training materials, BCC materials, supervision and monitoring tools, and evaluation plans. Additionally, on-site technical assistance was provided to nine grantees through visits to six countries.[7] In Mozambique, MCHIP worked with Aga Khan Foundation (AKF) to revise and refine monitoring and supervision tools for APEs (CHWs). AKF is collaborating with the MOH to conduct joint training and supervision of CCM activities; AKF focuses on the community mobilization and prevention messaging, while MOH trains and supervises diagnosis and treatment. In Mali, MCHIP assisted in operationalizing the rollout of community health solidarity funds by

[6] ADPP Angola, ERD Angola, FIDO Ethiopia, ASPI Ghana, ERD Ghana, HealthRight Kenya, Merlin Kenya, EQUIP Liberia, MENTOR Liberia, CRWRC Malawi, Concern Universal Malawi, Lutheran World Relief Mali, AKF Mozambique, Caritas Senegal, CSSC Tanzania, HealthPartners Uganda, MTI Uganda, CMMB Zambia.
[7] Mali (1 grantee), Senegal (1 grantee), Liberia (2 grantees), Ghana (2 grantees), Malawi (2 grantees), and Mozambique (1 grantee).

Lutheran World Relief, which is setting the stage for the forthcoming nationwide health insurance scheme, and their efforts have been well received by local government counterparts.

In Year 3, MCHIP organized and facilitated the second MCP regional training event for all grantees, held in Lilongwe, Malawi. Capitalizing on MCHIP's global leadership and technical expertise in MIP and iCCM, the MIP and iCCM teams contributed to curriculum development and facilitation of the training's two concurrent tracks in these areas. The five-day training event strengthened technical competency in MIP and iCCM strategies and implementation efforts through MCP grantees' community-based malaria programming being implemented in 12 countries. The training also disseminated best practices and lessons learned, and facilitated sharing of program experiences among grantees, MCHIP and PMI. Joint sessions—including Community Intervention Approaches and Tools, Workplan and Final Report Development, and Seeking Opportunities for New Partnerships—strengthened organizational capacity of grantees and better positioned them to pursue new partnerships and funding. Workplans for the MCP projects developed following the workshop include a pilot of RDTs by HealthRight Kenya, and development of benchmarks for quality of CHWs' activities by CMMB Zambia.

MCHIP's continued support 1) strengthened training for community cadres across the portfolio of grantees, 2) ensured streamlining of training and BCC approaches with national protocols and messages, and 3) strengthened grantees' understanding and implementation of supervision systems for cadres of community-based volunteers, thereby strengthening linkages with health facilities and reinforcing the continuum of care and supervision from facilities to communities.

Malaria in Pregnancy

Core Funded

- Through its leadership role in the RBM Malaria in Pregnancy Working Group, MCHIP joined global partners and experts to review MIP programming in low-prevalence settings and in settings of mixed infections for countries in Asia, as well as a growing number of countries in Africa, and determined that further guidance and support is essential to accelerate effective MIP programming. This resulted in contributing to the final draft of "Malaria in pregnancy in Asia Pacific region: A literature review from an area of mixed infections with P.vivax and P.falciparum."
- MCHIP also provided input to the WHO Global Fund Policy Brief, intended to support countries in the development of their Global Fund Proposals for Malaria. The guidance specifically outlines the need to link and strategically integrate malaria programming on the MNCH platform.
- MCHIP provided global leadership in MIP by sharing country experience and technical knowledge on the Changing Face of Malaria in Maternal Health for over 100 participants at the Global Health Council Conference in Washington, DC in June 2011. Panelists presented information on innovative MIP programs from two countries, as well as research priorities and the donor perspective on MIP program priorities in an era of changing epidemiology.
- MCHIP completed two country case studies on MIP in **Senegal** and **Malawi** that will be disseminated in year four to enhance program learning of best practices and lessons learned among key stakeholders at the country and global levels.
- MCHIP provided MIP technical support and facilitation during the Malaria Communities Program workshop,

Distribution of LLINs in Malawi.

which targeted 18 grantees across 12 countries. MCHIP oriented grantees to applying the malaria in pregnancy program implementation framework to their programs for improved performance. Grantees learned from other country program challenges and successes.

Field Funded

- In **Malawi**: MCHIP distributed 934,830 Long Lasting Insecticide Treated Nets (LLINs) to health facilities countrywide, in accordance with the National Malaria Control Program's distribution plan. Distribution was completed through routine distribution channels as well as a LLIN Mass Distribution Campaign in Salima and Nkhotakota district in June 2011. The campaign was in collaboration with CHEMONICS, PSI/Malawi, DHMTs, NMCP, and Peace Corps.
  - The campaign placed malaria IEC messages on treatment of malaria according to national guidelines. The campaign taught correct and consistent use of LLINs countrywide, reaching a total estimated audience of 218,989 with the following specific outputs:
    - 812 LLIN posters were placed on walls of health facilities countrywide
    - 9,975 Malungo Zi calendars and posters, 4500 brochures promoting use of LLINs and 600 brochures for IPTp were distributed to health facilities and malaria partners countrywide
    - 7 drama group team leaders were oriented on key messages for MNH. 5 Local drama groups at district level were also identified in preparation to perform in their communities on messages for IMCI, IPTp and promotion for use of LLINs. These drama groups performed 450 shows reaching an estimated audience of 74,576
    - 2,375 radio spots were placed on local radio promoting use of LLIN every night to reduce malaria in pregnant women and children under five.

Photograph taken by Ousmane Badolo

Providers in Gorom district, Burkina Faso, practice RDT.

- In **Burkina Faso,** MCHIP trained health care providers, forged partnerships and provided support to improve malaria prevention and care:
  - MCHIP increased the number of health care providers skilled in malaria prevention and control in 20 districts across 9 regions with a total of 1095 providers and 165 trainers trained. Copies of the national malaria guidelines were disseminated at the trainings.
  - MCHIP provided support and mentoring through supervision visits to regional and district level trainers as well as 353 providers at facility level in 17 districts.
  - MCHIP supported the National School of Public Health in the training of 60 teachers in comprehensive malaria prevention and control, recognizing the critical importance of giving teachers the correct knowledge and skills to students before they graduate.
  - MCHIP developed and printed communication materials (8 job aids and 3 brochures) to improve providers' and clients' knowledge about malaria prevention and control.
  - MCHIP built a partnership with Peace Corps Volunteers to engage communities in malaria prevention and control efforts; leveraging further support for the program.
- In **Rwanda**, MCHIP supported the MOH to expand iCCM to four districts and to introduce RDTs to confirm malaria cases before treatment at the community level.

iCCM

(Please also see ARI/pneumonia/iCCM core-funded results under the Child Health section and AFR/SD results.)

Core Funded

- MCHIP completed case studies of national scale iCCM programs in DRC and Senegal and shared lessons learned and best practices with key CCM partners. The case studies will be available in both English and French at the end of October 2011. Synthesis reports will be widely circulated, including in a peer-reviewed CCM journal supplement, on Web sites, in meetings, etc.

FAMILY PLANNING OVERVIEW

As a critical contribution to the reduction of newborn, infant, child, and maternal morbidity and mortality, MCHIP continues to support the introduction and expansion of FP services in the countries where we work. MCHIP/FP interventions promote expansion of contraceptive choice, improvement in the quality of FP services, increased access to quality services, including innovative and underutilized technologies, and integration of services across a broad scope of critical interventions such as policy strengthening, capacity development, quality improvement, BCC and community involvement.

In Program Year 3, MCHIP worked at the global, regional and national levels to promote, advance learning and expand key evidence-based FP interventions, such as PPFP, LAM and postpartum intrauterine devices (PPIUDs), through working groups/conferences, PSE strengthening and supporting operations research. At the global level, MCHIP continued to provide leadership in FP integration, specifically with MIYCN and immunization. MCHIP produced five country profiles, led three online discussion forums, hosted a PPFP technical meeting in Washington and PPIUD study tour in India, and worked with WHO on developing PPFP service delivery guidelines. At the national level, MCHIP expanded activities focused on community-based distribution of FP services in Bangladesh, Malawi, Mali, Nigeria and Rwanda; and strengthened facility-based provision of FP services including long-acting methods at the facility levels in Ghana, Guinea, India, Liberia and Rwanda. Integration of postabortion care and EmONC is being done in Ghana, Guinea and Liberia. Special studies in exploring new integration are also being carried out in Kenya, India and Liberia. Finally, ongoing operations research in Bangladesh demonstrated promising results—showing significantly higher contraceptive use in the intervention group at 18 months postpartum (46% intervention group vs. 31% control group).

Core Funded

- In June 2011, in collaboration with the Government of India, MCHIP conducted a five-day PPIUD standardization workshop in Jaipur, India, to develop regional PPIUD training capacity. The PPIUD Study Tour that took place in India generated a pool of technical expertise in the field and will contribute to the quality of field implementation in clinical services, follow-up with clients, demand generation and relevant materials in the future. 7 physicians and one midwife from Afghanistan, Guinea, Mozambique, Nepal and Tanzania took part in the tour. In addition, quality PPIUD services were implemented in four countries through MCHIP technical assistance (TA) (Rwanda, Paraguay, India and Guinea). At the global level, MCHIP-FP co-hosted a PPIUD Technical Meeting with RESPOND in July 2011 that generated much interest both domestically and internationally, representing PSI, MSI, CDC, EngenderHealth, Women Care, FHI 360, Jhpiego and others. Participants agreed to work collaboratively in a working group to share programmatic implementation and areas for

global learning. Both reports for the study tour and technical meeting were completed and disseminated and are available on the K4H and MCHIP websites..

- The Healthy Fertility Study in **Bangladesh** is an operations research activity aimed at addressing unmet need for contraception in the postpartum period in Sylhet District, Bangladesh. In December 2010, the Healthy Fertility Study transitioned from ACCESS-FP to MCHIP for technical oversight and program management. In this reporting period, three key milestones were completed. The 12-month postpartum results were analyzed and disseminated in a final report. Among other key findings, any modern method use of contraception was 42% at 12 months in the intervention group compared to 25% in the control group. Intervention activities were associated with a greater than 20% increase in the probability of adopting contraception in the first 12 months. A sub-study for the integrated service delivery quality was completed and preliminary results are available. A national dissemination meeting will be held in Dhaka on October 26, 2011.
- MCHIP/**Mali** initiated an integrated package of services (AMTSL, ENC, PPFP) focused on the postpartum period in Kita and Diema, two districts in the Kayes region. MCHIP/Mali developed a six-day integrated training for staff at the facility level with the focus at the community health center and contributed to the "Essential Care in the Community," CCM with integration of FP and ENC for a new cadre of CHWs. Results from facility assessments indicated that providers need an update on FP and that there is an opportunity to integrate FP with ENC, such as messages about immediate and exclusive breastfeeding along with messages on LAM. Results from the community assessment showed that 33% of women (n=860) had six or more children and 27% (n=482, those who had more than one live births) reported that their last two pregnancies (birth to next conception) were less than 15 months apart. MCHIP/Mali also trained 91 facility providers (physicians, midwives and nurses) and 73 auxiliary midwives from both Kita and Diema districts.
- In 2011, MCHIP initiated an activity linking MIYCN and FP in Bondo District, **Kenya**, in partnership with the Ministry of Public Health and Sanitation and other local stakeholders. During October-December 2010, initial advocacy meetings were held with the Division of Nutrition and Division of Reproductive Health at the Ministry of Public Health and Sanitation (MOPHS) to build support for activities to integrate MIYCN and FP in Bondo District as a demonstration site (with potential for scale up to other districts). It is notable that this effort represents one of the first times the two divisions have worked together. MCHIP then worked with the Ministry to identify focus sites where the integration model could be piloted. MCHIP collaborated with in-country teams to develop background materials for ongoing advocacy and to inform the message and materials development process, including an advocacy presentation, a desk review of published and unpublished resources related to MIYCN and FP in Kenya, a BEHAVE framework to guide program activities and a list of key MIYCN-FP behaviors for Kenya. In July 2011, an assessment was conducted in the focus facilities and catchment areas to identify current behaviors, service delivery mechanisms, barriers and enablers for FP and MIYCN in Bondo District, followed by a message and materials development workshop in August 2011 with the MOPHS and other stakeholders to identify a program strategy and tailor MIYCN-FP messages and materials for use at the facility and community levels. During September 2011, materials were pre-tested in three sites in Bondo.
- At the global level, the MIYCN/FP integration working group is organized by MCHIP and PATH. This working group meets on a quarterly basis and currently has 52 members from 23 active nutrition or FP programs. In this past year, working group members collaborated to develop a four-page advocacy brief, a review of related literature in MIYCN/FP integration (bibliography) and advocacy presentation for stakeholders and policymakers for country adaptation, and also updated the LAM Toolkit and drafted M&E indicators. During this past year, sub-working groups, including literature review, BCC and M&E, were formed

and prior working groups on LAM and healthy timing and spacing of pregnancies also emerged as part of the working group.

- Technical **Leadership and Field Implementation of FP/Immunization Integrated Service Delivery:** During 2011, MCHIP began an initiative to integrate FP and immunization in 10 facilities in Bong and Lofa counties in **Liberia**. An initial needs assessment was conducted in two facilities in Montserrado and five in Bong Counties to identify possible opportunities for linkages between immunization and FP and observe current activities and strategies in the field at the county level. In May 2011, in order to inform the FP/immunization integration activity design, MCHIP conducted an assessment in four of the 10 focus health facilities. The assessment aimed to generate useful information on enablers, barriers and perceived benefits of FP and immunization services, health facility systems and structures, and ideas on how best the intervention might be structured. Key findings from the assessment included:
  - **Norms around postpartum abstinence**: In the sites visited, respondents often cited the commonly held view that women should not return to sexual activity until the baby walks or until the infant reaches one year of age. There appears to be high levels of stigma surrounding return to sexual activity before the baby walks, which can prevent women from using family planning during the first year postpartum.
  - **Benefits of family planning**: Benefits of family planning most frequently cited by mothers included: health of the mother and baby, economic stability, and the ability to stay in school. Additionally, none of the women interviewed desired to become pregnant again in the next year.
  - **Partner opposition**: Partner opposition was frequently mentioned by women and service providers as a barrier to family planning use. Several providers also mentioned that women seek family planning services covertly, without their partners' knowledge.
  - **Views of Vaccinators**: All vaccinators reported that they consider family planning to be "very important" or "important" and were open to the idea of providing FP messages and referrals to EPI clients.

Findings from this assessment will generate insights that will be critical for informing the message and materials development process. Field testing of the FP/EPI messages and materials was conducted in June by an assessment team comprised of representatives from MCHIP and the National Health Promotion Division. In August, Liberia EPI/FP assessment findings were presented at the September 15 meeting of the FP/immunization integration working group meeting.

- A global FP/immunization integration working group was organized by MCHIP-FP in collaboration with FHI 360, meets semi-annually and currently has 74 members from 26 organizations. Major efforts carried out in the past year were: success in advocating for integration of FP and immunization services to be included in the PRH High Impact Practices (HIPs), "A Promising Approach: Immunization as a Platform for FP Integration" panel at the 2011 Global Health Council Conference, a two-week online discussion forum, information sharing and documentation of programmatic experiences, finalization of a bibliography on immunization, and FP integration and support to an FP/immunization integration online map managed by FHI 360.

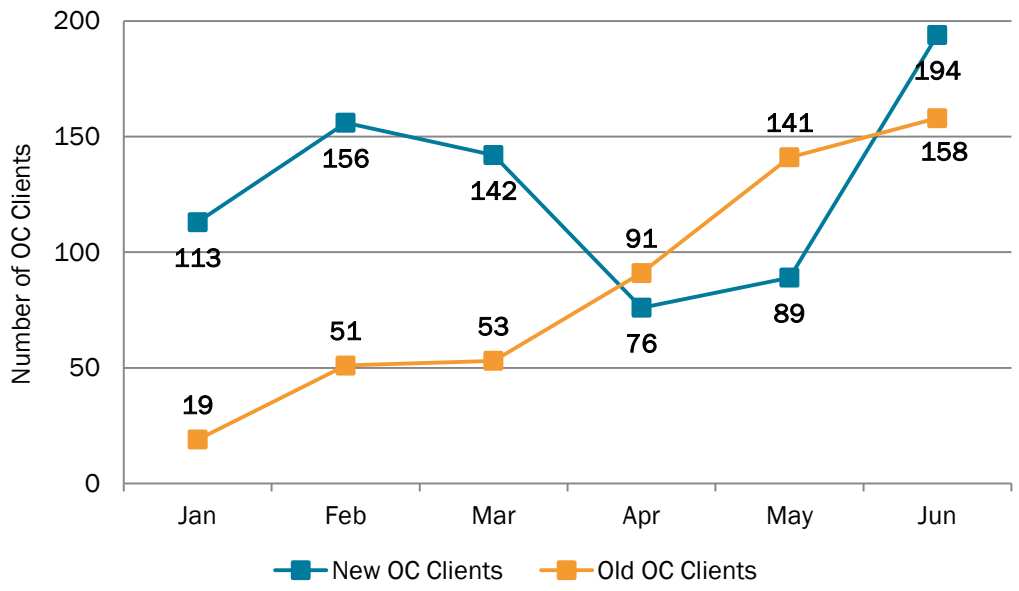
Field Funded

- In **Malawi**, MCHIP launched FP initiatives such as a pilot project with Community-Based Distribution Agents (CBDAs), finalized job aids, distributed contraceptives and provided supportive supervision:
  - MCHIP pretested, finalized and translated into Chichewa PPFP job aids. The job aids will support service providers and HSAs in providing adequate FP information and

facilitate the provision of PPFP services and contribute to consistent quality and efficiency of those services. MCHIP also trained 116 skilled providers in PPFP and BEmONC core competencies from the 16 MCHIP scale-up health facilities in four focus districts and Likoma.

- MCHIP launched a small scale six-month FP pilot project in two Traditional Authorities in Machinga district, with support from the Ministry and the district teams, to test using community-based distribution agents (CBDAs) to increase access to and uptake of FP. Fifty new CBDAs were identified and trained on FP counseling and community mobilization. Supervision visits to these CBDAs revealed: there is a significant proportion of people who can pay for contraceptives; perception of roles of CBDAs has not changed since inception of social marketing of FP products; the most cited reason for not buying FP products is negative attitude toward FP; and CBDA profit margin may be too low to result in sustainable motivation. During the life of the pilot, the CBDAs distributed 1,305 cycles of pills, 1,201 male condoms and 349 female condoms (Figure 13). The CBDAs have counseled 8,683 people though home visits.

Figure 13. Uptake of FP Methods Provided by CBDAs in Malawi

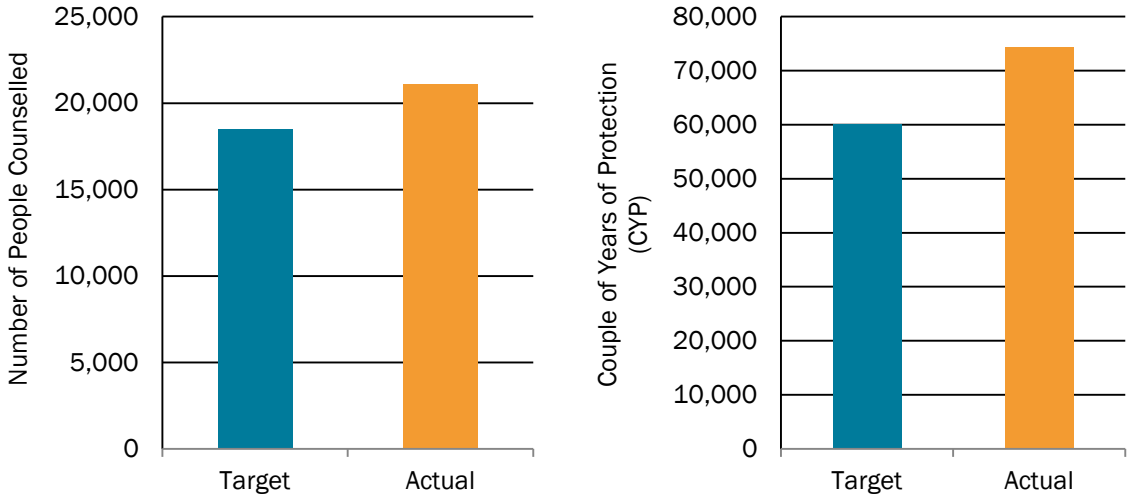


- MCHIP distributed 60,251 vials of injectable contraceptives and 29,716 cycles of oral contraceptives through the private sector, providing 18,235 couple years protection (CYP). Demand for contraceptives through private clinics has been high during this program year due to frequent stock-outs in the public sector. Distribution of these contraceptives ensures adequate supply for women seeking FP methods, offers an alternative service delivery point and increases contraceptive use in Malawi.

- In **Nigeria**:
  - Through MCHIP's support of FP community outreach activities by community health workers, access to and use of long-acting and other FP methods, notably Jadelle implants and IUDs, increased in the three northern states (Kano, Zamfara and Katsina). In all, 450 clients in living in the facility catchment areas of six facilities (three in Zamfara state and three in Kano state) received FP services during outreach efforts. A total of 274 received Jadelle insertions, 26 received IUD insertions, 124 received injectables, 15 received oral pills and one received the male condom. For a region where use of FP methods is still very low, this was a significant achievement.

- MCHIP continued to support provision of FP services at facilities in the three northern states of Kano, Zamfara and Katsina. Figure 14 on the shows FP counseling and CYP at these facilities (57 health facilities in Kano, Zamfara and Katsina states reporting FP data) for the reporting period.

Figure 14: Exceeding FP Expectations in Northern Nigeria: Counseling and CYP achieved in in FY11 in Three States at 57 Health Facilities

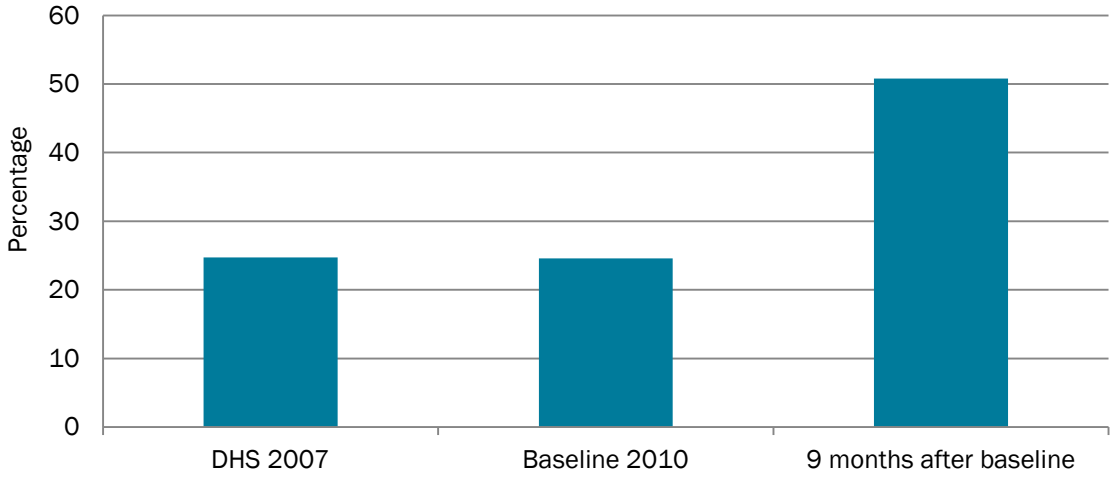


- In **India**, MCHIP helped to strengthen and reposition FP within MNH services, including:
  - MCHIP developed a PPFP/PPIUCD LRP, information, education and communication (IEC) materials and recording and reporting formats at the national level and their adaptation at the MCHIP focus states.
  - MCHIP strengthened FP service delivery sites in three focus districts in Jharkhand state and Urban Health Centres in Uttarakhand state.
  - MCHIP established decentralized clinical training centers—10 DCTCs in UP.
  - MCHIP revitalized PPFP/PPIUCD services at the national level and is providing state-level strategic support for the scale-up of PPFP/PPIUCD services in 165 additional facilities in Jharkhand state.
  - MCHIP introduced PPIUCD services to 233 providers in the private sector though the "Saathiya" Network of Private Providers in states of UP and Uttarakhand.

Official launch of PPFP/PPIUCD services in the state of Jharkhand, India by the Minister of Health at the inaugural posters session of the Family Planning Fortnight.

- In **Rwanda**:
  - MCHIP support to the MOH resulted in the scaling-up of community-based distribution of FP methods in four districts.
  - MCHIP also supported MOH participation in the annual national and international MCH conferences, aided the MOH in data collection and management (with the involvement of the USAID System Strengthening Team and USAID-funded Monitoring and Evaluation Management system) and reviewing/updating the national policies, including the FP policy and strategy documents.
  - MCHIP assisted the MOH to expand FP options for women in Rwanda to include mini-laparotomy for tubal ligation through building the capacity of providers to offer this service. For the first phase of the project, six district hospital providers were targeted to be trained and equipped.
- In collaboration with the MOH in **Guinea**, MCHIP has strengthened local capacity in the provision of long-acting and permanent FP methods to expand access and increase uptake. IUD, interval IUD and PPIUD use has almost tripled in six health facilities in Conakry since last year. These facilities have benefited from MCHIP training, supportive supervision and supplies support.
- In October 2010, MCHIP assessed the results of a one-year collaboration with the **Ghana** Nursing and Midwifery Council to strengthen teaching and learning around PPFP in 12 midwifery schools, one public health nursing school and six clinical sites. Results were assessed using nationally developed standards and found that performance improved from an average of 58% at baseline to 94% in the schools, and from 44% baseline to 85% in the clinical sites. A recognition and award ceremony was held in December 2010 to acknowledge this progress and to share experiences and success stories. In addition, a PPFP external assessment of performance standards conducted in 12 midwifery schools, one public health nurses school and six clinical sites in November. Performance improved from an average of 58% at baseline to 94% at external assessment of the schools and 44% at baseline to 85% at external assessment of the clinical sites.
- In FY11, the MaMoni program in **Bangladesh** trained community-based health workers in FP counseling and provision, increasing acceptance of FP methods as a preventive health intervention for mothers and newborns. All government FWAs, HAs and MaMoni CHWs in the districts of Sylhet and Habiganj have been trained in promotion, counseling, provision of oral contraceptives and injectables, and referral for long acting and permanent FP methods. Community Action Groups (CAGs) are also using IEC messaging and materials to promote birth spacing and FP in their communities. A rapid FP assessment conducted in Sylhet in May showed a 14% increase in contraceptive prevalence rate (CPR) in the district following the introduction of the intervention just nine months prior. The bar graph below shows the increase in CPR from 34% to 50.8% over a nine-month period from two program-supported household surveys of 524 currently married women of reproductive age (Figure 15).

Figure 15. CPR in Sylhet District, Bangladesh



- In **Liberia**, MCHIP created a pool of providers competent in provision of FP methods, through skill and knowledge updates and through the development of clinical trainers. To expand FP services and broaden the range of contraceptive methods, 153 service providers were trained in provision of short- and long-acting methods and an additional 27 providers in the provision of long-acting methods such as IUCD and implants (Jadelle). In addition, trainings focused on postpartum and postabortion FP equipped 19 providers with knowledge and skills to expand FP options to women in their most vulnerable period of life. To strengthen national training capacity, MCHIP develop 25 new national trainers to ensure local training capacity to support future clinical training needs and quality improvement interventions.

HIV/AIDS OVERVIEW

MCHIP continues to work to build the capacity of both health workers and health systems to ensure the provision of high-quality care and respond to emerging priorities in HIV prevention, care and treatment. MCHIP was successful in integrating the prevention of mother-to-child transmission of HIV (PMTCT) with MNCH services, an example being in Kenya, where new national PMTCT and IYCF guidelines were rolled out to improve performance and are being used at all health facilities in the Bondo District. MCHIP has also had success in integrating cervical cancer services with HIV care and treatment in clinics, such as in Guyana, where MCHIP has increased the provision of cervical cancer prevention services to HIV-positive and other women. In Malawi, MCHIP contributed to scaling up Malawi's Voluntary Medical Male Circumcision (VMMC) program by training service providers in MC clinical skills training from nine high HIV prevalence districts identified by the MOH and implementing the first national VMMC campaign in Mulanje district. MCHIP also supported the implementation of one of the most highly efficient and high-quality VMMC programs in Tanzania over the last three years.

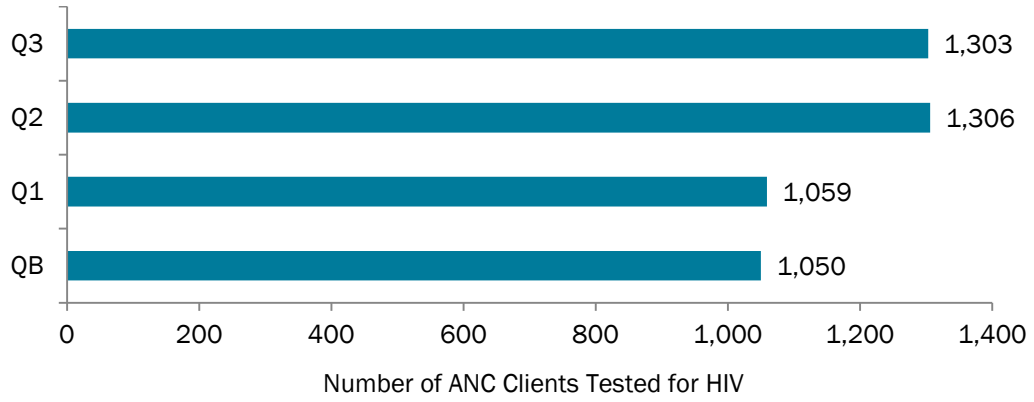
Given that working closely with MOHs and other partners is vital for MCHIP in scaling up safe and comprehensive VMMC services for adults, neonates and adolescents, MCHIP was able to advocate for the inclusion of adult male medical circumcision (MMC) in Lesotho as part of their national HIV prevention strategy. In Swaziland, MCHIP increased access to early infant MC services and revisions and updates to the WHO/Jhpiego learning resource package for Early Infant MC were also made based on experiences using it in the country. In Mozambique, the Single Visit Approach, a cost-effective and sustainable nurse-led intervention that combines testing and treatment of services with HIV care, was used on more than 8,500 women, and of those who had pre-cancerous cervical lesions, nearly 64% received same-day treatment.

Integrated HIV/AIDS/PMTCT

Core Funded

- In **Kenya**:
  - MCHIP supported the Kenya MOPHS, through the Divisions of Child and Adolescent Health and Reproductive Health and the Bondo District Health Management Team, to roll out the new national PMTCT and IYCF guidelines to help improve the performance of PMTCT and MCH services in Bondo district. MCHIP oriented 31 health care providers in Bondo on these guidelines, which are currently in use at all health facilities in Bondo district.
  - MCHIP piloted an adaptation of the Reach Every District (RED) approach in Bondo district to identify villages with high numbers of unreached pregnant women. CHWs were mobilized to reach these women and link them with clinical services, with the aim of improving clinical adherence, longitudinal follow-up and referral. Health workers were supported to develop 25 health facility RED micro-plans to improve ANC utilization in communities with poor coverage.
  - Introduced the use of mobile technology for ANC/PMTCT service support in Bondo district. MCHIP is using, *Mpesa,* an innovative mobile phone-based money transfer service from the mobile operator, Safaricom, which enables MCHIP to send money by phone to CHWs for incentive payments. MCHIP is also using SMS messaging to remind mothers of upcoming clinic days and to call or text those who do not come back for follow-up appointments.
  - Improved the quality and increased provision of PMTCT services in Bondo district through implementation of the SBM-R approach and an integrated MCH services job aid (Figure 16). SBM-R PMTCT standards were developed nationally by NASCOP and DRH with MCHIP support and applied at 12 facilities, which have shown substantial improvement in the quality of PMTCT services provided. To further strengthen links between the health facilities and communities, MCHIP has supported monthly community dialogue days. At these meetings, health workers meet with community representatives to address any health matters in the community.

Figure 16. Increasing Numbers of ANC Clients Tested for HIV at 12 Facilities in Bondo District, Kenya, over Four Quarters: Baseline Quarter (QB) and Follow-up Quarters (Q1-Q3)



- In **Malawi**, MCHIP developed PQI standards on early infant diagnosis, early infant feeding, integrated FP-HIV, integrated Sexually Transmitted Infections-HIV, integrated Cervical Cancer Prevention (CECAP)-HIV and inclusion of PMTCT in focused ANC, L&D and postpartum care. Following the finalization of these standards, MCHIP trained 66 PMTCT service providers from 36 sites on PQI for PMTCT-RH integration. In addition, MCHIP trained 359 providers from 10 districts on the new PMTCT service delivery guidelines, which include provision of ART for all HIV-positive pregnant women.

- In **Mozambique**, HIV prevention-related theatre presentations reached 46,570 participants to create debates around HIV risk and encourage community-based discussions around how best to reduce one's risk of HIV (via consistent condom use, staying out of sexual networks or cross-generational sexual relationships and the importance of knowing one's HIV status).

Male Circumcision Overview

Core Funded

- MCHIP finalized revision of global MC training materials that included:
  - The didactic portion is now individualized (self-paced) learning that shortens the face-to-face training time. This reduces the time of providers are away from work and aims to reduce the expenditure of program funds.
  - There is new content on surgical efficiencies (MOVE) including use of diathermy.
  - A global e-learning course was also developed, which has become one of the global health open courses provided by USAID.
  - An MC video for service providers and program managers has been developed and is in its final stage.
- MCHIP contributed to the scientific write-up of the global VMMC program in collaboration with stakeholders such as USAID, CDC, UNAIDS, DOD, WHO, Futures Institute, PSI and SCMS. The scientific supplements have been accepted by PLoS Medicin and PLoS One for publication in November 2011. This demonstrates the leadership role MCHIP is playing in the program design, implementation and documentation of key HIV prevention, care and treatment programs.

Field Funded

- In **Tanzania**, MCHIP's work in Iringa represented a very successful model for the implementation of a VMMC program in eastern and southern Africa. "The Iringa male circumcision campaign is an excellent example of a program implemented well and has been very successful in getting quality services to where it matters—the people," says Dr. Delivette Castor, Epidemiology and Statistics Advisor at USAID. In one campaign undertaken between June 20 and August 13, the program exceeded its target of serving 20,000 adolescent boys and men between the ages of 10–34 with services that included a health check, counseling and testing for HIV, screening for sexually transmitted infections and treatment, risk reduction counseling and condom promotion, serving nearly 31,000.
- In **Malawi**, MCHIP contributed to scaling up Malawi's VMMC program showing the following results:
  - Trained 42 service providers in MC clinical skills training from nine high, HIV-prevalence districts identified by the MOH. During the practicals, 147 MC were conducted. All 45 MC clients from the first training received counseling on HIV and none had any adverse events following the surgery. Of the 102 clients operated upon during the second training, all were tested for HIV and only one client had moderate adverse events (hematoma) reported on the follow-up visit.
  - Continued to monitor VMMC services following the clinical skills training for MC providers that was conducted in the previous quarter. A total of 777 routine adult circumcisions and one neonatal circumcision had been conducted since late February. HIV testing uptake continues to be high at 86.8% (n=675). A total of 61% of clients returned for a post-op visit within 48 hours, decreasing to 39% post-op follow-up at one week. The rate of moderate to major adverse events continues to be low at 1.1% (n=9).

- Strengthened Dedza and Mulanje District hospitals to serve as VMMC model sites. Using a checklist developed by Malawi's National MC Task Force, MCHIP conducted a needs assessment, developed an action plan and provided supportive supervision to implement the action plan. The action plan focused on improving availability of supplies and equipment, improving client flow and shifts toward efficiency models. These changes will support Malawi's efforts to reach VMMC targets, a key component of the HIV prevention strategy.

- In **Swaziland**, MCHIP helped increase access to early infant MC services: 14 health care workers have been trained (five doctors and nine nurses) from four public health facilities. Revisions and updates to the WHO/Jhpiego LRP for Early Infant MC were also made based on experiences using it in the country.
- In **Lesotho**, MCHIP participated in national-level discussions and in MMC Technical Working Group meetings over the course of PY3, advocating for the inclusion of adult MMC as a part of their national HIV prevention strategy. In June 2011, the MOHSW made the strategic decision to include voluntary adult MMC to their MMC strategy as an HIV prevention intervention. In PY4, MCHIP will provide technical leadership to the MOHSW in VMMC in addition to their existing work in early infant MC.
- In **Mozambique**:
  - 2,213 new condom outlets opened (63% of outlets in high-risk areas)
  - 9,247,976 male condoms were sold
  - 4,670,596 male and 131,026 female condoms were distributed through free distribution mechanisms
  - 266,255 individuals reached with individual and/or small group level interventions seeking to increase risk perception and self-efficacy around using condoms, partner reduction and the importance of HIV counseling and testing. An agreement for condom distribution at night clubs and pubs was signed with Too Sexy – a Mozambican company working on events promotion and online advertisement. Too Sexy is distributing condoms, targeting middle class urban young people at places where they are more exposed to high-risk behaviors.

Cervical Cancer Prevention

- In **Mozambique**, through the cervical and breast cancer prevention component, more than 8,500 women at the 17 health facilities providing services using visual inspection with acetic acid (VIA) and cryotherapy received breast and cervical cancer screening nationwide by the end of 2010. Of the 472 women with pre-cancerous cervical lesions, 63.8% received same-day treatment.
- In **Guyana**:
  - MCHIP has trained additional providers in VIA and cryotherapy, and worked with them to improve clinical service quality by introducing SBM-R and supportive supervision. MCHIP has also worked closely with the MOH to prepare for scale-up to a national cervical cancer prevention and control program, building the MOH's capacity and sharing increasing responsibility with the MOH for program management. The MOH, MCHIP and the Georgetown Public Hospital Corporation have conducted significant public awareness raising, including creating new relationships with stakeholders that will increase outreach to both general population and HIV-positive women
  - MCHIP increased provision of cervical cancer prevention services to HIV-positive and other women. From October 2010 to September 2011, 7,771 women were screened (7,033 of them were first-time screenings), of whom 861 were HIV-positive; 724 women screened VIA-positive and 561 of the 634 (89%) VIA-positive and cryotherapy eligible

patients received immediate cryotherapy. Since services began in January 2009, 18,203 women have been screened. Of these, 1,812 (10%) were HIV-positive women (self-reported; prevalence is approximately 2.5% in general population); 2,388 out of the total screened were VIA-positive, and 1,598 out of 1,903 or 84% of those women tested VIA-positive and eligible for cryotherapy received treatment immediately, at the screening appointment, with cryotherapy.

- MCHIP completed a process evaluation of the Guyana cervical cancer prevention and treatment project implementation. The purpose of the evaluation was to investigate successes and lessons learned over three years; perceived barriers and solutions to scale-up; institutionalization of service at facilities including supervision and management support; quality of record-keeping and utilization of data; referral and follow-up mechanism; and stakeholder's perception of program and handover/transition readiness. The data are currently being analyzed.

URBAN HEALTH OVERVIEW

Core Funded

- Ethiopia presents an important opportunity to better understand and address urban challenges given the Government of Ethiopia's (GOE) leadership in establishing an Urban Health Extension Program (UHEP) throughout the country to improve access to and demand for health services. This past year MCHIP supported a team from the USAID-funded UHEP program to identify opportunities for further integration of urban HIV/MNCH programming and link Ethiopia's key urban health champions and stakeholders to the broader urban health professional communities of practice, to create opportunities for sharing of implementation experiences. To further this objective, MCHIP organized a study tour to India, which has the highest numbers of urban residents in the developing world, for 15 Ethiopian urban health leaders (from the Federal Ministry of Health (FMOH), Regional Health Bureau (RHB) and USAID/UHEP) to better understand the unique challenges posed by working with urban populations. This tour was fully planned for and expected to occur in August 2011, but had to be rescheduled at the last minute to January 2012, due to a last minute conflict at the FMOH.

WATER, SANITATION AND HYGIENE OVERVIEW

Core Funded

- The Handwashing with Soap for newborn Survival Global Development Alliance was officially launched at the Global Health Council in June 2011, followed by a technical consultation with WASH, behavior change and newborn and maternal health experts. The experts convened to share formative research findings and work toward consensus on messaging and programming for handwashing for newborn survival. Formative research was completed in Indonesia, led by the London School of Tropical Medicine (LSHTM), and formative research in Bangladesh is in progress, led by ICDDRB. Development of a global package of communication materials is also underway based on the outcomes of the technical consultation and findings from formative research. This package will be rolled out to programs in PY4. Advocacy in Indonesia with the MOH and National HW Alliance has resulted in the inclusion of newborn handwashing as a topic in a large conference for Global HW Day 2011.

Field Funded

- In **India**, the double blinded randomized placebo controlled trial to assess the efficacy of Aquatabs® NaDCC tablets to prevent diarrheal disease was initiated in 20 villages of Dhenkanal and 11 slums of Bhubaneswar during the previous quarters. PSI has designed and delivered targeted messages through interpersonal communication by "Inter Personal Communicators," street plays, game shows and wall paintings at the community level to enhance the ability and motivation of target audiences to use Aquatabs. In addition, leaflets, stickers and calendars were distributed among the enrolled households.

Sample Aquatabs Wall painting from India.

- MCHIP/Indonesia, in collaboration with Hygiene Center of the LSHTM and Unilever, conducted a study in Serang district to identify opportunities for handwashing for mothers and newborns. The study aimed to answer questions around the context and practices of handwashing among those who come into contact with newborns. The study found that handwashing with soap (HWWS) was rare before meals and was occasional after meals. Water and soap availability was not a barrier to handwashing. HWWS was more frequent in households in urban areas, and among better educated and more affluent women. Women trust midwives more than traditional birth attendants (TBAs), although both types of birth attendants have important roles and influence over new mothers. A foundation of practice for HWWS exists in this community, on which a handwashing promotional campaign can be built. Based upon these findings, IEC materials to promote handwashing for mothers and newborns are currently being developed with Unilever support. These findings from Indonesia, as well as a study in Bangladesh, will contribute to the global understanding and best practices for handwashing promotion. At the national level, MCHIP will continue to advocate for inclusion of handwashing for mothers with newborns in national programs. MCHIP, in collaboration with the Global Alliance for Handwashing, is also planning handwashing with soap campaigns in the three districts for the Global Handwashing Day on October 15, 2011. In Serang, the campaign will be launched by the Bupati. Handwashing day was also celebrated with high visibility events in all three districts in 2010.

Recognition of Aquatabs product Champion in India

PVO/NGO AND CORE GROUP SUPPORT OVERVIEW

MCHIP's vision is to maximize the contributions and potential of the PVO and NGO grantees in the scale-up of proven interventions at the country level. MCHIP assisted the Child Survival and Health Grants Program (CSHGP) to further its objectives through strategic analysis and dissemination of CSHGP portfolio data; and targeted technical support to the active portfolio of CSHGP grantees and support to existing CSHGP management systems that are utilized to guide, organize, collect and diffuse portfolio-level data. Program Year 3 saw the CORE Group join MCHIP as a more significant partner than it had been in the past, expanding its role on MCHIP from diffusion of CSHGP-related experience and tools, to also include collaboration with MCHIP's technical teams on a variety of initiatives.

In Year 3, the PVO/NGO support team maintained its high level of support to the CSHGP and MCP Programs (see Malaria section for information on MCP results), and strengthened linkages between MCHIP's global and country efforts, and CSHGP grantee activities. An increased understanding between CSHGP grantees and MCHIP core staff was facilitated through MCHIP participation in grantee orientation and DIP review meetings and the CORE Fall and Spring Meetings. These interactions led to in-country collaborations in Rwanda, where MCHIP's Rwanda Country Team helped to facilitate value-added activities in MCHIP districts for the Final Evaluation of the CSHGP Expanded Impact project; and in Liberia, where Africare's new CSHGP grant benefited from technical support in FP integration from MCHIP staff. The CORE Group, in its second year as an MCHIP partner, added value to MCHIP activities beyond the CSHGP, specifically related to the HBB Initiative; the CHW performance technical advisory group and follow-up processes; and contributing to MCHIP's Equity Guidelines.

Core Funded—PVO/NGO Support Team

MCHIP's PVO/NGO Support Team continued to provide ongoing technical support to a CSHGP portfolio of 30 projects operating in 24 countries, including 17 grantees in the innovation category who are exploring innovative approaches that are integrated into community-based health and development programming platforms and harness the potential for impact, scalability and sustainability within local health systems.

- Produced four documents highlighting CSHGP portfolio level experience, and diffused these widely through the CORE Spring Meeting and other MCHIP events. These documents included:
  - Collaborating with Communities and Aligning with National Systems to Achieve High Impact and Coverage for Mothers and Newborns: USAID's partnerships with International Non-Governmental Organizations through the Child Survival and Health Grant Program. This document examined historical trends in CSHGP data across a range of MNC interventions, focusing on areas such as recognition of danger signs, ANC visits, skilled birth attendance breastfeeding, and post-natal visits. Among other findings, the document highlighted that across the 26 projects starting between 2000 and 2006 with available endline data and at least a 30% MNC LOE, there was an average of a 41 percent increase in SBA coverage in the project areas. Five projects saw SBA coverage more than double over the life of the project. Four projects ending in 2010 showed significant increases in the number of children receiving postnatal visits, while other project demonstrated an ability to significantly improve multiple indicators through integrated programs.
  - Testing innovative MNCH approaches to serve vulnerable communities: USAID's partnerships with 14 International Non-Governmental Organizations (INGOs) through the Child Survival & Health Grants Program in 16 countries
  - Achieving Impact, Building Local Capacity, Enhancing Global Networks: The Experience of the Child Survival and Health Grants Program's New Partner Initiative
  - Building on the Current Evidence to Strengthen Community-Based Service Delivery Strategies for Promoting Child Survival
- Participated in the Final Evaluation of CSHGP's Expanded Impact Program in Rwanda, with the specific objectives of facilitating meetings with different national stakeholders to document the process of how CCM has gone to scale in Rwanda and to map out the events in a scale-up map; and to work with the Final Evaluation Team of CWI Kabeho Mwana EIP Project to implement a complementary qualitative study in a non-EIP district (Ruhango) to supplement the learning from the six EIP districts. Learning from this experience will be further shared during PY4, as this evaluation report is officially due from the grantee in December 2011.

Core Funded—CORE Group

The CORE Group made important contributions to ensuring robust fora for learning and diffusion of experience between MCHIP technical teams and the wider NGO community; ensured that the community perspective was reinforced in a range of MCHIP-led initiatives; and benefited from MCHIP technical input into CORE Group-led activities. Specifically, the CORE Group:

- Supported NGO and MCHIP Program Learning through CORE Group Community Health Network functions. For its Spring Meeting, CORE Group hosted 217 participants from 94 organizations, making it the most extensive meeting ever. With the theme, "Equity in Health: Ensuring Access, Increasing Use," not only were key technical MCHIP documents disseminated at the meeting, but MCHIP and CORE Group collaborated on several sessions on key mutual program learning themes including equity, community health work, integration, innovation and operations research. At the heart of the Community Health Network, CORE Group successfully supported its eight technical working groups in the development and implementation of their annual work plans, engaging members and liaising with MCHIP, partners and donors. CORE Group also improved and expanded collaborative relationships and program learning among members, MCHIP and other partners through its multiple modes of dynamic communication.
- Contributed to the MCHIP draft *Health Equity Guidance* and *the Health Equity Checklist*; the design and planning of the MCHIP-led CHW Performance technical advisory group (TAG) and follow-on activities related to CHW typologies and community health systems; and planning and facilitating the back-to-back Care Group TAG, which led to an update on Care Group info at www.caregroupinfo.org. As an outcome of the CHW TAG meeting, CORE Group led a multi-organization working group on community health systems, and took the lead in writing a discussion paper, "How Social Capital in Community Systems Strengthens Health Systems: People, Structures and Processes." CORE Group continued to lead the mHealth interest group where lessons learned were diffused, and collaboratively designed and administered an mHealth survey to assess related program experiences and capacities.
- Provided practical input into the development of the HBB Implementation Guide with the GDA partners and is making links to CORE Group members for field testing and related workshops. In addition to newborn health, CORE Group worked collaboratively on increasing immunization coverage through greater CSO involvement, integrated approaches to maternal and child anemia, community-based TB programs including pediatric TB, and extended program learning on several other topics through its Webinar series and meetings.
- Widely diffused products both co-branded with MCHIP and complementary to MCHIP technical initiatives, including the Nutrition Program Design Assistant Tool, CCM Essentials Guide and Graphic, and community-based TB programming resources were made through the Community Health Network mechanisms. CORE Group also finalized the Essential Nutrition Actions trilogy in English and French. With the goal of promoting diffusion of related products and civil society leadership, CORE Group participated in task forces and meetings to promote the Road Map for Scaling-Up Nutrition, hosted a booth at the International Union Against TB and Lung Disease conference and assumed the position of Co-Focal Person for the RBM CMWG Expanding Access to Effective Treatment Workstream in order to advocate for iCCM and improve community-based malaria programming. CORE Group also hosted and jointly planned with MCHIP a CCM TAG meeting that brought together 24 representatives of implementing partners and stakeholders from 19 different organizations to identify ways to address some of the key challenges related to CCM.

STRATEGIC COMMUNICATIONS

- MCHIP continued to increase the visibility/brand of the program within the global community:
  - Responded to inquiries from several media outlets such as ABC News on the Health Fertility Study in Bangladesh and from National Public Radio (NPR) on the humanization of childbirth in Mozambique;
  - Several pieces picked up by the State Department and USAID; being highlighted in "featurettes" in high-profile global health media such as the Global Health Council magazine (print/online);
  - Represented in various news outlets (more than 20 during the reporting period) such as Irin News, which published an article on the MNH Africa regional meeting in Addis Ababa;
  - Supported a media roundtable on maternal health with journalists from across the globe;
  - Several key pieces of project collateral created to include translation of the MCHIP brochure into French, Portuguese, Spanish and Swahili; fact sheets by intervention area; 39 country profiles; key messages; promotional giveaways; overseeing publication of over 50 resources, which are posted to Web site.
- MCHIP continued to ensure that its staff—both in Washington, DC, and abroad—have the skills and tools required to effectively communicate to external audiences about the Program:
  - A virtual communications briefing to MCHIP field offices was conducted that highlighted communications activities, provided a tour of mchip.net and various social media sites, and detailed ways program staff can help communicate their work.
  - Various mini-communications workshops were held in the field and at headquarters, covering topics such as how to write a success story, branding, how to utilize social media, how to use key messaging and how to communicate the investment of USAID as part of ongoing MCHIP work, as well as media training and messaging special seminars.
  - MCHIP communicated best practices and program learning results through presentations at numerous forums that offered opportunities for influencing the global dialogue. A list of events/presentations is included in Annex F.
- The functionality of MCHIP.net continued to expand rapidly over the reporting period and now provides a broader range of information on MCHIP programs, tools and resources; global leadership activities; and technical areas of focus. From October 2010 to September 2011, 96 blogs, 63 featured articles, 34 press mentions and 22 event descriptions were posted to the external Web site. Page views for each of the aforementioned range from 500 to over 7,000. MCHIP also maintained success in increasing the number of site visits per month to mchip.net: September (11,400); October, 2011 (22,000). These numbers represent unique visitors. Nearly 30 international health themes were celebrated such as Global Handwashing Day, World AIDS Day, Nutrition Month, with in-country events, blogs, articles, banner graphics, photos, etc.
- MCHIP continued to post regularly to Facebook and its Twitter feed. Facebook has increased from 20 followers in September 2010, to nearly 450 in September 2011, and there are, on average, 150–300 site visits per week. There are currently 828 MCHIP followers on Twitter, up from close to 200 during the last reporting year. Throughout Year 3, there were over 300 posts to Facebook and over 1,000 tweets sent.

Challenges

ADMINISTRATIVE AND FINANCIAL

- FP activities within MCHIP expanded considerably during PY3, placing a strain on management and support systems. Urgent requests for support for Southern Sudan and Rwanda have been managed, but presented unique challenges.

TECHNICAL/PROGRAMMATIC

- With the successful replenishment of GAVI in June and GAVI's announced plans to fund 46 additional vaccine introductions in 37 developing countries, there is a real danger that other partners (including bilateral developmental partners) will believe that GAVI is taking care of all immunization needs. USAID itself has greatly increased its contribution to GAVI for the next three years, of which the entire USG contribution goes toward vaccine procurement. Bilateral partners will need to understand that technical assistance is required in many countries to protect this increased investment. Vaccination programs require more than just vaccines. The Decade of Vaccines, in which MCHIP plays a leadership role, provides an opportunity to re-balance the global approach to vaccination.
- Due to lack of cultural adaptation and sub-optimal quality of currently available HBB materials in Spanish, the USAID LAC Bureau postponed all trainings. An additional revision of the text is currently being finalized by MCHIP and the AAP, and MCHIP is working on cultural adaptation of the images; Laerdal will produce and distribute the new version. MCHIP will use the new materials during PY4 for trainings of Master Trainers in South America in Paraguay and in Peru (Midwifery Association), two trainings during the regional ICM meeting in Ecuador; and further expansion in DR with the MOH (200 providers from the highest neonatal mortality rate areas). The proposed HBB indicators will be tested in DR, contributing to the global M&E GDA effort.
- An important challenge for child health has been lack of visibility, resources and a comprehensive strategic approach to programming. Available multi-partner funding at the country level, including USAID bilateral projects, the Global Fund is not coordinated and channeled toward implementing programs to deliver the key effective interventions at scale. The Child Health team is working to shape policies and develop strategies at global, national and sub-national levels to expand access to preventive and case management interventions for the main causes of death among children under five. Working with WHO and UNICEF, MCHIP provides strong leadership in global advocacy and coordination of the global action plan for control of pneumonia and diarrhea to increase visibility of these issues, while directly supporting countries technically and operationally to bring their programs to scale. At the country level, using the child health profiles and scale-up map approach, MCHIP is supporting country programs to build partnerships and mobilize resources to take child health interventions to scale.
- Despite the availability of simple, cost-effective interventions to reduce diarrheal disease deaths through ORS, the condition continues to claim 1.3 million children per year. At the global level, there is a lack of leadership on diarrheal disease and MCHIP is advocating for leadership and resources, and promoting champions. MCHIP has the opportunity to provide technical support to national MOH program managers and build their skills to leverage available resources in country through funding sources, such as PMI and Global Fund, to implement coordinated child health programs.
- Securing USAID mission support for the newborn handwashing GDA has been challenging. Plans to work in both India and Nigeria were dropped after the missions were not supportive of GDA efforts. Furthermore, a lack of commitment of field funds will limit the ability to roll out GDA in Kenya as core funds are not available in PY4.

LACK OF NEEDED SUPPLIES, DRUGS AND INFRASTRUCTURE

- RDT stock-outs resulted in reduced service delivery capacity and reduced practice of the related skills by providers in Burkina Faso during PY3. MCHIP continues to coordinate closely with DELIVER to ensure the delivery of correct supplies including RDT; however, in this instance the supply issue seemed to have been beyond the program.
- In Guinea, contraceptive stock-outs and issues with MVA kits (damaged syringes) occurred in a number of facilities. The MCHIP in-country staff coordinated with UNFPA to provide new MVA kits to the facilities. Contraceptives ordered through USAID bilateral ESD had arrived at the time of this report.
- Stock-outs of FP commodities at the facility level continue to be a debilitating challenge in all counties of Liberia in which MCHIP works. With increased demand generated through FP trainings, the stock-outs create a gap in service provision. Stock-outs of implants and Depo-Provera are listed as the most persistent. In addition, a nationwide shortage of IUCD insertion kits have hampered provision of IUCD methods even though a large number of providers have been trained in this method. USAID is addressing the overall commodity issues. There is very little bottom-up feedback on commodities availability, so MCHIP is doing its best to inform the MOH and USAID every time we know of a shortage, as well as emphasizing shortages during regular supportive supervision visits. Regarding the IUD insertion kits, MCHIP informed USAID—they were aware of it and are addressing this issue through JSI/DELIVER that is starting in Liberia.
- During MNH trainings in Madagascar, participants professed a readiness to adopt the new practices but many do not have access to all equipment used in the trainings, including delivery kits, episiotomy (suture) kits, neonatal resuscitation materials (neonatal bags and masks) and other supplies. At the health facility and community levels, MCHIP is therefore trying to address key systems factors, including equipment, that affect the quality of care by leveraging this type of support through other partners, given that we cannot provide equipment or supplies to facilities directly.

MOH PRIORITIES AND MANAGEMENT AND SUPERVISION

- A common challenge seen across the Africa region is that while most countries have permissive policies for iCCM, they have limited funding for implementation. This includes meeting costs for supervision; assuring the supply chain of essential medicines and commodities; and building up health information systems to adequately capture disaggregated iCCM data. Program managers need additional technical support to leverage available funding (e.g., PMI and Global Fund) to plan, introduce and scale up iCCM.
- In Ethiopia, following the FMOH's requirement to standardize all refresher trainings for HEWs by following the Integrated Refresher Training (IRT), MCHIP is required to adapt its training materials on newborn care (including HBB and KMC) in order to train HEWs and the newly titled community health promoters. For MCHIP, the IRT poses some limitations as it does not sufficiently address CKMC. However, as the CKMC study will be research, in discussion with the RHBs and the FmOH, it may be possible for MCHIP to use its training materials for the study alone.

POLITICAL

- Since the coup d'état in Madagascar in early 2009, the USG and many of the other international aid agencies have either withdrawn or placed restrictions on direct support to Madagascar's government and its public sector agencies, including its MOH. MCHIP has therefore had to reorient its strategic approach and find new and creative ways to achieve program objectives. During this past fiscal year, MCHIP was able to launch activities at

both the national and district level by working with members of professional associations. Given MCHIP's restrictions on being directly involved in supporting health facilities, we have not only prioritized close coordination with professional associations, but also with agencies like UNICEF and UNFPA, through regular meetings, MOUs and collaboration on key workplan activities. Our engagement with UN organizations is an opportunity to be meaningfully engaged at the national level, but especially at the health facility level, which is important, as we are committed to an approach reflecting the continuum of care from household through health facility. One of MCHIP's primary roles has been to provide technical assistance to USAID bilateral programs and other collaborating partners mentioned above for introduction and scale-up of high-impact interventions. For example, MCHIP has sought to complement the efforts of partner Santenet2 by helping them integrate community-level management of maternal and newborn complications in their service delivery package in the three demonstration districts. Importantly, MCHIP will actively seek to replicate proven, targeted MNH technical assistance in other districts with collaborating USAID, UN and other implementing partners in order to reach a greater number of beneficiaries.

MONITORING AND EVALUATION/HEALTH MANAGEMENT INFORMATION SYSTEMS

- Getting approval for LAC Bureau-funded maternal health study protocols required much more time than anticipated as they had to go through USAID/DC, respective MOHs, the PATH RDC, and in-country and USA-based ethical committees. In the future, planning for studies should include at least 9–12 months for getting approval prior to implementing the study.
- A limitation to accomplishing the core FP learning agenda in the past year is that several special studies were delayed due to the prolonged protocol development and research clearance process. We realize that as this is a new process, it may require more time than originally anticipated; however, it has significantly affected our global learning agenda.
- Throughout FY11, some MCHIP indicators have proven very difficult to measure given the current state of data collection forms/registers in Zimbabwe's health facilities, and current challenges faced by the country's HMIS. In particular, it has been challenging to measure the indicator related to provision of essential newborn care services, as there is no routine data currently being collected about these services. In order to measure this indicator (and others with similar data collection/quality issues), MCHIP has had to consider developing separate data collection tools for use at facilities, and orienting/training health workers as to proper use of new tools. To date, these activities have not occurred however, given ongoing concerns about creating parallel data systems and overburdening health care workers, and thus this data has remained unavailable to MCHIP. During Q4 and likely into FY12, USAID and MCHIP will assess whether indicators like the essential newborn care indicator should remain part of the Zimbabwe performance monitoring plan, or should be revised or eliminated.

Annex B: Africa S/D Results

INTRODUCTION

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

Africa Bureau funds are used strategically to support Africa Bureau priorities as well as to strengthen and advance specific technical components under MCHIP. Complementary use of Africa Bureau funds has reached over 25 countries in Africa. This report presents MCHIP program results that were achieved with the support of Africa SD funds during the period from October 1, 2010 to September 30, 2011.

SUMMARY OF ACHIEVEMENTS

Maternal Health

Interventions for Impact in Essential Obstetric and Newborn Care:

- MCHIP continued to advance the agenda related to PPH and pre-eclampsia by bringing partners together for an Africa Regional Meeting on *Interventions for Impact in Essential Obstetric and Newborn Care* in February 2011. Working in partnership with global and regional partners including WHO/AFRO, RCQHC, ECSA, WAHO and Africa's Health in 2010 (see details below), more than 250 came together to exchange ideas and have access to the latest research and program developments on key maternal and newborn health interventions. Some meeting highlights included:
  - Opening speech by the African Union highlighting the importance of improved maternal and newborn health on the continent
  - Stimulated country programs to focus more specifically on maternal health including those with existing MCHIP support (Kenya, Zimbabwe, Ethiopia, Mozambique, Rwanda), and those with bilateral programs focused on maternal and newborn health or interested in this type of programming (Uganda, Zambia, Tanzania, South Sudan, Angola)
  - Use of scale up maps to understand the status of PPH and PE/E programming in multiple countries.
  - Presentation of research results, exchange of programmatic experiences and skills sessions

- **Pre-service education strategy, implementation guide and compilation:** A Pre-Service Education toolkit was developed through an extensive collaborative process with WHO, USAID and other partners. The Toolkit includes an implementation guide, which highlights the pathway toward sustainable change in the structure and function of PSE programs, as well as an extensive collection of tools and resources for improved education and educational management. The Toolkit was launched during program year 3 and is being used by MCHIP programs and partners in Bangladesh, Ghana, Liberia and South Sudan. To ensure that the Toolkit is both widely used and regularly updated, a process has been put in place to ensure regular engagement with a broad community of practice of technical experts,

program managers and end users. Monthly user statistics are being collected, and the first updates to tools were added in September. An online orientation was conducted and another is scheduled for the end of November. Individual and small group orientations were done with ICM executive staff in Accra, Ghana, and with UNFPA Country Midwife Advisors in 4th Quarter (August). The e-toolkit is available on the K4Health website at: http://www.k4health.org/toolkits/pse. This toolkit has been viewed by more than 9,335 people in 153 countries and has been requested as tool for program expansion in Bangladesh, Ghana, Afghanistan and South Sudan.

- **Collaboration with WHO/AFRO, RCQHC and ECSA, the West African Health Organization (WAHO):**
  - Meetings were held in Brazzaville with the AFRO team regarding collaborations and the content of the Africa Regional Meeting.
  - Dr. Pyande Mongi, representing WHO/AFRO, delivered the keynote address. She focused on the somber facts of maternal and neonatal health in Africa, the coverage for the key interventions and the way forward.
  - Matthews Mathai, Medical Officer at WHO/Geneva, described the latest WHO recommendations for the prevention of PPH and guidelines for its management, spoke on the issue of induction of delivery in case of pre-eclampsia or eclampsia, and collaborated with Sheena Currie to lead a Skills Session on Induction of Labor. Dr. Pyande Mongi, of WHO/AFRO, focused on the importance of neonatal resuscitation within essential neonatal care (ENC), described the newborn health situation in Africa, touched on key components of ENC, and described newborn resuscitation in context of the WHO Essential Newborn Care Course.
  - Various colleagues from RCQHC, WAHO and ECSA-HC were participants at the Addis meeting.
  - WHO/AFRO colleagues met with MCHIP and Jhpiego to request further technical assistance in the development of a resource kit for training in EmOC in Africa. Work on this has been continuing by the MH team and will be a key element in the Africa Champions Initiative being undertaken in PY4.
  - MCHIP participated in a WHO regional meeting in Ouagadougou on Maternal Health in West Africa. The meeting was an opportunity to understand WHO activities in the region and provide technical support as needed.
  - MCHIP has been in conversation with WHO, WAHO and ECSA-HC about the development of technical resources for MNH, and the development of Maternal Newborn Health Champions. This is a process that will be most active in the coming 2 years of the MCHIP program and **WAHO has committed some of their own funding to support this initiative.**

Newborn Health

- **Strengthening Newborn Pre-Service Training**: MCHIP trained 20 tutors from 18 pre-service midwifery schools in Ghana who in turn trained 625 midwifery and nursing students prior to their graduation from the schools. This core-funded activity has leveraged field support for the continuation of strengthening the newborn health component of pre-service midwifery and nursing training in Ghana. In addition to leveraging funds from the USAID/Ghana mission, MCHIP has succeeded in advocating for the bilateral program, FOCUS Regions Project, to integrate HBB into its MNH training in their assigned regions in Ghana.
- **Program Learning on Newborn Sepsis Management:** MCHIP completed an assessment of newborn sepsis management by non-physician health providers in selected

health facilities in three States in Northern Nigeria - Katsina, Kano and Zamfara. The findings were used to inform program design and training. Providers at primary health centers were trained to identify and manage sick newborns with possible severe bacterial infection using an adapted WHO IMNCI protocol. This activity will contribute to program learning, and will better inform and facilitate dialogue in working together with government and professional bodies on how to move treatment of newborn infections closer to the community. An evaluation is planned for PY 4.

- **Regional Collaboration to Improve Newborn Care:** In PY3, MCHIP worked with the Regional Center for Quality Health Care (RCQHC) and the East, Central and Southern Africa – College of Nursing (ECSA-CON) to improve newborn care including resuscitation in pre-service institutions in the East, Central and Southern African countries. RCQHC is the lead agency for this activity with MCHIP and Africa 2010 providing technical and financial support. A key challenge has been to get RCQHC to complete agreed upon tasks in a timely manner. In year 3, a newborn curriculum assessment should have been completed, curriculum revision initiated curriculum revision, and training of tutors and preceptors begun. However, only the assessment was initiated, and not yet completed.
- **Helping Babies Breathe:** Immediately following the Africa Regional Meeting on *Interventions for Impact in Essential Obstetric and Newborn Care* meeting, MCHIP and partners hosted a Helping Babies Breathe (HBB) training of trainers (TOT) to facilitate the implementation of neonatal resuscitation in the context of essential newborn care using the HBB training materials and approach across multiple countries. One hundred and twenty-one (121 trainers from Ministries of Health and NGOs in 25 sub-Saharan African countries, and two from non-African countries, were trained. Participants at the workshop also discussed how the HBB training would be rolled out in their respective countries and integrated into ongoing maternal and newborn programs. To date, since the Addis Ababa training, participants from Rwanda, Malawi, Ghana, Zimbabwe and Nigeria have co-facilitated training in their respective countries. In Rwanda, HBB has been integrated nationally into the BEmONC trainings. Others from Mozambique and Uganda are members of teams reviewing and revising current MNH training materials to include HBB in preparation for nationwide improvement of newborn care. Furthermore, MCHIP Nigeria trained 208 service providers in 15 health facilities on sepsis management. The Ministry of Health in Bangladesh has adopted HBB as a national strategy based on findings of a pilot test of the approach supported by MCHIP, UNICEF, and the Laerdal Foundation.

Child Health

- **Global Leadership in Integrated Community Case Management:** With USAID, MCHIP functions as Global CCM Task Force Secretariat, and facilitated the development of a program of work among Task Force members to advance the global child health agenda. Through this forum, MCHIP built consensus on the iCCM scale-up benchmarks and indicators. Support materials for indicators and reference sheets are in the final stages of development. MCHIP also facilitated a review of a sample of tools among Task Force Members, which led to the compilation of a Tool Kit of program management guidelines including training and supervision. Through this process gaps were identified, and tools were developed, most notably in the area of logistics. All are being posted on **www.CCMCentral.com,** a website MCHIP manages, which serves as global CCM resource center, which provides latest updates, key links, meeting updates and outcome reports, in addition to a vast selection of tools to improve management of and access to program materials, for managers implementing country-level programs. The Website was launched in September 2011.

- **iCCM Joint-Work Plan:** With WHO and UNICEF, MCHIP co-facilitated three regional Global Action Plans for Prevention of Pneumonia and Diarrheal Disease (GAPP-DD) conferences in Bangladesh, Kenya, and Senegal. MCHIP provided technical support for the development of country action plans of the 26 countries from respective regions represented, to strengthen the prevention and control of pneumonia and diarrhea, with focus on introduction and scale up of CCM programs. Post GAPP-DD, MCHIP as part of a multi-partner team, undertook a follow-up visit to Kenya for continued advocacy for CCM of pneumonia.
- **Diarrheal Disease Advocacy:** MCHIP and USAID advocated for increased attention to diarrhea disease in the context of GAPP meetings, making diarrheal disease a key meeting agenda item. MCHIP presented the public sector's perspective on challenges in scaling-up zinc programs at the Zinc e-Conference and participated in the meeting organized by London School of Hygiene and Tropical Medicine (LSHTM) and Unilever, to explore the need, potential leadership and structure of a coalition to advocate for high level champions and resources for diarrhea prevention and control. MCHIP presented on diarrheal disease at the Mini University organized USAID Global Health Bureau.

Immunization

Immunization Regional Leadership

MCHIP has continued to provide regional leadership and immunization support to individual countries with AFR/SD and other funding. Below are the key regional and country achievements during this reporting period.

- **Regional work in Africa**
  - Revision and field testing of the AFR EPI Mid-Level Management training modules (MLM modules):
    MCHIP was invited by WHO/AFRO as one of the key partners to attend a workshop to revise AFR EPI MLM modules held in Accra, Ghana from June 13-18, 2011. MCHIP provided technical assistance and coordinated the revision of the following modules: "Monitoring and Data Management", "EPI Assessment" and "Role of EPI manager". In addition, MCHIP technical officers assisted in validating the modules "Communication" and "New Vaccines Introduction." From October 3-14, 2011, WHO/AFRO, in collaboration with other key immunization partners, including MCHIP, organized an inter-country MLM course in Nairobi, Kenya for Anglophone countries. The purpose was to test the revised, or newly developed, MLM modules and handouts. MCHIP co-facilitated this workshop and supported the participation of two field staff (from Rwanda and Kenya) who were trained as trainers. Lessons learned from this training will be used for the next workshop, planned early next year, for Francophone countries.
  - **NUVI meeting in Arusha, Tanzania:**
    From April 4-15, 2011, two MCHIP technical Officers from HQ and three from Kenya, Rwanda and Zimbabwe field offices attended the WHO/AFRO ESA (co-organized by GAVI), "Workshops on Comprehensive Multi-Year Plan (cMYP) Development and GAVI Applications for New Vaccines Introduction Support." MCHIP staff co-facilitated both workshops and provided specific support to Kenya, Rwanda, Tanzania/Zanzibar, and Zimbabwe. These countries revised or developed their cMYP, and drafted and submitted their applications for new vaccine introduction during this time. 24 countries were approved outright and seven countries were approved with clarifications or conditions that will require rewriting and resubmitting their applications.
  - **NUVI meeting in Harare, Zimbabwe:**
    MCHIP immunization team members co-facilitated a workshop on new vaccine introduction organized by AFRO East & South and AFRO West & Central for

Anglophone countries. The workshop was held after the decision by the GAVI Alliance Board to approve countries' applications for new and underutilized vaccines. The purpose of the workshop was to assist countries that were approved for a new vaccine to prepare for the introduction phase and to help those countries approved with clarifications or conditions to address GAVI's issues with their applications. MCHIP staff provided specific technical assistance during this workshop to teams from Kenya, Rwanda, Tanzania, and Zimbabwe.

- **Africa Regional Conference on Immunization (ARCI) and EPI managers' meetings:**
  MCHIP team members from HQ, Kenya and Zimbabwe attended the annual ARCI in Ouagadougou, Burkina Faso in December 2010. MCHIP technical officers from HQ and field offices also attended three EPI managers' meetings organized by WHO/AFRO Center, West and East & South ISTs and co-facilitated the meetings with WHO, UNICEF and other partners.
- **Contributions to other WHO/AFRO strategies and technical documents:** MCHIP served on an external panel reviewing and providing input to a draft AFRO strategy on reaching un-reached children with immunization services, which will be presented to the WHO/AFR Regional Committee.

Country Specific Technical Assistance

MCHIP provided immunization technical assistance to DRC, Kenya, Malawi, Rwanda, Senegal, South Sudan, Tanzania, Uganda, and Zimbabwe during this period. AFR/SD funding was used in combination with core MCH and Polio funding in DRC, Senegal, and Uganda.

Democratic Republic of Congo

- **Strengthening the performance of routine immunization systems**
  After DRC began a phased introduction of the pneumococcal conjugate vaccine (PCV13) in 2011, MCHIP assisted in reviewing and developing a revised version of its cMYP for 2011-2015, actively participated in the annual EPI review and was involved in the development of the EPI macro plan and the micro planning tools, used by health zone officers. MCHIP also provided direct technical assistance to the new USAID bilateral Integrated Health Project (IHP), supporting the health zones of Sankuru, Kasai Occidental and Sud Kivu and training 133 health professionals (Medical Chief Officers, Health Zone Supervisors, and Health District Supervisors. MCHIP, in collaboration with IHP and EPI, also provided technical assistance during supervision visits in Kasai Oriental and Sud Kivu provinces to identify and prioritize lower performing health zones. During supervision visits, MCHIP and partners trained staff in the health zones (e.g., Medical Chief Officers, Supervisors of the zones) using the WHO MLM training modules. They also assisted health zone management teams to carry out Data Quality Self Assessment (DQSA) and to use their immunization data to identify problems for additional attention. MCHIP provided assistance in the new vaccine introduction (PCV13) Training of trainers and health workers at the facility levels: MCHIP worked with partners to provide technical assistance in a training of trainers for health workers at the health zone level, training 201 staff, in preparation of the PCV13 vaccine introduction (Table 2, Appendix B).

Sénégal and Uganda

- **Technical support to External EPI reviews in countries**
  MCHIP played a key leadership role during multi-agency EPI reviews in both Senegal and Uganda. In Uganda, an external EPI review was conducted from September to November 2010, with technical and financial support from MCHIP and various other partners. Three MCHIP technical officers coordinated all agencies involved in the review, conducted

interviews and field visits, and worked with UNEPI to present the findings and recommendations to the immunization ICC and USAID/Uganda.

The USAID/Senegal Mission requested technical assistance from MCHIP for an external EPI review and immunization coverage survey that were carried out in 2010/11. Working with the MOH and its EPI, MCHIP coordinated the cold chain and logistics assessment, communications and social mobilization review, and review of program operations, structure and financing that are part of the EPI review methodology. MCHIP also worked with the coverage survey teams to clean and analyze their data and subsequently provided extensive technical support for two workshops: one for the analysis of findings from the EPI review and coverage survey (strengths, weaknesses, opportunities and recommendations) and the second for the development of the first draft of the EPI review report. MCHIP presented findings and recommendations to MOH officials and its partners during a special ICC meeting, in addition to sharing the draft report with partners in the country. The MOH and partners then developed an implementation plan to strengthen the EPI based on the review's findings and recommendations.

MCHIP CONTRIBUTION TO STANDARD INDICATORS FOR AFR/SD HEALTH ELEMENTS

Malaria

Number of people trained in monitoring and evaluation: n/a

Number of people trained in other strategic information management n/a

Maternal and Child Health

Number of people trained in maternal and newborn health through USG supported programs 349

Number of people trained in child health and nutrition through USG supported programs** 334
Number of men 293
Number of women 41

Number of improvements to laws, policies, regulations or guidelines related to improved Access to and use of health services drafted with USG support 3*

*In Kenya: DD policy; Diarrhea Communication Strategy; Guidelines for ORT corners;
**Total in DRC trained in immunization and PCV13 introduction with MCHIP support

Table 3. Immunization training in supported-IHP health zones by MCHIP in DRC

TOPIC	CATEGORY OF PERSONNEL TRAINED	SITE OF TRAINING	NUMBER OF PERSONS TRAINED		
			Male	Female	Total
Mid-Level Management Course for EPI Managers	Health Zone staff members	Tshumbe, for 14 IHP supported Health Zones staff in Sankuru	28	6	34
	Health Zone staff members	Tshikaji, for 11 IHP supported Health Zones staff	25	0	25
	Health Zone staff members	Bukavu, for 34 Health Zones staff members	70	4	74
TOTAL STAFF TRAINED			123	10	133

Table 4. Training for PCV13 introduction in DRC with support from MCHIP, 2011

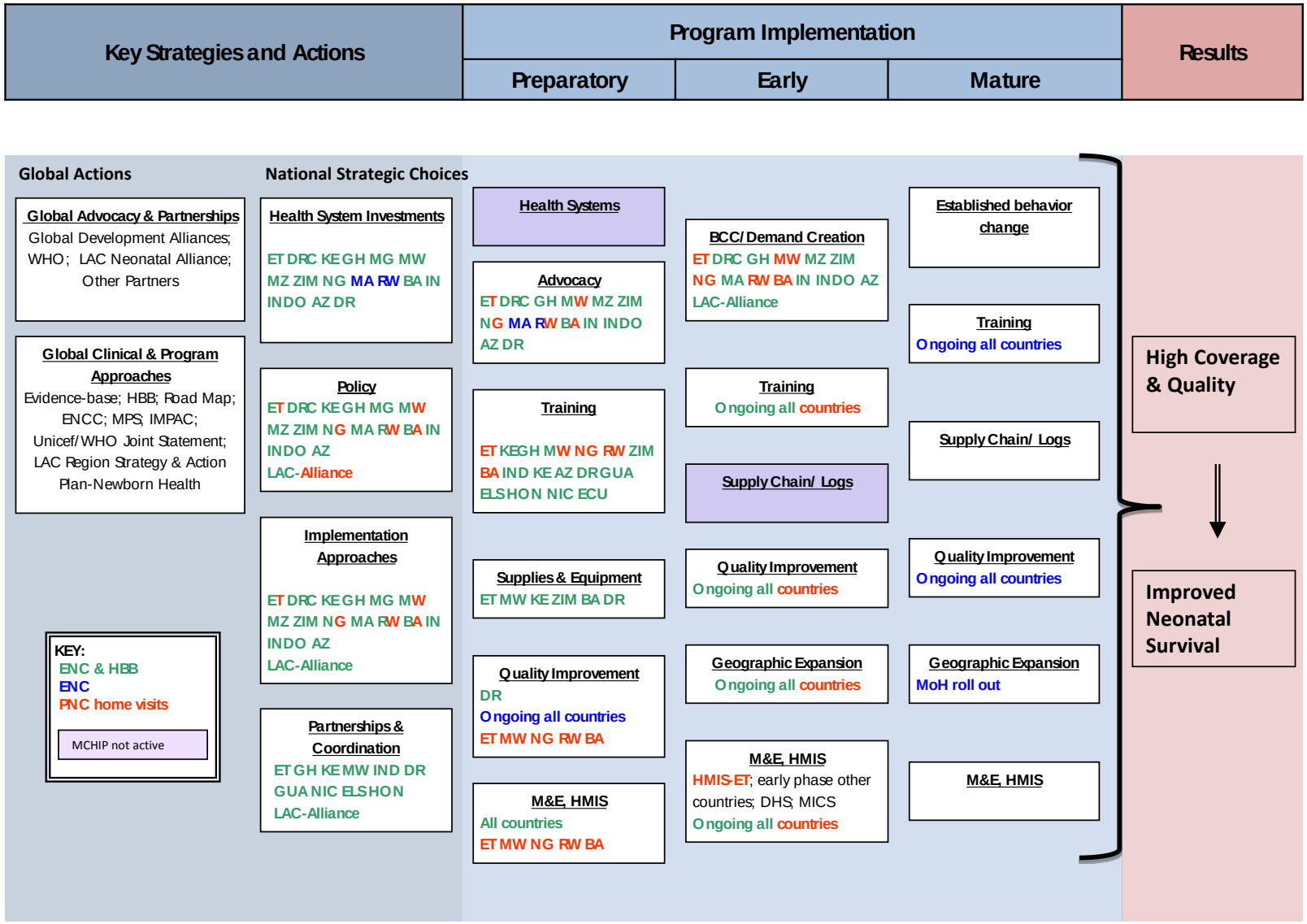
TOPIC	CATEGORY OF PERSONNEL TRAINED	SITE OF TRAINING	NUMBER OF PERSONS TRAINED		
			Male	Female	Total
New vaccine introduction	National trainers	Kinshasa (EPI staff)	11	8	19
	Provincial and HZ trainers	Matadi and Mbanza Ngu	41	7	48
		Bukavu and Uvira	91	7	98
	Clinicians (sensitization)	Matadi (Bas Congo)	27	9	36
TOTAL PERSONS TRAINED			170	31	201

- CAMBIO intervention (Changing AMTSL Behavior in Obstetrics) to increase uptake of AMTSL and reduce episiotomy rates replicated in Nicaragua. Developed study materials and received ethical approval on July 28, 2011. In addition, PATH staff in Nicaragua and Seattle worked closely with the MOH to get special permission to import oxytocin in the Uniject (OiU) device for the intervention. Study team members from Argentina and Uruguay traveled twice to Nicaragua to work with study team members in the country to begin implementation of the intervention.
- The OiU device was introduced in selected facilities in **Honduras** and the study team submitted the protocol to USAID/MCHIP and the MOH in Honduras; finalized the study protocol and documents based on their feedback; assisted the MOH and Child Fund in applying for and receiving FWA numbers; submitted the study protocol to an ethical committee in Honduras and the research ethics committee for PATH/Seattle; and received the final ethical approval on July 26, 2011. The delay in getting ethical approval for the study severely impeded implementation of the study as field funding for the study expired before even starting and USAID/Honduras is now reconsidering if they will support implementation of the study.
- OiU pilot in **Guatemala** was explored. Maternal Health consultants visited Guatemala twice to discuss progress with various stakeholders. USAID and the MOH continue to express interest in supporting efforts on introduction of OiU in the context of AMTSL in Guatemala. At present, the MOH is still envisioning a way to scale up use of OiU at the facility level in Guatemala.
- Formative research on use of cesarean operations in **Nicaragua** initiated**.** Study team members from Argentina and Uruguay traveled twice to Nicaragua to work with study team members in the country to finalize the study protocol and begin data collection with selected key informants.
- Technical assistance, South-to-South learning and sharing best practices in support of midwifery education in Paraguay initiated. A trip is being planned for a team from Instituto. A doctor in Paraguay, together with a representative from the MOHSW and the Midwifery Association to visit the Universidad San Martín de Porres in Peru during MCHIP Year 4. As a follow-up to this visit, a team of Peruvian midwives will then return to Paraguay to hold a workshop focused on strengthening the curriculum in the country and to create a plan of action for improvement of the Paraguay system over the next two years.
- MCHIP was elected chair of the Newborn Alliance for 2011, and represented it in panel presentations and discussions with stakeholders at the LAC Pediatric Association regional meeting in April in Panama and the LAC Federation of Obstetrics and Gynecology in September in Nicaragua (in collaboration with the Maternal Health Team Leader and MCHIP/SNL). These activities have brought much interest from the professional community for implementation of priority newborn activities promoted by the Alliance. MCHIP also co-organized the sub-regional meeting of Central America and the Caribbean national newborn alliances in Nicaragua in May, with the participation of committees from seven countries; this activity was focused on presenting advances on newborn health and analyzing the way forward.
- **Paraguay** joined the regional neonatal sepsis initiative in January with the participation of three referral facilities in vulnerable areas of the country. In **DR**, the initiative was started in one additional facility (where the KMC program has been implemented since 2009). This activity covered a total of six referral facilities with 25,000 deliveries in 2010. It has been focused on prevention but the three facilities in the DR are currently collecting data on treatment (field funded); the results will be disseminated to the participants in the sepsis

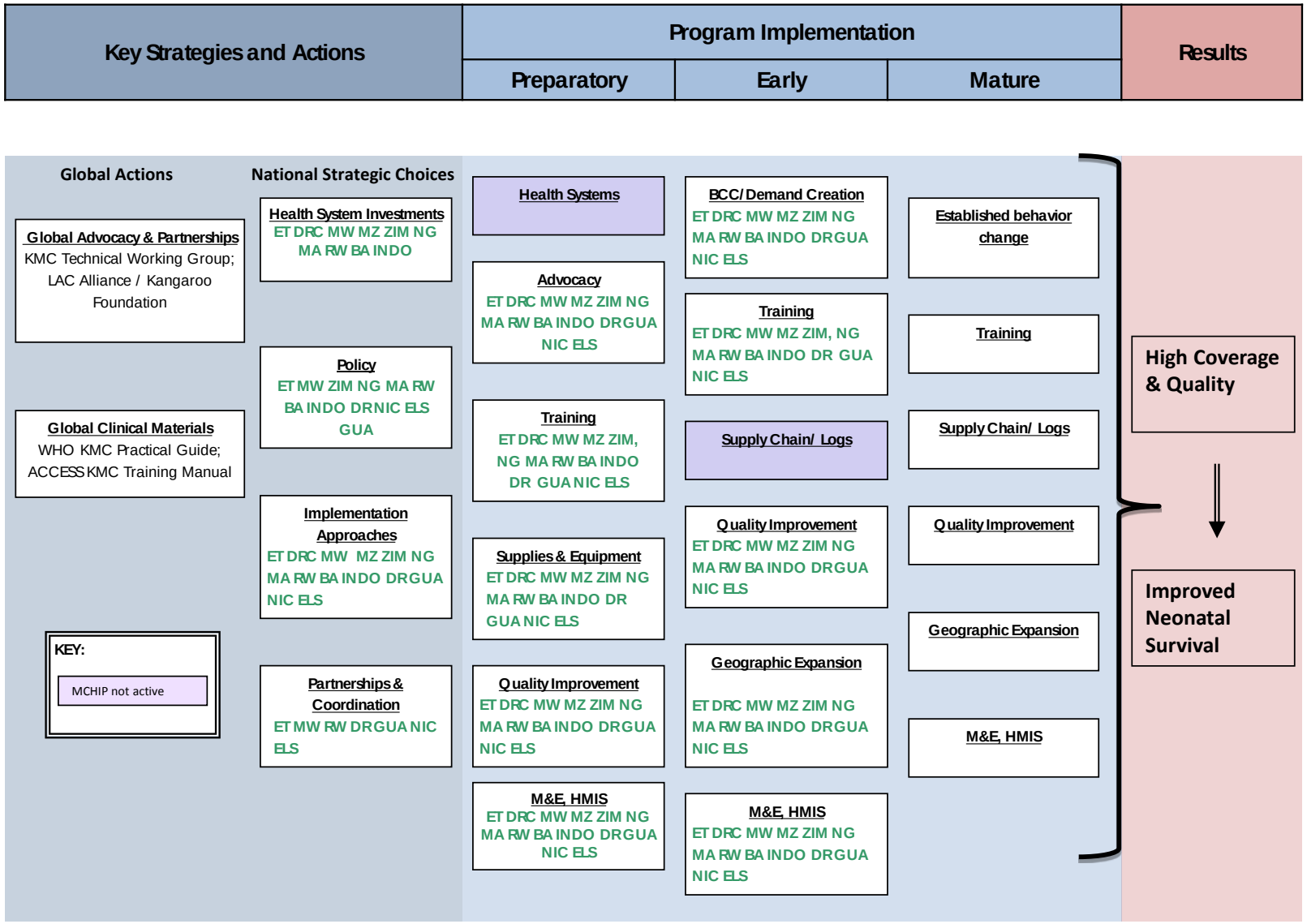
intervention. Three virtual sessions were carried out for technical updates and sharing of results and experiences (recordings are available in Spanish).

Annex D: Scale up Maps Showing Progress for Key Interventions

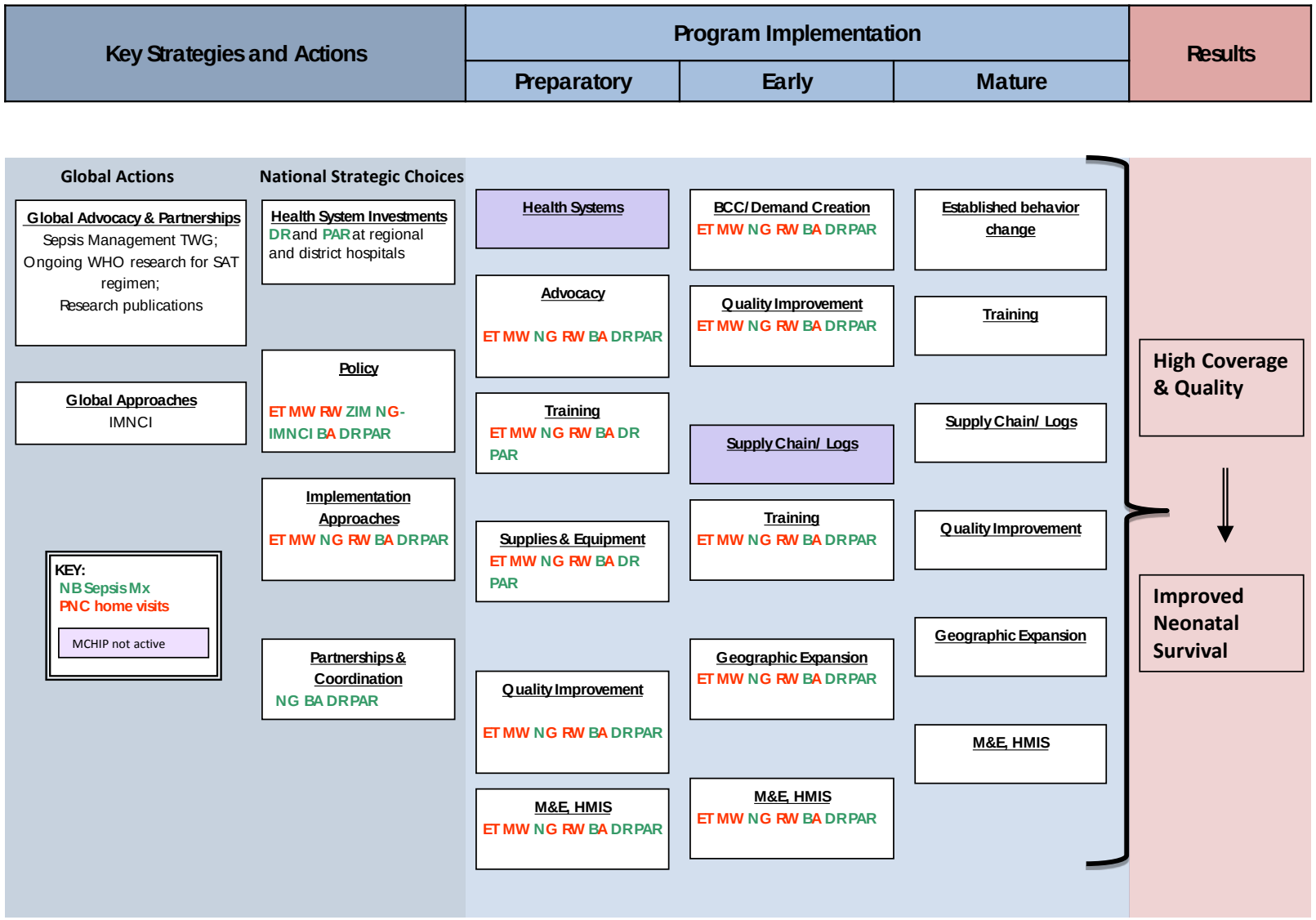
MCHIP Pathway to Implementation of **Essential Newborn Care & Newborn Resuscitation** At Scale



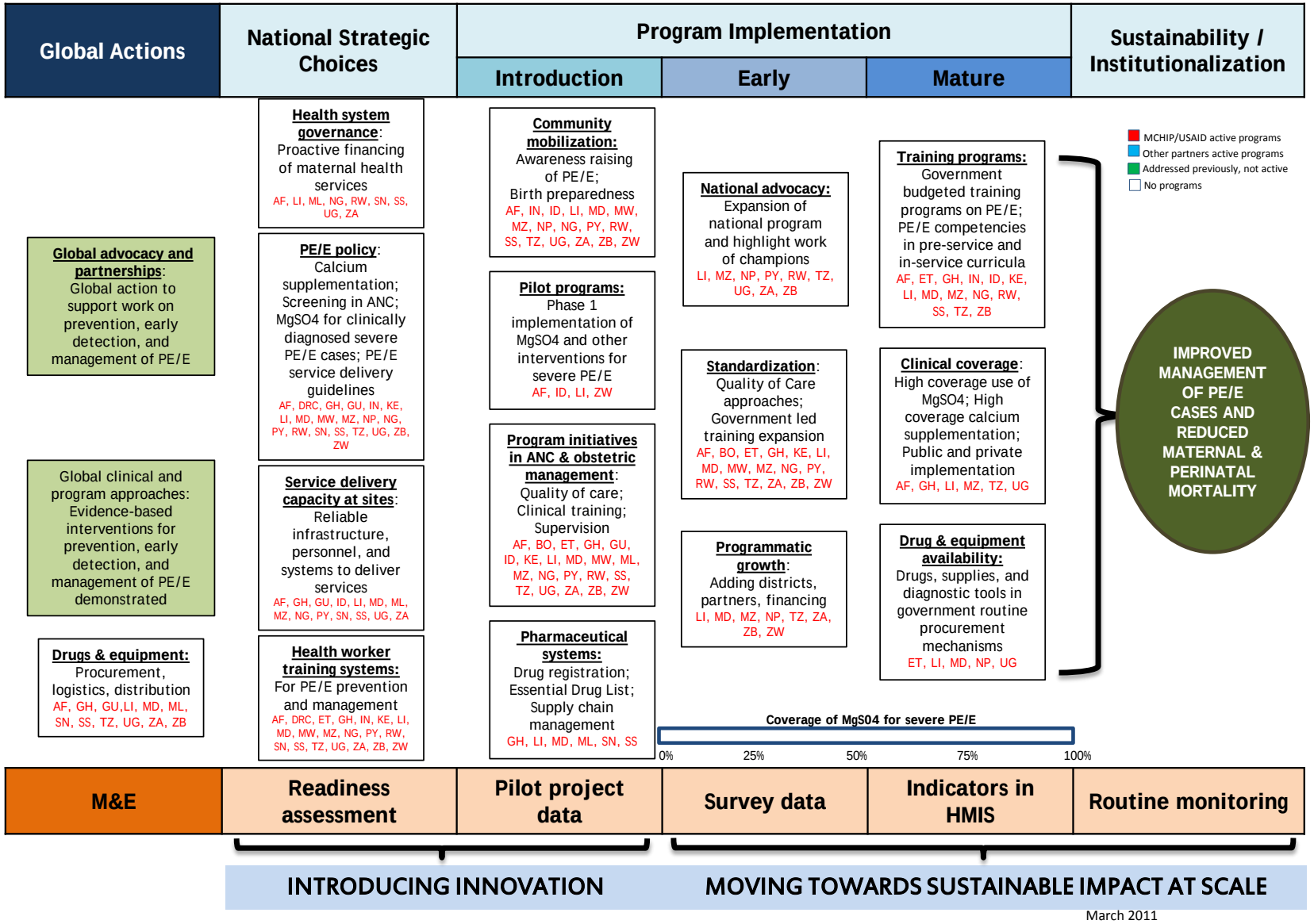
MCHIP Pathway to Implementation of **Kangaroo Mother Care (KMC)** At Scale



MCHIP Pathway to Implementation of **Newborn Sepsis Management** At Scale



PATHWAY TO IMPLEMENTATION OF PRE-ECLAMPSIA/ECLAMPSIA MANAGEMENT AT SCALE



March 2011

PATHWAY TO IMPLEMENTATION OF POSTPARTUM HEMORRHAGE PREVENTION AND MANAGEMENT AT SCALE

Global Actions	National Strategic Choices	Program Implementation: Introduction	Program Implementation: Early	Program Implementation: Mature	Sustainability / Institutionalization
Global advocacy and partnerships: Global action to support work on reduction of PPH	**Health system governance**: Proactive financing of maternal health services AF, DRC, GH, LI, ML, NG, RW, SN, SS, UG, ZA	**Community mobilization**: Awareness raising of PPH; Birth preparedness AF, DRC, ET, IN, ID, LI, MG, MW, ML, MZ, NP, NG, PY, RW, SN, SS, TZ, UG, ZA, ZB, ZW	**National advocacy**: Expansion of national program and highlight work of champions AF, DRC, LI, ML, MZ, NP, PY, RW, SN, TZ, UG, ZA, ZB	**Training programs**: Government budgeted training programs on PPH; PPH competencies in pre-service and in-service curricula AF, BO, ET, GH, GN, IN, KE, LI, MG, ML, MZ, RW, SN, SS, TZ, ZA, ZB	REDUCTION OF PPH AND IMPROVED MATERNAL HEALTH STATUS
Global clinical and program approaches: Evidence-based interventions for prevention and management of PPH demonstrated	**PPH policy**: AMTSL/misoprostol use; Expanded job descriptions for skilled birth attendant cadres managing PPH; PPH service delivery guidelines AF, DRC, GH, GN, LI, MW, NP, NG, PY, RW, SN, SS, TZ, ZW	**Pilot programs**: Phase 1 implementation of misoprostol and/or AMTSL for all skilled birth attendant cadres DRC, GN, KE, LI, ML, NG, RW, SN, ZW	**Standardization**: Quality of care approaches; Government led training expansion AF, BO, DRC, ET, GH, GN, ID, KE, LI, MG, MW, ML, MZ, NP, NG, SN, SS, TZ, ZA, ZB, ZW	**Clinical coverage**: High coverage use of a uterotonic; Public and private implementation AF, GH, GN, ID, LI, MG, ML, MZ, NP, SN, SS, TZ, UG, ZA	
Drugs & equipment: Oxytocin/ misoprostol procurement, logistics, distribution AF, DRC, GH, GN, LI, MG, NP, SN, SS, TZ, UG, ZB	**Service delivery capacity at sites**: Reliable infrastructure, personnel, and systems to deliver services AF, DRC, ET, GH, GN, LI, MG, MW, MZ, NP, NG, PY, SN, UG	**Program initiatives in obstetric and postpartum management**: Quality of care; Clinical training; Supervision AF, BO, DRC, ET, GH, GN, ID, KE, LI, MG, MW, ML, MZ, NP, NG, PY, RW, SN, SS, TZ, UG, ZA, ZB, ZW	**Programmatic growth**: Adding districts, partners, financing AF, DRC, GN, ID, LI, MG, ML, MZ, NP, SN, TZ, ZB	**Drug & equipment availability**: Drugs and supplies in government routine procurement mechanisms GN, LI, MG, ML, NP, SN, SS, UG, ZA	
	Health workers training systems: For PPH prevention and management AF, BO, DRC, ET, GH, GN, KE, LI, MG, MW, ML, MZ, NP, NG, PY, SN, SS, TZ, UG, ZA, ZB, ZW	**Pharmaceutical systems**: Uterotonics on Essential Drug List and in Drug Registration; Supply chain management AF, DRC, GH, GN, LI, MG, ML, SN, SS, TZ			
M&E	**Readiness assessment**	**Pilot project data**	**Survey data**	**Indicators in HMIS**	**Routine monitoring**

MCHIP/USAID active programs
Other partners active programs
Addressed previously, not active
No programs

Coverage of uterotonic in third stage of labour

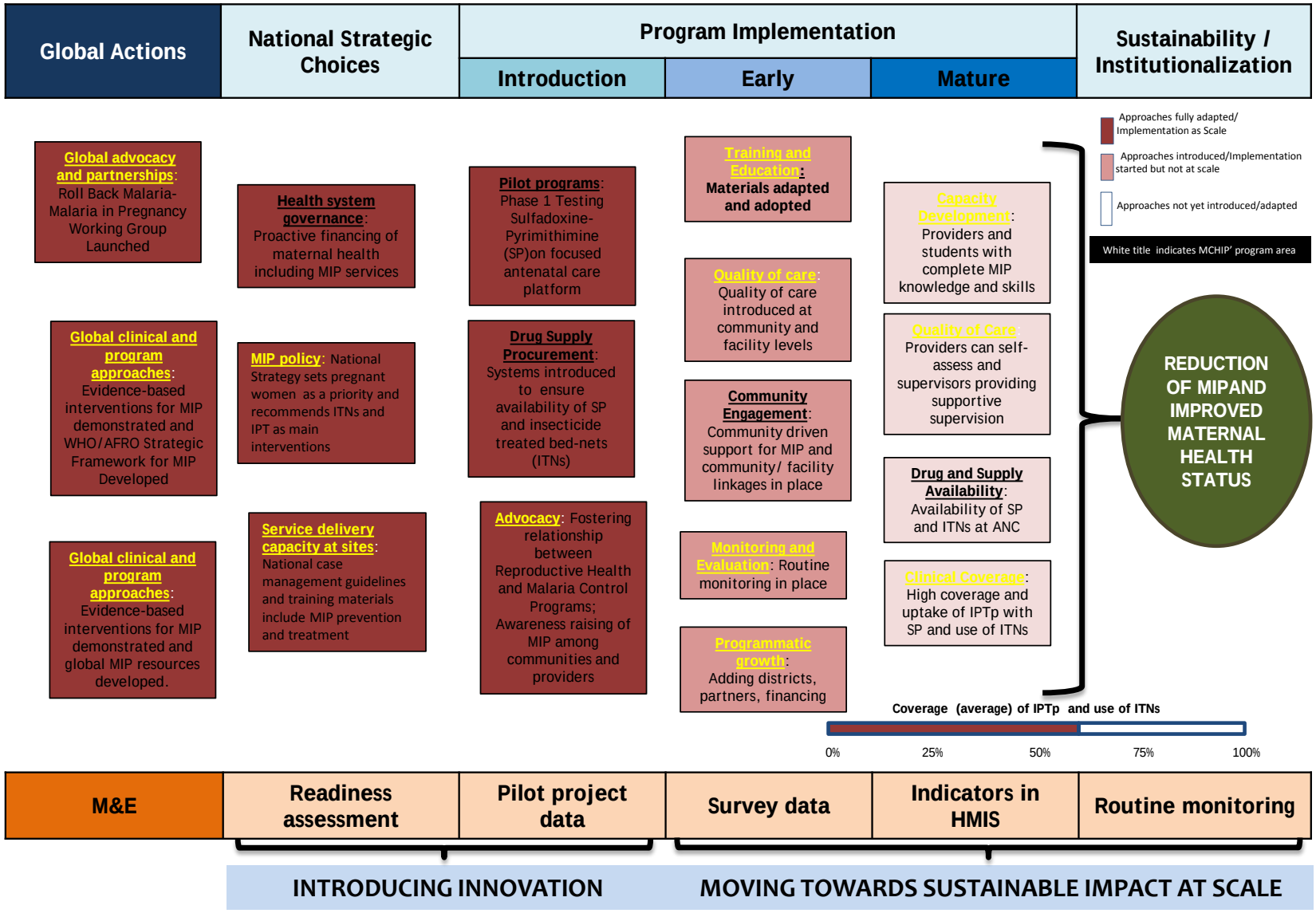
0% 25% 50% 75% 100%

INTRODUCING INNOVATION

MOVING TOWARDS SUSTAINABLE IMPACT AT SCALE

March 2011

PATHWAY TO IMPLEMENTATION OF MALARIA IN PREGNANCY PREVENTION AND MANAGEMENT AT SCALE in Burkina Faso



Ethiopia: A Midwife Beating the Odds

With the aim of recognizing the invaluable efforts midwives make throughout the country in saving lives, MCHIP in collaboration with the Ethiopian Midwifery Association, organized the first "Midwife of the Year" award for outstanding contributions made by midwives. This award, to be given annually in the years to come, inspires and motivates other midwives to continue doing their part to save lives.

From 26 nominee's designated from different parts of the country, Hodan Ahmed was awarded "Midwife of the Year for 2011" during the Ethiopian Midwifery Association Annual General Assembly in September 2011.

The Somali State Regional Health Bureau and the Ethiopian Midwifery Association Somali Branch both nominated her for the tremendous work she is doing, undeterred from the extreme challenges she faces.

This is her story.

In Ethiopia, located about 1,200 km away from Addis Ababa and 500 km away from Jijiga, the regional capital, sits a town named Werder, or Wardheer as called by the locals. With a population of 18, 357 people, the town has electricity for only 6 hours a day, a constant absence of potable water, an extreme desert climate and a very poor infrastructure that makes it virtually inaccessible. To make matters worse, the area suffers from security issues due to its close proximity to the border of Somalia.

Hodan is a young midwife who works in Werder's only hospital. One of her main reasons for becoming a midwife was that there were no midwives in Werder. Hodan learned the importance of quality care when her own mother once almost died delivering a stillbirth.

"I vividly remember the anxiety and trauma when my mother had a stillbirth while she was delivering at home," Hodan recalls. "We were lucky she didn't die."

Now, after becoming a midwife, Hodan understands that her mother's near death experience was caused by Postpartum Hemorrhage, the leading cause of maternal deaths in Ethiopia.

Hodan receives the 2011 Midwife of the Year Award

Werder Hospital only recently upgraded from the status of health center but it is still not capable of providing up to standard services.

This, coupled with the weather, inaccessibility, security and other obstacles has not deterred Hodan from doing her part to save the lives of mothers and babies in her community.

She was trained by MCHIP on Basic Emergency and Obstetric Care to equip her with the skills necessary to manage complications in delivery. She considers her lucky to have received this education and has already shared her knowledge with other colleagues in the hospital.

Says Hodan, "Now I can continue to give back to my community so that women and families do not have to experience what my mother experienced."

Hodan is a woman beating the odds so that other women can, too.

Rwanda: Community Health Workers Are Saving Lives

Approximately 2 hours South of Kigali in Busasamana lives the 32 year old mother of four children, Jacqueline Nyanzera. Sitting on the floor of her hut next to a bed that is covered with a mosquito net, she cradles her three day old newborn in her arms. She beams proudly as she shows her baby to visitors, one of whom is Jean Umurara or better known as Mama Jean, a community health worker (CHW).

Mama Jean places a tablet in her watering can to purify the water, lathers her hands with soap, and washes them. She inspects the baby for signs of jaundice and dehydration, asking the mother how many times the baby is fed and a series of other questions aimed at ensuring the newborn is healthy. The mother carefully listens along with her prepubescent daughter, Angelique. The mother is comfortable speaking with the community health worker as she has known her for some time. It was Mama Jean who accompanied her to the clinic when she began labor and counseled her throughout the pregnancy.

"My eldest two children were not born in the clinic because I was too afraid to go," says Jacqueline. "This time I went because of Mama Jean, and my experience was very nice and I felt safe."

Mama Jean is among Rwanda's 15,000 CHWs. She, along with nearly 12,000 other CHWs, received their training by MCHIP this year so that they would be fully equipped to recognize pregnancy and newborn health danger signs and the importance of family planning and immunization.
"Before my training, I wasn't quite sure why I was doing some things and sometimes I didn't feel they were necessary," she says. "Now I realize what I am doing and am doing it correctly."

In Mama Jean's catchment area, there are 152 women of reproductive age who she visits on foot throughout each month to provide counseling on family planning, malaria and the importance of getting four antenatal visits. Currently, she is carefully following 13 of these women who are at various stages of their pregnancy. She is supervised by fellow CHW Rehana Uwinmana who visits with her monthly when she comes in to drop off their surveillance forms.

"Initially in Rwanda we didn't believe that someone with a 6th grade education would be able to do this job, and such a good job of it," says Rehana. "Previous to the trainings by MCHIP we saw 4–5 deaths each month. In the last three months, we haven't had a single death."

There are also hasn't been a single home birth or birth in route to a facility since then.

"There are no mothers dying now in the community," says Mama Jean. "Where there is no death, there is no unhappiness."

For Jacqueline, as she watches her daughter kiss her little brother, that is happiness.

Paraguay: Tailoring Health Provider Training Women's Needs

As often happens when Maria Peña visits a local hospital, she comes upon a woman who is struggling to adjust to her new role as mother of the tiny baby now in her care. On this day at Hospital Regional de Ciudad del Este, a young mother is shifting from side to side in her narrow bed, trying to find the right position so that her newborn will breastfeed. Maria is the community interventions advisor in the MCHIP Paraguay office.

"Two caring women were standing by her, giving advice, but nothing seemed to help and the baby was getting fussy," recalls Peña. "I couldn't help my impulse and I reached out to her, talked to her for a while, asked her name and baby's, and finally asked her if it was okay to touch her and help with her baby."

It takes just a few moves—Peña turns the mother and baby a few degrees to one side or another, wraps a blanket or two to use as pillows and positions them under the mother's head and beside the infant—and a few encouraging words. Within minutes, both the mother and baby are nursing beautifully. "Baby latched to the breast, sucking vigorously, and mom resting in a comfortable position—a happy, loving couple," says Peña, 46, the mother of five children. "One of the relatives who was trying so hard to help the mom said in her native language, 'Heise ko la professional!'—Professional help does make the difference!"

Incidents like this provide Peña and her colleagues at MCHIP with valuable information as they assess maternal and child health services in facilities in two districts of Paraguay and work in partnership with the Ministry of Health to update the skills of health providers. When preparing health worker training courses, they take into consideration the discussions and interviews they have had with pregnant women and new mothers during facility assessments. The reason is: "Most women from these hospitals, in spite of their frequent hospital visits, had little knowledge of essential maternal and neonatal health, and although breastfeeding was the norm, newborn care and feeding practices required improvement," says Peña. "Most pregnant women

A new mother in Paraguay with her baby

and new mothers could not identify danger signs related to pregnancy and the postpartum and newborn periods."

"New moms and babies are essentially in a vulnerable situation during the maternal year," says Peña. "Mother, family and community education is essential because more than 70% of all maternal and neonatal deaths occur during the week following birth."

Based on these assessments, MCHIP's Paraguay experts identified additional training information that should be included, while building the capacity of service providers, to meet the needs of women and families more effectively, enhance satisfaction, strengthen health systems, and contribute to the prevention of maternal and newborn deaths.

Community work is a valued and vital part of the MCHIP Program implementation, says Peña. "We are looking forward to building strategies to improve maternal and neonatal knowledge among mothers and families in hospitals where we will be working," she says. "It is essential to empower women so that they feel confident with motherhood and communities can support the well-being of moms and babies."

As one birth companion came to understand: "Professional help does make the difference."

Nigeria: It Takes a Community to Make a Difference

Community Core Group Advocacy Yields Results
In the rural settlement of Tudan Wada, with a population of over 230,000, the local Community Core Group have been successful in increasing the demand for maternal and newborn services in the community, but knew their General Hospital needed work in order to accommodate the influx of patients. With a training provided by MCHIP, the Tudan Wada CCG were educated on advocacy and community mobilization. Immediately following this, they arranged an advocacy visit to the facility with a local philanthropist who in turn donated the funds necessary to construct a 25-bed capacity maternity ward with a scanning room and theatre for emergency obstetric care.

"The advocacy skills we have acquired has helped in our resource leveraging efforts through the mass education of individuals and highly influential people," says Ibrahim Sule DanTanko, the Secretary of the Tudan Wada CCG. "We have already had great success with our newly constructed maternity ward."

And because of this group, there are now 25 more beds waiting for women to deliver in.

In Tsafe, the local CCG knew there were many problems plaguing their community including inadequate health services at Tsafe General Hospital due to its dilapidated wards and equipment. Due to their training by MCHIP, they knew these were issues that needed to be addressed in order to increase demand for maternal and newborn health services. They visited Alhaji Yahya Garba, a local philanthropist who immediately answered their call. He paid a visit to the hospital and volunteered to build a new theater complex, renovate the Pediatric Ward and build a hall for patients' relatives to stay while their loved ones are being cared for. On top of that, he donated a brand new ambulance.

"All this would not have been possible if not for MCHIP who trained us and made us take responsibility for our health," says Tsafe Chairman Aminu Musa Anka. "Our community members are now aware and helping to make more contributions." Just recently a community member opened a small stall in the hospital and stocks it with drugs monthly for patients free of charge.

"Since that day we paid a visit to Alhaji, people stop us on the road and ask how they can be part of the CCG," continues Anka. "You see, it is not a small achievement."

It is an achievement, indeed.

Emergency Transportation System Driver Saves a Life
Emergency transport is an organized way of ensuring prompt transportation to a health facility when needed and is being deployed in Nigeria by volunteer community drivers. Aliyu Bello is one such driver and one day, he went home knowing he had saved a life.

Aisha Abubakar, a 38 year old woman with seven children, had been ill at home for five days before her husband decided she needed to get the General Hospital Kaura Namoda. Aliyu answered the call. Aisha was taken to the hospital where she gave birth with the help of a skilled birth attendant, but still suffered from postpartum hemorrhage. Aliyu was the one who donated a pint of blood so that Aisha could survive.

"If not because of his help, if I had delivered at home I know I would have lost my life with the amount of blood that I lost after delivery," says a grateful Aisha. "I was also able to learn about how to prevent another birth and had an IUD inserted so that I can keep healthy for my family."

"Who says rewards are just monetary?" asks Aliya. "See the reward!"

Malawi: Voluntary Medical Male Circumcision Campaign Launched

A thrill of excitement was in the air as the Government of Malawi prepared to open a new chapter in the history of the country's HIV prevention efforts. Crowds of men, women and children lined the football field cheering and clapping on as Malawi's Deputy Minister of Health, the Honorable Ralph Jooma, MP, officially launched the country's Voluntary Male Medical Circumcision (VMMC) campaign in Mulanje district. The campaign, which will take place in three health facilities, aims to reach 5,700 men aged 14-49 years.

To the large crowd gathered at Suwazi football grounds, the message was clear: the Deputy Minister was urging all eligible males to receive the free services. "The provision of [VMMC] services will be done within the broader provision of reproductive health services and be comprised of a minimum [VMMC] minimum package," he said. This package includes HIV testing and counseling and referral for antiretroviral therapy, sexually transmitted infection screening and treatment, risk reduction counseling, surgery, and condom programming.

Before arriving at the launch venue, a delegation of senior Ministry of Health (MOH) officials joined USAID Mission Director Douglas Arbuckle in visiting the VMMC outreach site at Muloza Health Center. Located on the border with Mozambique, the health center is small with limited infrastructure. As such, it is typical of the types of facilities that provide the majority of services to 80% of Malawians. Three large tents were erected strategically around the site to enhance the provision of dedicated VMMC service delivery. The tents were used for group education, individual VMMC counseling, HIV testing and counseling, client screening, and recovery.

Mr. Arbuckle praised the MOH and MCHIP Program, saying: "The United States Government extends a message of gratitude to the MOH and MCHIP for this milestone, which has come along due to the leadership of MOH (HIV unit and Health Education Unit) and the great collaboration with partners (PSI, BRIDGE, BLM, Pakachere)."

USAID Mission Director giving remarks at the launch event

"To do this will require rapid scale-up of high-intensity services such as the use of a time-limited campaign model which we are launching today," he said. "We cannot rely on routine service delivery alone to reach the 80% target and achieve greater impact."

With MCHIP support, the MOH decided to launch the campaign when routine VMMC services at Mulanje District Hospital were only reaching 8% of the target in a given month. The campaign aims to maximize the efficiency of service delivery so that there is greater impact with the intervention. Other countries in the region have made headway in the provision of MC services through such outreach campaigns. Malawi's will run six days a week for four weeks, from 10 October–5 November.

In his final remarks, the Deputy Minister added his thanks, saying: "The MOH and Government of Malawi, through the leadership of His Excellency Ngwazi Professor Bingu Wa Mutharika, extend its appreciation to the United States Government for the continuous support it provides to the health sector."

Tanzania: Exceeding All Expectations

A group of 26 program managers and health care providers from different visited a voluntary medical male circumcision campaign in Iringa to observe the successful implementation of high volume services in rural and remote health facilities.

The visitors from Kenya, Malawi, South Africa, Uganda, Zambia and the United States toured sites in Iringa region from August 10-13, where a campaign to provide this important HIV prevention intervention was underway. The campaign, which ended on Saturday, August 13, provided safe and efficient male circumcision for HIV prevention services to nearly 31,000 adolescent and adult males over eight weeks, exceeding the campaign's original target by 150%. The program was implemented by the Iringa Regional Medical Office with support from the U.S. President's Emergency Plan for AIDS Relief through MCHIP.

Study tour participants from Malawi, Uganda, Zambia and South Africa observe surgical efficiencies that help Tanzanian MC providers serve up to 150 clients per day.

The HIV prevalence in Iringa is estimated at nearly sixteen percent—three times the national average and currently the highest in Tanzania. Unlike other parts of the country, male circumcision is not a routine health practice in the region with only one-third of men being circumcised.

"The Iringa male circumcision campaign is an excellent example of a program implemented well and has been very successful in getting quality services to where it matters—the people," said Dr. Delivette Castor, Epidemiology and Statistics Advisor at USAID. "This campaign is also a good example of doing a lot with little."

As part of the circumcision program, clients received services that included a health check, counseling and testing for HIV, screening for sexual transmitted infections and treatment, risk reduction counseling and condom promotion.

The visiting male circumcision program officers toured six sites, including hospitals, small health centers and larger health facilities. They also participated in a day of topic-specific briefings and discussions on: demand creation, monitoring and evaluation, data management, finance, procurement, transportation and quality assurance.

"I have learned a lot and I am very impressed with what I saw. What I liked most is how facilities are implementing task-shifting and task-sharing among the team for increased efficiency", said Luwiza Puleni, MCHIP/MNH Specialist from Malawi. "This is also the first time I am seeing MOVE in action", she added. MOVE stands for Model for Optimizing the Volume and Efficiency of male circumcision services.

"We will soon be launching campaigns in Malawi and the experience gained here will be vital" said Ms. Puleni.

The group was able to see facilities serving more than 100 – and in one case, up to 150 -- clients a day. The objective was to show them how, with the right planning and partners, even very rural, distant and small health facilities can be turned into highly-efficient male circumcision (MC) sites.

"The Iringa MC Program is doing fantastic work. There is a lot of experience to take from this campaign", said Dr. John Sehlangu Kekana, Chief of Party for the Nkangala Male Circumcision Program in South Africa, whose team will be launching a male circumcision services next month.

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

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

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

When she was pregnant for the second time and looking for a viable, long-term family planning method to limit future pregnancies, Seema received counseling by a visiting team from MCHIP.

The Majra facility is one of 20 heath care centers established in the urban slums of Uttarakhand by local nongovernmental organizations as part of a public-private partnership with the Uttarakhand government. MCHIP, which is providing technical assistance to the project, set up the family planning services as a part of an integrated program of maternal and child health and nutrition services for the urban poor.

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

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

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

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

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

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

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

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

Madagascar: Saving Lives through Innovation

Voahangy had just given birth to her 2nd child, but the bleeding wouldn't stop. Luckily she had chosen to have her baby girl at the busy private health facility run by nuns in Mahajanga, in North Western Madagascar, where an average of 4–5 babies are born per day. Even more fortunate, the nun who assisted her during the birth, Sister Lydie, was a seasoned midwife who had just attended an MCHIP training covering how to help women who experience complications during childbirth. In this training, MCHIP trainers introduced a cutting edge tool for fighting postpartum hemorrhage (excessive bleeding) known as the condom tamponade. The tamponade is very effective at controlling bleeding and utilizes accessible, low-priced materials, ideal for resource challenged settings like Madagascar where state of the art drugs, equipment, and trained medical staff are scarce. MCHIP is introducing this and other innovative techniques to combat the high maternal death rate in Madagascar, now at 498 per 100,000 women.

When Sister Lydie noticed that Voahangy was losing excessive amounts of blood, she didn't hesitate to insert the tamponade, which quickly stopped the bleeding. Having stabilized Voahangy, she knew from her MCHIP training to organize immediate transfer to a hospital where Voahangy could receive care from doctors trained to deal with obstetrical complications. Not everyone is as lucky as Voahangy. Even when they give birth in a facility, too many women or their newborn babies die when complications arise. Since the two leading causes of maternal death in Madagascar include hemorrhage and eclampsia (high blood pressure and convulsions), MCHIP program targets these two areas in their trainings.

Georgette, another experienced midwife, attended a similar MCHIP training, this time in the capital, Antananarivo. There she learned another vital procedure to treat excessive bleeding after childbirth known as aortic compression, in which the provider presses firmly on the woman's abdomen, over the aorta, to control bleeding. Though a simple technique, many health care providers in Madagascar are not familiar with this life-saving procedure. Georgette's training was led by Myrta Rahaga, a retired midwife and one of MCHIP's pool of 18 trainers who have trained 437 doctors and midwives throughout Madagascar since June on vital maternal and newborn interventions. Myrta had taught Georgette and about 20 other doctors and midwives this technique through supervised practice on mannequins. That same evening, Georgette helped a woman give birth who started to hemorrhage. She applied firm pressure to the woman's aorta and was able to stop the bleeding. Myrta described how Georgette returned to the training the next day and excitedly related her success, very pleased to have participated in such a practical, hands-on training.

Doctors and midwives expressed similar sentiments at another MCHIP training conducted by Myrta in Fenerive Est, in North-East Madagascar. Dr. Andriantsiory and two other participants- a doctor and a midwife- had already attended trainings on how to provide emergency care for women and newborns with complications, which briefly covered the use of magnesium sulfate, the first line drug to treat eclampsia (high blood pressure and convulsions). However, they said that it wasn't until the MCHIP training that they felt capable of actually using this drug. All three confirmed that their health facilities had magnesium sulfate, but Dr. Andriantsiory explained "I didn't use it because I was nervous to get the dosage wrong. I feared I might not be able to revive someone if I gave them too much."

Not surprisingly, on pre-tests evaluating training participants' ability to treat eclampsia, they scored poorly, averaging 20%. During the training, Myrta and her co-trainers required each participant to simulate magnesium sulfate injections, in 4 skills stations where participants practiced their new skill under the supervision of the trainer. Myrta proudly explained that at the end of the session, participants scored on average of 80– 90%. And when she asked them "Are you going to use magnesium sulfate now?" they responded with a resounding "Yes!"

Bangladesh: Ensuring Women Have Access to Family Planning

Topkhana, Bangladesh- Rayhana Ferdous is a 31 year old mother of six children, ages 14, 12, 9, 7, 5, and 3. Ferdous desired a small family, however, because her husband's family wanted a girl, she and her husband continued having children until they had a daughter, who is now 3 years old. Ferdous felt that her pregnancies should have been spaced with wider intervals, but she knew little about family planning; she had heard of oral contraceptives but did not know where they could be accessed or what other methods were available.

Sylhet District, where Ferdous and her family live, has among the worst health indicators for women and children in the country. The maternal mortality ration is highest in Sylhet (471 per 100,000 live births, compared to the national average of 322) and the infant mortality rate is twice what it is elsewhere in the country, according to country health data. Women in Sylhet District have about four children, compared to an average of about three in the five other divisions of the country. Only 31% of currently married women of reproductive age use any method of contraception, compared to 56% for the country as a hole. And, about 26% of women in Sylhet give birth to their children with less than two years between them, and unhealthy interval that leads to increased risk of poor health outcomes for them and their babies.

The Healthy Fertility Study is a collaboration of the Bangladesh Ministry of Health and Family Welfare, MCHIP, and two local nongovernmental organizations- Shimantik and Center for Data Processing and Analysis. The study, underway since 2007, tests a package of maternal and newborn health including postpartum family planning through female community health workers. By including simple counseling messages on pregnancy risks during the first year postpartum, the importance of exclusive breastfeeding and the benefits of healthy pregnancy spacing, together with the provision of pills, condoms, and injectables, these community health workers are making a difference in the lives of many women in the program area in avoiding closely spaced pregnancies.

One year results from the study demonstrated a 20% increase in contraceptive use in the intervention area compared to the control area. In addition, through the promotion of effective use of the lactational amenorrhea method (LAM) the study showed an additional increase of 10% in the practice and duration of exclusive breastfeeding.

Under the Healthy Fertility Study, community health worker Anjana Apa and community health mobilizer Rina Apa, visited Ferdous in her home. They counseled her about family planning methods, where the methods could be accessed, and the advantages and disadvantages of each. Ferdous elected to use LAM after the delivery of her youngest child. She was counseled on the three criteria of LAM and the importance of transitioning to another modern method when she was no longer eligible to continue using LAM. As such, Ferdous transitioned to using oral contraceptives when LAM ended, which she received from the Healthy Fertility Study community health worker. When her youngest child was three years old, Ferdous and her husband decided that they did not want more children and her husband obtained a vasectomy from the Zakiganj Health Complex.

Ferdous shares, "This year I have been elected as a woman member in the Union Parishad Election. Now I am a representative of the people of this locality. I feel proud that I can share my experiences with the people of this area."

Guinea: Preventing Postpartum Hemorrhage

Health care providers at the Minière Urban Medical Center have increased their use of active management of the third stage of labor (AMTSL) and helped reduce women's risk of bleeding to death during childbirth.

The progress made at Miniere and other health centers in this West African country can be attributed to a series of capacity-building initiatives on emergency obstetric and newborn care (EmONC) led by Dr. Yolande Hyjazi, who represents MCHIP in Guinea. AMTSL is an intervention that requires use of oxytocin, controlled cord traction and uterine massage to prevent postpartum hemorrhage, which is the leading cause of maternal deaths worldwide.

The use of AMTSL at Minière was reinforced during follow-up supervision visits.

Midwives at the Ratouma Urban Medical Center help pregnant women give birth safely.

"We see very few cases of postpartum hemorrhage now that we do AMTSL," says Dr. Hawanatou Camara, chief of maternity at Minière medical center. "Before (2008), we had two or three cases a month. AMTSL has worked here. It is not like before."

It was only two years ago that a maternal health specialist visiting the Minière center observed that nurses and other key staff were unfamiliar with the components of AMTSL. The health providers at Minière, although capable, were using only oxytocin to treat a woman who began bleeding heavily after childbirth. To prevent postpartum hemorrhage, all three components of AMTSL—use of oxytocin, performing controlled cord traction and uterine massage—must be used.

Since then, the work of Hyjazi and her MCHIP colleagues has inspired change. Earlier this year, a visit to the center found that the registry for delivery care in almost all births had a notation about AMTSL (with the exception of those women who had given birth at home or had been referred to the hospital). The success in upgrading and strengthening the capacity of health providers can be seen in other health care facilities in Guinea.

Dr. Ami Kaba, chief of maternity at Ratouma Urban Medical Center in the city of Conakry, can attest to improved outcomes: "Before AMTSL was introduced here in 2008, we had 16 cases of postpartum hemorrhage. In 2010 after we introduced AMTSL, we only had six cases, only three of whom received AMTSL—the other three gave birth at home and came in later."

Not only were nurses and midwives adept at actively managing the third stage of labor, several midwifery students who were observed assisting in a delivery also displayed knowledge of AMTSL.

In Guinea, where maternal mortality is still very high with close to 1,000 deaths for every 100,000 live births, AMTSL has been an innovation that is now routinely used for 86.5%of women who deliver in health facilities supported by the MCHIP project.

The involvement of site managers, close follow-up of service providers and use of performance standards for service provision were key for success," said Hyjazi in discussing the increased use of AMTSL. "The results achieved were appreciated by the service providers, and the Ministry of Health—which was involved from the beginning. And these results motivated both groups. Nevertheless, the efforts should be maintained by all stakeholders to improve the quality of maternal health services, which includes other emergency obstetrical and neonatal care."

Mali: Teaching New Skills to Community Health Centers Staff

Modibo Coulibaly is the head of the CSCOM in Niagane, a town in the Kita district. He is a nurse with over 5 years of experience working in the area. When he became the Health Center's director, he was encouraged to participate in trainings on various topics, yet without any "personal satisfaction".

When he was invited to participate in an MCHIP training, he resolved himself to the idea that this was yet another routine training, without any new tangible knowledge or skills. He was happily surprised by what he saw. During the program, he observed that MCHIP was using an innovative approach for the training, combining theoretical and practical courses with an emphasis on practice in the local context. His enthusiasm grew. By the end of the program, he was one of the participants with the highest improvement rates.

When he returned from the training, he initiated a meeting with his peers to inform them that he planned to train others CSCOMs staff members on important health areas. He also organized an advocacy day with local authorities, religious leaders, community members and women leaders, asking them to help promote postpartum family planning and healthy spacing and timing as part of the solution to save mothers' lives. In response to his campaigning, an Imam now organizes two sermons on FP/PPFP every Friday. These trainings include participants from other health areas that are not part of the formal health system and Community Health Agents, to ensure that behavior change and communication activities include the crucial messages that could save lives.

Foulematou Soucko is a dynamic young woman who was recruited as a Community Health Worker in the village of Makana Bamaman at the Dafela CSCom. Before accepting Community Health Agent position, she worked for over 3 years in health promotion activities at the community level, especially with

Foulematou meeting with community members

regards to family planning. Foulematou was trained with the support of MCHIP. During the training, she expressed interest in community mobilization and asked for more information on the topic.

After the training, she returned to her village where she used her new knowledge and skills to mobilize men and women around family planning services. She organized a meeting with men and women community members and set up a support group in her village. The Village Chief, seeing her initiative and motivation, decided to support her work by providing her with equipment (chairs, a table, a box for drugs, etc.) and built a space where she now receives patients. As a Community Health Agent, she counsels many patients, and receives on average more than 3 women per week. She refers women to the larger and better-equipped health centers if need be; for instance, two women have recently received implants in the Kita Referral Health Center. She is part of a women's social group, and she often discusses healthy behavior messages with an emphasis on postpartum family planning during their weekly meetings.

Modibo and Fouletmatou are proof that trainings can have an immeasurable impact.

Uganda: Educating Communities to Stamp Out Malaria

The old adage "good health begins at home" is proving true for malaria thanks to the efforts of community health workers in Uganda and Zambia.

The President's Malaria Initiative (PMI) Malaria Communities Program (MCP) supports the efforts of communities and indigenous organizations to combat the disease throughout Africa. Working through local grantees in close collaboration with communities and households, MCP builds local capacity and promotes change in individual and community behavior to save lives.

These changes include the use of Long-Lasting Insecticide-Treated Nets (LLINs), antenatal care and intermittent preventive treatment for pregnant women (IPTp).

In Uganda, HealthPartners, a MCP grantee, is working with Village Health Teams (VHTs) in Rubirizi District to deliver health education messages to household members.

"The major role of a VHT is to save lives and mobilize community members for health action," said Dr. Owembabazi Wilberforce, Director of the HealthPartners MCP project. VHTs are linked to health workers from nearby health facilities for support supervision.

Mr. Lawrence Tumweisigire, 43, is a resident of Kisita B Village in Rubirizi district, and is familiar with the role of VHTs in his community: "[They] visits my family every two to three months to advise my household on health issues. As a result, sickness in my household has reduced."

Before VHTs began visiting his home, Mr. Tumweisigire had assumed his child had epilepsy. "But when Bairu Steven, a VHT, visited my family, he advised me to immediately visit Katerera health Centre III and to always ensure that all my family members sleep under a LLIN every night to prevent malaria." When Tumweisigire visited the health center as instructed, his child was found to have cerebral malaria. Since then, none of his family members have suffered from malaria again, and his sick child has improved.

In Dokolo and Lira Districts in Northern Uganda, Medical Teams International (MTI), another MCP grantee, is training VHT female leaders to mobilize communities and assist with antenatal services at health facilities.

Among those grateful for these health education messages are Ms. Atim Rose and Mrs. Paska Moro. They learned the importance of antenatal care attendance, proper care during pregnancy (including use of IPTp), early care seeking when a child develops a fever, male involvement, and proper use of mosquito nets.

"We are not ashamed to declare the benefits received from MTI through its MCP project in Dokolo and, particularly, in our Health Center III of Bata where pregnant women are referred by VHTs for antenatal care and later followed up by the women leaders at the health center," says Mrs. Moro. They now encourage other pregnant women to attend antenatal care and, with their husbands support, had safe, malaria-free pregnancies.

Above all, "we had safe deliveries at the health center in the hands of women leaders with supervision from the midwife," said Ms. Atim.

MCP grantee Catholic Medical Missions Board (CMMB) is the first nongovernment organization to actively involve traditional leaders in health programs in Luapula Province, Zambia, an underserved area. Through CMMB, community volunteers, traditional leaders, and health workers are trained in malaria control and prevention using national guidelines and addressing cultural issues.

Headman Kunda Chipunka of Chipunka Village in Kawambwa district was delighted to receive their training, and has pledged to educate communities in his villages on the importance of sleeping under mosquito nets, and encourage pregnant women to attend antenatal clinics regularly, take IPTp, and take their children under five with signs and symptoms of malaria to health facilities early for diagnosis and treatment.

These community members from Uganda and Zambia remind us of the vital role that community health workers play in decreasing the burden of malaria- and that good health does indeed begin in the home.

India: "RAPID" Implementation—Using a Supportive Supervision Approach at Scale

Based on WHO/UNICEF official immunization coverage estimates in 2009, India accounted for almost 88% of the 9.8 million children who did not receive DPT3 (third dose of the diphtheria, pertussis and tetanus vaccine). To address this high percentage, MCHIP has supported India's government in strengthening its Universal Immunization Program (UIP) through technical assistance, which includes implementation of a supportive supervision and mini-immunization review approach, known as RAPID, in Uttar Pradesh and Jharkhand states. RAPID (Regular Appraisal of Performance of Immunization in District) is a model used by MCHIP that helps program managers improve the quality of the immunization program and service delivery, focusing on: program management; vaccine and logistics management; cold chain maintenance; injection safety and immunization waste disposal; and records, reports and use of data for action. Conducted at the district level in periodic intervals (e.g., every six months, primarily with government and partner funding, not external MCHIP resources), the RAPID approach is a process of guiding, supporting and assisting staff through supportive supervision to perform well in their assigned tasks and includes a capacity-building intervention adapted to individual needs.

Examples of data results posted on a health facility wall

In the introductory period of program implementation, MCHIP assisted in: the development of standard checklists for data collection from the health facility (PHC) and for outreach sessions; standard presentations for orientation of the approach; and an Excel-based tool that facilitated data compilation and ready analysis. To ensure buy-in and engagement of key stakeholders, MCHIP staff met with district-level officials. In addition, MCHIP hosted a one-day orientation with stakeholders that included district and PHC officials, cold chain handlers and other NGO and health partners. Subsequently, target PHCs received a letter from the district head explaining the upcoming visit, date of the visit, the personnel visiting and what records the PHC should have available at the time of visit. As part of this ongoing process, teams visited all identified PHCs (one to two PHCs per team, two to three sessions per day) and selected outreach session sites. Each team is comprised of a district official in charge of the PHC and one trained supervisor from the health office. The team observes the cold chain, vaccine management, records and reports, injection safety and waste disposal practices. In addition to the PHC head filling out the checklists, the team is able to discuss program-related issues with facility staff and provide correct practices and capacity building on site to contribute to the strengthening of skills and service delivery by the PHC staff.

Collected data are compiled and analyzed, contributing to an analytical report with indicators and grading of PHCs (Image 1). After the analysis, meetings are organized to disseminate the findings with the district and PHC officials to develop an action plan for the next six months. Regular visits are organized to ensure activities are followed per the action plan and feedback is shared with the district and block officials. After the first stage of implementation visiting the health centers, capacity-building workshops are organized for health center staff and front-line functionaries. Subsequently, three rounds of visits to the PHCs take place, upon which an assessment is conducted to identify progress made and identify any remaining gaps for correction.

This process has contributed to improved coverage in the focus states and each visit shows an increase in quality improvement in the PHCs for all key indicators. For example, at 11 health facilities in Jharkhand, 9% of quality improvement standards were rated as good and 45% percent were rated as poor during the first round of visits. These percentages increased to a 55% rating of good and 45% of average by the third round. In addition to improved service delivery for immunization services, visited health facilities also have improved planning; better management of vaccines in the cold chain by improving vaccine storage; and correct packing of ice packs, storage of non-electrical equipment and placement of electrical equipment.

As a result of the RAPID approach, quality improvement of vaccine management and immunization service delivery has been facilitated through joint problem analysis with the health staff. This approach empowers them in a non-threatening way to handle issues by providing on-site demonstrations and capacity building to correct behavior and follow up with the health facilities to ensure sustainability. In an effort to achieve scale-up of RAPID, MCHIP has shared feedback with program managers, decision makers and donors to demonstrate the benefits of this approach. Consequently, in 2009, RAPID was scaled up in six districts of Jharkhand state, with concurrence of the government and assistance of partners, with plans to extend it to all 24 districts with government funding. In Uttar Pradesh, RAPID was implemented in 15 districts by UNICEF with government support, with plans of further scale-up in 17 additional districts by UNICEF with the participation of the Government Medical Colleges

Annex F: List of Communications Events

EVENT	DATE	LOCATION	CO-SPONSORS	NOTES
mHealth Conference	12/6/2010	Washington DC Convention Center		MCHIP's experiences doing quality of care surveillance using mobile technology.
Global Health Strategies for Women and Children's Health	11/16, 2010	New Delhi, India	Global Health Council, CEDPA, and MCH-STAR	Regarding India's commitment to the global strategy for women and children's health.
Performance-Based Financing in Developing Countries	4/72011	SAIS	JHU-SAIS	
A Special Session on "Defining Integration"	4/12/ 2011	Washington, DC	Global Health Council	Led by Steve Hodgins, Cat McKaig and Joseph de-Graft Johnson
Special event on the topic of "Designing Health and Populations to Improve Equity"	4/26/2011	Woodrow Wilson Center, DC	Woodrow Wilson Center	Featured Mickey Chopra of UNICEF, Jennifer Luna of MCHIP, Davidson Gwatkin of Results for Development and Cesar Victoria of the Federal University of Pelotas in Brazil.
Special event to commemorate World Malaria Day	425/2011	National Press Club		
Special event on "Why Family Planning Matters"	4/26/2011	Council on Foreign Relations	Council on Foreign Relations	Koki Agarwal's paper on this topic was published as part of a special edition and this high level event was on its content and message.
Messaging to Board Members	4/28/2011	CORE Group DC Office	CORE Group	Hosted by and presented by MCHIP Communications.
International Day of the Midwife March	5/5/2011	Washington D.C. Walk to the White House	White Ribbon Alliance	
"Operations Research: Methods, Challenges, Emerging Lessons, and Opportunities"	5/9–5/13/2011	CORE Group Spring Meeting		Presented by Florence Nyangara, PVO/NGO Support Team
"CHWs on the move"	5/9–5/13/2011	CORE Group Spring Meeting		Presented by Laban Tsuma, PVO/NGO Support Team
"LQAS—Pitfalls, controversy and addressing concerns"	5/9–5/13/2011	CORE Group Spring Meeting		Presented by Jennifer Luna, PVO/NGO Support Team

EVENT	DATE	LOCATION	CO-SPONSORS	NOTES
"Considerations for Incorporating Health Equity into Project Design"	5/9–5/13/2011	CORE Group Spring Meeting		Presented by Jennifer Luna and Debra Prosnitz, PVO/NGO Support Team
Water Scarcity and Implications for the Developing World	5/31/2011	United Nations Foundation	UN Foundation and UN Association of the USA	
Newborn Sepsis Management Elluminate Session	6/3/2011	Virtual	--	Virtual learning session with participation from all sites in the Dominican Republic and Paraguay.
Global Launch event on "Handwashing with Soap" GDA	6/13/2011	Global Health Council Annual Meeting	Unilever/Lifebuoy	Launched Global Development Alliance to over 170 attendees.
Exhibit booth	6/13–6/17/2011	Global Health Council Annual Meeting	--	Provided promotional materials and hosted ask-the-expert sessions, including interactive demonstrations for neonatal resuscitation and handwashing.
Healthy Fertility Study: Integrating FP within a Community-Based Maternal and Neonatal Health Program in Rural Bangladesh (poster	6/13–6/17/2011	Global Health Council Annual Meeting	--	Presented by Salahuddin Ahmed, MCHIP Bangladesh
Learning from Polio Eradication: Community Involvement in Reaching Under-Immunized in Northern Nigeria	6/13-6/17/2011	Global Health Council Annual Meeting	--	Presented by Lora Shimp, Senior Technical Officer for Immunization
Postpartum IUCD: Opportunities for a Languishing Innovation	6/13–6/17/2011	Global Health Council Annual Meeting	--	Presented by Barbara Deller, Family Planning team
Rapid Diagnostic Tests for Malaria in Burkina Faso	6/13–6/17/2011	Global Health Council Annual Meeting	--	Presented by William Brieger, Senior Malaria Specialist
Strengthening Health Facilities to Provide Quality Emergency Obstetric Care and Family Planning Services	6/13–6/17/2011	Global Health Council Annual Meeting	--	Presented by Lydia Airede, MCHIP Nigeria

EVENT	DATE	LOCATION	CO-SPONSORS	NOTES
in Northern Nigeria				
Testing a FP/MNCH Integration Model: Postpartum Systematic Screening in Northern Nigeria	6/13–6/17/2011	Global Health Council Annual Meeting	--	Presented by Lydia Airede, MCHIP Nigeria
Successful Integration of PMTCT Services with Maternal and Child Health Services	6/13–6/17/2011	Global Health Council Annual Meeting	--	Presented by Oniyire Adetiloye, MCHIP Nigeria
Participated in a panel of presentations on the "Changing Face of Malaria in Maternal Health"	6/13–6/17/2011	Global Health Council Annual Meeting		Panel presentation with presentations by Bill Brieger and Aimee Dickerson
Helping Babies Breathe Performance Evaluation Workshop	6/17/2011	Save the Children	AAP, Laerdal Medical, Save the Children, USAID, NIHCD.	Hosted and facilitated event.
Public Sector: Lessons Learned and Challenges to Scaling up Zinc Programs	6/2011	Virtual	Abt/SHOPS Project	219 health professionals and students from 42 countries participated. MCHIP highlighted progress and lessons learned in introducing and scaling up zinc for diarrhea management in Nepal.
Handwashing Technical Workshop	6/2011	MCHIP Headquarters	USAID	
Monitoring and Evaluation Workshop	6/2011	Nairobi, Kenya	Jhpiego	MCHIP M and E Team organized and facilitated the event with Jhpiego M and E staff. Communications team provided banner stands, agendas, conference bags, and other collateral.
Special event on the topic of Pediatric HIV/AIDS	8/8/11	MCHIP HQ	UN Foundation	

Annex G: Global Monitoring and Evaluation Framework for MCHIP

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

INDICATOR	DEFINITION AND DISAGGREGATION	BASELINE DATA (2008 OR EARLIER)	FY2009/PY1 DATA	FY2010/PY2 DATA	FY2011/PY3 DATA
1. Number of MCHIP countries demonstrating reductions in maternal mortality since the last survey	This may be measured or statistically modeled using LiST at the national or sub-national level (data will be disaggregated), depending on the scale of MCHIP-supported interventions, and includes contributions by CSHGP grantees. Note: In select countries, a valid and reliable estimate of maternal mortality will be generated either by adapting existing measurement methods, i.e. DSS, DHS, census or modeled methods (e.g. UN estimates for MMR); or through innovative primary data collection efforts, i.e. verbal autopsy follow up of deaths of women identified in the census; community based vital events informants; use of or adaptation of methods to acquire adequate sample sizes such as the Sampling at Service Sites method.	▪ Bangladesh – 340 ▪ Bolivia – 180 ▪ DRC – 670 ▪ Ethiopia – 470 ▪ Ghana – 350 ▪ Guyana – 270 ▪ India – 230 ▪ Indonesia – 240 ▪ Kenya – 530 ▪ Lesotho – 530 ▪ Liberia – 990 ▪ Madagascar – 440 ▪ Malawi – 510 ▪ Mali – 830 ▪ Nepal – 380 ▪ Nigeria – 840 ▪ Paraguay – 95 ▪ Rwanda – 540 ▪ Sierra Leone – 970 ▪ South Africa – 410 ▪ South Sudan – n/a ▪ Zimbabwe - 790 **Note:** Two WHO data points, comparable across countries, from within the life-of-project are not available. WHO/UNICEF 2008 data has been provided as a baseline for all MCHIP countries with maternal health activities.	N/A	N/A	N/A

INDICATOR	DEFINITION AND DISAGGREGATION	BASELINE DATA (2008 OR EARLIER)	FY2009/PY1 DATA	FY2010/PY2 DATA	FY2011/PY3 DATA
2. Number of MCHIP countries demonstrating reductions in newborn and under-five mortality since the last survey	This may be measured or statistically modeled using LiST at the national or sub-national level (data will be disaggregated), depending on the scale of MCHIP-supported interventions. The indicator will be disaggregated by newborn and under five. This includes contributions by CSHGP grantees **Note:** U5MR estimates for CSHGP projects were modeled using any indicators collected during a project that showed a statistically significant change and could be modeled in LiST. Projections were made using the most recent (regional if available) U5MRs prior to the start of the project as a baseline.	NNMR ▪ Azerbaijan – 22 ▪ Bangladesh – 34 ▪ DRC – 48 ▪ Dom Rep – 18 ▪ Ethiopia – 38 ▪ India – 36 ▪ Indonesia –20 ▪ Kenya – 30 ▪ Lesotho – 44 ▪ Madagascar – 26 ▪ Malawi – 33 ▪ Mali – 50 ▪ Mozambique – 43 ▪ Nepal – 33 ▪ Nigeria – 43 ▪ Paraguay – 16 ▪ Rwanda – 35 ▪ Senegal – 32 ▪ Sierra Leone – 49 ▪ South Africa – 22 U5MR ▪ DRC – 181.4 ▪ India –73.2 ▪ Indonesia – 43.7 ▪ Kenya – 97.5 ▪ Mali – 195.2 ▪ Rwanda – 127.8 ▪ Senegal –95.0 ▪ Tanzania –102.8 ▪ Zimbabwe –100.2 Data Source: WHO/UNICEF 2005 U5MR ▪ Bangladesh – 88 (CSHGP, CRWRC 2004–2010) ▪ Cambodia – 101 (CSHGP, IRD 2006–		NNMR ▪ Azerbaijan – 19 ▪ Bangladesh – 27 ▪ DRC – 46 ▪ Dom Rep – 15 ▪ Ethiopia – 35 ▪ India – 32 ▪ Indonesia – 17 ▪ Kenya – 28 ▪ Lesotho – 35 ▪ Madagascar – 22 ▪ Malawi – 27 ▪ Mali – 48 ▪ Mozambique – 39 ▪ Nepal – 28 ▪ Nigeria – 40 ▪ Paraguay – 14 ▪ Rwanda – 29 ▪ Senegal – 27 ▪ Sierra Leone – 45 ▪ South Africa – 18 U5MR ▪ DRC – 169.90 ▪ India – 62.7 ▪ Indonesia – 35.3 ▪ Kenya – 84.7 ▪ Mali – 178.1 ▪ Rwanda – 91.1 ▪ Senegal –75.8 ▪ Tanzania –75.8 ▪ Zimbabwe –79.8 Data Source: WHO/UNICEF 2010 U5MR ▪ Bangladesh—81 (CSHGP, CRWRC 2004–2010) ▪ Cambodia – 88 (CSHGP, IRD	Newborn mortality: 21 countries Under-five mortality: 9 countries **Note:** All 21 countries where MCHIP has newborn health programs have demonstrated a decrease in NNMR. All 9 countries with child health programs have demonstrated a decrease in under-five mortality. (Data from WHO/UNICEF, 2005–10)

INDICATOR	DEFINITION AND DISAGGREGATION	BASELINE DATA (2008 OR EARLIER)	FY2009/PY1 DATA	FY2010/PY2 DATA	FY2011/PY3 DATA
		2010) ▪ DR Congo – 145 (CSHGP, CRS 2005–2010) ▪ India – 47 (CSHGP HOPEWW 2006–2010) ▪ Indonesia – 44 (CSHGP Mercy Corps 2006–2010) ▪ Kenya – 144 (CSHGP, AMREF 2005-2010) ▪ Kenya – 77 (CSHGP, HealthRight 2006-2010) ▪ Liberia – 142 (CSHGP, MTI 2006–2010) ▪ Mozambique – 205 (CSHGP, FH 2005–2010) ▪ Uganda – 181 (CSHGP, HealthPartners 2005–2010) ▪ Zambia – 148 (CSHGP, SAWSO 2005–2010)		2006–2010) ▪ DR Congo – 134 (CSHGP, CRS 2005–2010) ▪ India – 44 (CSHGP HOPEWW 2006–2010) ▪ Indonesia – 44 (CSHGP Mercy Corps 2006–2010) ▪ Kenya – 128 (CSHGP, AMREF 2005–2010) ▪ Kenya – 66 (CSHGP, HealthRight 2006–2010) ▪ Liberia – 104 (CSHGP, MTI 2006–2010) ▪ Mozambique – 156 (CSHGP, FH 2005–2010) ▪ Uganda – 174 (CSHGP, HealthPartners 2005–2010) ▪ Zambia – 134 (CSHGP, SAWSO 2005–2010)	
3. Estimated number of lives saved among children under five in USAID MNCH focus countries as a result of MCHIP-supported interventions, Including CSHGP and MCP-supported grants in these countries.[9]	This will be disaggregated for CSHGP grantees versus achievements of other MCHIP country programs. These 10 focus countries include the 5 countries where MCHIP will scale up an integrated package of high impact MNCH interventions. **Note:** Additional lives saved estimates for CSHGP projects were modeled using any indicators collected during a project that showed a statistically significant change and could be modeled in LiST.			19, 990 ▪ Bangladesh – 200 (CSHGP, CRWRC 2004-2010) ▪ Cambodia – 100 (CSHGP, IRD 2006-2010) ▪ DR Congo – 3,000 (CSHGP, CRS 2005-2010) ▪ India – 100 (CSHGP HOPEWW 2006-2010) ▪ Indonesia – 0 (CSHGP Mercy Corps 2006-2010) ▪ Kenya – 900 (CSHGP, AMREF 2005-2010) ▪ Kenya – 700 (CSHGP, HealthRight 2006-2010) ▪ Liberia – 1,300 (CSHGP, MTI 2006-2010) ▪ Mozambique – 4,000 (CSHGP,	Data are reported with a year lag. Data for FY11 will be reported in FY12.

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

INDICATOR	DEFINITION AND DISAGGREGATION	BASELINE DATA (2008 OR EARLIER)	FY2009/PY1 DATA	FY2010/PY2 DATA	FY2011/PY3 DATA
				FH 2005-2010) ▪ Uganda – 2,000 (CSHGP, HealthPartners 2005-2010) ▪ Zambia – 700 (CSHGP, SAWSO 2005-2010)	
4. Percentage of children aged 12-23 months who received 3 doses of DPT vaccine	Numerator: Number of children aged 12–23 months receiving 3 doses of DPT vaccine Denominator: Total number of children aged 12–23 months surveyed	▪ Benin – 76% ▪ Bolivia – 81% ▪ Ethiopia – 56% ▪ Ghana – 80% ▪ Guinea – 43% ▪ India – 64% ▪ Liberia – 62% ▪ Nigeria – 26% ▪ Rwanda – 86% ▪ Senegal – 52% ▪ South Sudan – n/a ▪ Tanzania – 85% ▪ Timor Leste – n/a ▪ Ukraine – 99% ▪ Zimbabwe – 75% Data from: WHO/UNICEF, 2003 **Note:** Data for MCHIP countries with population based surveys and immunization activities. ▪ Bangladesh – 35.9% (CSHGP, CRWRC 2004-2010) ▪ Cambodia – 78.0% (CSHGP, IRD 2006-2010) ▪ DR Congo – 11.6% (CSHGP, CRS 2005-2010) ▪ India – 33.9% (CSHGP HOPEWW 2006-2010) ▪ Indonesia – 27.4% (CSHGP Mercy		▪ Benin – 83% ▪ Bolivia – 85% ▪ Ethiopia – 79% ▪ Ghana – 94% ▪ Guinea – 57% ▪ India – 66% ▪ Liberia – 64% ▪ Nigeria – 42% ▪ Rwanda – 97% ▪ Senegal – 86% ▪ South Sudan – n/a ▪ Tanzania – 85% ▪ Timor Leste – 64.2% § ▪ Ukraine – 90% ▪ Zimbabwe – 73% Data from: WHO/UNICEF, 2009 § DHS 2009-10 ▪ Bangladesh[10] – 94%* (CSHGP, CRWRC 2004-2010) ▪ Cambodia[11] – 81.2% (CSHGP, IRD 2006-2010) ▪ DR Congo[10] – 50.2%* (CSHGP, CRS 2005-2010) ▪ India[11] – 51.5% (CSHGP HOPEWW 2006-2010) ▪ Indonesia[11] – 40.2% (CSHGP Mercy Corps 2006-2010)	N/A

[10] 2000+ Rapid CATCH indicator definition: Percentage of children age 12–23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday
[11] 2006 Rapid CATCH indicator definition: Percentage of children age 12–23 months who received a DPT 3 vaccination before they reached 12 months

INDICATOR	DEFINITION AND DISAGGREGATION	BASELINE DATA (2008 OR EARLIER)	FY2009/PY1 DATA	FY2010/PY2 DATA	FY2011/PY3 DATA
		Corps 2006-2010) ▪ Liberia – 30.6% (CSHGP, MTI 2006-2010) ▪ Mozambique – 85.9% (CSHGP, FH 2005-2010) ▪ Uganda – 76.7% (CSHGP, HealthPartners 2005-2010) ▪ Zambia – 32.6% (CSHGP, SAWSO 2005-2010)		▪ Liberia[11] – 87.6%* (CSHGP, MTI 2006-2010) ▪ Mozambique[10] – 69.1% (CSHGP, FH 2005-2010) ▪ Uganda[10] – 60.4% (CSHGP, HealthPartners 2005-2010) ▪ Zambia[10] – 55.8%* (CSHGP, SAWSO 2005-2010)	
5. Percentage of children aged 0-59 months with diarrhoea receiving oral rehydration	Numerator: Number of children aged 0-59 months with diarrhoea in the 2 weeks prior to the survey receiving oral rehydration therapy (oral rehydration solution and/or recommended homemade fluids or increased fluids) Denominator: Total number of children aged 0–59 months with diarrhoea in the 2 weeks prior to the survey	▪ DRC – 42.3% (2007) ▪ Kenya – 33.3% (2003) ▪ Rwanda – 23.7% (2005) ▪ Tanzania – 53.0% (2005) ▪ Zimbabwe – 46.7 (2006) Data Source: UNICEF with year noted above in parentheses **Note:** Data are included for MCHIP countries with child health activities that had population-based surveys before or during MCHIP ▪ Bangladesh – 57.1% (CSHGP, CRWRC 2004-2010) ▪ Cambodia – 37.9% (CSHGP, IRD 2006-2010) ▪ India – 34.9% (CSHGP HOPEWW 2006-2010) ▪ Indonesia – 49.0% (CSHGP Mercy Corps 2006-2010) ▪ Liberia – 74.2% (CSHGP, MTI 2006-2010) ▪ Mozambique – 66% (CSHGP, FH 2005-2010)	▪ Kenya – 42.6% (DHS 2008-09) ▪ Zimbabwe – 34.9% (UNICEF 2009)	▪ Tanzania – 50.4% (DHS 2010) ▪ Bangladesh[12] – 72.3% (CSHGP, CRWRC 2004-2010) ▪ Cambodia[12] – 38.5% (CSHGP, IRD 2006-2010) ▪ India[12] – 72.4%* (CSHGP HOPEWW 2006-2010) ▪ Indonesia[12] – 43.1% (CSHGP Mercy Corps 2006-2010) ▪ Liberia[12] – 84.1% (CSHGP, MTI 2006-2010) ▪ Mozambique[12] – 93%* (CSHGP, FH 2005-2010)	N/A

[12] 2006 Rapid CATCH indicator definition: Percentage of children age 0–23 months with diarrhea in the last two weeks who received oral rehydration solution (ORS) and/or recommended home fluids (Note: neither continued feeding nor increased fluids is included)

INDICATOR	DEFINITION AND DISAGGREGATION	BASELINE DATA (2008 OR EARLIER)	FY2009/PY1 DATA	FY2010/PY2 DATA	FY2011/PY3 DATA
6. Percentage of children aged 0–59 months with suspected pneumonia taken to an appropriate health provider	Numerator: Number of children aged 0–59 months with suspected pneumonia in the 2 weeks prior to the survey who were taken to an appropriate health provider Denominator: Total number of children aged 0–59 months with suspected pneumonia in the 2 weeks prior to the survey	▪ DRC – 41.9% (2007 DHS) [5yrs] ▪ Kenya – 53.0% (2003 DHS) ▪ Rwanda – 28.6% (2007-08 Interim DHS) ▪ Tanzania – 60.6% (2004-05 DHS) ▪ Zimbabwe – 24.8% (2005-06 DHS) **Note:** Data are included for MCHIP countries with child health activities that had population-based surveys before or during MCHIP ▪ Cambodia – 73.1% (CSHGP, IRD 2006-2010) ▪ India – 74.3% (CSHGP HOPEWW 2006-2010) ▪ Indonesia – 77.8% (CSHGP Mercy Corps 2006-2010) ▪ Liberia – 43.2% (CSHGP, MTI 2006-2010) ▪ Zambia – 81.3% (CSHGP, SAWSO 2005-2010)	Kenya – 57.3% (2008-09 DHS)	▪ Rwanda – 50.2% (2010) Preliminary DHS) ▪ Tanzania – 71% (2010 DHS) ▪ Cambodia[13] – 66.7% (CSHGP, IRD 2006-2010) ▪ India[13] – 69.0% (CSHGP HOPEWW 2006-2010) ▪ Indonesia[13] – 75.0% (CSHGP Mercy Corps 2006-2010) ▪ Liberia[13] – 90.8%* (CSHGP, MTI 2006-2010) ▪ Zambia[13] – 89.4% (CSHGP, SAWSO 2005-2010)	▪ Zimbabwe – 47.4% (2010-11 Preliminary DHS

[13] 2006 Rapid CATCH indicator definition: Percentage of children age 0–23 months with chest-related cough and fast and/or difficult breathing in the last two weeks who were taken to an appropriate health provider

INDICATOR	DEFINITION AND DISAGGREGATION	BASELINE DATA (2008 OR EARLIER)	FY2009/PY1 DATA	FY2010/PY2 DATA	FY2011/PY3 DATA
7. Percentage of children aged 0–59 months with suspected pneumonia receiving antibiotics	Numerator: Number of children aged 0–59 months with suspected pneumonia in the 2 weeks prior to the survey receiving antibiotics Denominator: Total number of children aged 0–59 months with suspected pneumonia in the 2 weeks prior to the survey	▪ DRC – 41.9% (2007) ▪ India – 69% (2005-06) ▪ Indonesia* – 65.9% (2007) ▪ Kenya* – 43.5% (2003) ▪ Lesotho – 58.8% (2004) ▪ Mali – 38.1% (2006) ▪ Rwanda – 28.0% (2007-08) ▪ Senegal* – 40.6% (2005) ▪ Tanzania* –56.6% (2004) ▪ Zimbabwe –24.9% (2005-06) *Treament of ARI and/or fever All baseline data are DHS by year given, unless otherwise indicated.	• Kenya – 55.9% (2008–09 DHS) • Rwanda – 50.2% (2010 Preliminary DHS) **Note:** Data for MCHIP countries child health activities and population based surveys. The DHS in some countries with MCHIP child health activities did not include ARI treatment data. *Lesotho 2009 data available only in data set, not in report.	• Malawi – 70.3% (2010 DHS)	

INDICATOR	DEFINITION AND DISAGGREGATION	BASELINE DATA (2008 OR EARLIER)	FY2009/PY1 DATA	FY2010/PY2 DATA	FY2011/PY3 DATA
8. Percent of women attended at least four times during pregnancy by any provider (skilled or unskilled) for reasons related to the pregnancy in the 5 years prior to the survey	Numerator: Number of women attended at least four times during pregnancy by any provider (skilled or unskilled) for reasons related to the pregnancy in the 5 years prior to the survey Denominator: Total number of women who had a live birth occurring in the same period	▪ Bangladesh – 20.6% (2007 DHS) ▪ Burkina Faso- 17.6% (2003 DHS) ▪ India – 37.0%; (2005-06 DHS) ▪ Indonesia – 81.5% (2007 DHS) ▪ Kenya – 52.3% (2003 DHS) ▪ Lesotho – 69.6% (2004 DHS) ▪ Liberia – 66.0% (2007 DHS) ▪ Madagascar – 39.9% (2003-04 DHS) ▪ Malawi – 57.1% (2004 DHS) ▪ Mozambique – 53.1% (2003 DHS) ▪ Nepal – 29.4% (2006 DHS) ▪ Nigeria – 44.8% (2008 DHS) ▪ Paraguay – 90.5 (2008 RHS) ▪ Rwanda – 23.9% (2007-08 Interim DHS) ▪ Zimbabwe – 71.1% (2005-06 DHS) **Note:** Data for MCHIP countries maternal health activities and population based surveys. ▪ India – 53% (CSHGP HOPEWW 2006-2010) ▪ Kenya – 32% (CSHGP, AMREF 2005-2010) ▪ Kenya – 28% (CSHGP, HealthRight 2006-2010)	▪ Kenya – 47.1% (2008-09 DHS) ▪ Lesotho – 70.4% (2009 DHS) ▪ Madagascar – 49.3% (2008-09 DHS)	▪ Malawi – 45.5% (2010 DHS) ▪ Rwanda – 35.4% (2010 Prelim DHS) ▪ India[14] – 68%* (CSHGP HOPEWW 2006-2010) ▪ Kenya[14] – 49%* (CSHGP, AMREF 2005-2010) ▪ Kenya[15] – 28% (CSHGP, HealthRight 2006-2010	N/A

[14] 2008 Rapid CATCH indicator definition: Percentage of mothers of children age 0–23 months who had four or more antenatal visits when they were pregnant with the youngest child
[15] Percentage of mothers of children 0–11 months who attended ANC at least four times during most recent pregnancy

INDICATOR	DEFINITION AND DISAGGREGATION	BASELINE DATA (2008 OR EARLIER)	FY2009/PY1 DATA	FY2010/PY2 DATA	FY2011/PY3 DATA
9. Percentage of women who received intermittent preventive treatment for malaria during their last pregnancy	Numerator: Number of women at risk for malaria who received two or more doses of a recommended antimalarial drug treatment to prevent malaria during their last pregnancy that led to a live birth Denominator: Total number of women surveyed at risk for malaria who delivered a live baby within the last two years.	▪ Burkina Faso – 64.3% (2003 DHS) ▪ Malawi – 81.8% (2004 DHS) ▪ Mozambique – n/a ▪ Nigeria – 22.3%; North West Zone – 10.6% (2008 DHS) ▪ Rwanda – 19.9% (2007-08 Interim DHS) ▪ Zimbabwe – 37.9% (2005-06 DHS) **Note:** Data for MCHIP countries with malaria activities and recent population based surveys and ▪ Kenya – 4% (CSHGP, HealthRight 2006-2010) ▪ Zambia – 83.8% (CSHGP, SAWSO 2005-2010)		▪ Burkina Faso – 11% (2010 Preliminary DHS) ▪ Malawi – 55% (2010 DHS) ▪ Rwanda – 13.3% (2010 Preliminary DHS) ▪ Kenya[16] – 13%* (CSHGP, HealthRight 2006-2010) ▪ Zambia[17] – 87.7% (CSHGP, SAWSO 2005-2010)	▪ Mozambique – 20.5% (2011 Preliminary MIS) ▪ Zimbabwe – 23.2%(2010-11 Prelim DHS)[18]
10. Percentage of live births attended by skilled health personnel (doctor, nurse, midwife or auxiliary midwife)	Numerator: Number of live births to women aged 15–49 years in the 5 years prior to the survey attended during delivery by skilled health personnel (doctor, nurse, midwife or auxiliary midwife) Denominator: Total number of live births to women aged 15–49 years in the 5 years prior to the survey (Note: This reference period may differ between surveys.)	▪ Ethiopia – 6.3% (2005 DHS) ▪ Kenya – 41.6% (2003 DHS) ▪ Lesotho – 55.2% (2004 DHS) ▪ Liberia – 49.4% (2008-09 DHS) ▪ Madagascar – 44.8% (2004 DHS) ▪ Malawi – 56.6% (2004 DHS) ▪ Mozambique – 49.1% (2003 DHS) ▪ Nepal – 25.0% (2006 DHS) ▪ Nigeria –Kano-12.7%, Katsina-4.7%, Zamfara-7.7% (2008 DHS) ▪ Rwanda – 57.8% (2007-08 Interim DHS) ▪ Zimbabwe – 67.3% (2005-06 DHS) **Note:** Data for MCHIP countries maternal health activities and population based surveys. ▪ Bangladesh – 13.3% (CSHGP, CRWRC	▪ Kenya – 45.2% (2008-09 DHS) ▪ Lesotho – 61.5% (2009 DHS) ▪ Madagascar – 43.3% (2008-09 DHS)	▪ Malawi – 71.4% (2010 DHS) ▪ Rwanda – 69% (2010 Preliminary DHS) ▪ Bangladesh[19] – 19.1% (CSHGP, CRWRC 2004-2010) ▪ Cambodia – 83.5%* (CSHGP, IRD 2006-2010) ▪ DR Congo – 67.9% (CSHGP, CRS 2005-2010) ▪ India – 55.7% (CSHGP HOPEWW 2006-2010) ▪ Indonesia – 93.9% (CSHGP Mercy Corps 2006-2010) ▪ Kenya – 56.0%* (CSHGP, AMREF 2005-2010) ▪ Kenya[20] – 28.4% (CSHGP, HealthRight 2006-2010) ▪ Liberia – 34.7% (CSHGP, MTI	▪ Ethiopia – 10% (2011 Preliminary DHS) ▪ Nepal – 36% (2011 Preliminary DHS) ▪ Zimbabwe - 66.2% (2010-11 Preliminary DHS)

[16] Percentage of mothers of children 0–11 months who received IPT at least twice during ANC
[17] Percentage of mothers of children 0–23 months who received IPT for malaria during their last pregnancy (confirmed by maternal health card)
[18] Percentage of last births in the two years preceding the survey for which the mother got intermittent preventive treatment (IPTp) during an antenatal visit
[19] 2000+ and 2006 Rapid CATCH indicator definition: Percentage of children age 0–23 months whose births were attended by skilled personnel
[20] Percentage of children age 0–11 months whose births were attended by skilled health personnel

INDICATOR	DEFINITION AND DISAGGREGATION	BASELINE DATA (2008 OR EARLIER)	FY2009/PY1 DATA	FY2010/PY2 DATA	FY2011/PY3 DATA
		2004--2010) ▪ Cambodia – 40.0% (CSHGP, IRD 2006-2010) ▪ DR Congo – 64.7% (CSHGP, CRS 2005-2010) ▪ India – 50.0% (CSHGP HOPEWW 2006-2010) ▪ Indonesia – 94.2% (CSHGP Mercy Corps 2006-2010) ▪ Kenya – 25.6% (CSHGP, AMREF 2005-2010) ▪ Kenya – 28.2% (CSHGP, HealthRight 2006-2010) ▪ Liberia – 21.3% (CSHGP, MTI 2006-2010) ▪ Mozambique – 55.6% (CSHGP, FH 2005-2010) ▪ Uganda – 47.4% (CSHGP, HealthPartners 2005-2010) ▪ Zambia – 41.6% (CSHGP, SAWSO 2005-2010)		2006-2010) ▪ Mozambique – 77.5%* (CSHGP, FH 2005-2010) ▪ Uganda – 63.7% (CSHGP, HealthPartners 2005-2010) ▪ Zambia – 52.6% (CSHGP, SAWSO 2005-2010)	

INDICATOR	DEFINITION AND DISAGGREGATION	BASELINE DATA (2008 OR EARLIER)	FY2009/PY1 DATA	FY2010/PY2 DATA	FY2011/PY3 DATA
11. Percentage of live births delivered by caesarean section	Numerator: Number of live births to women aged 15–49 years in the 5 years prior to the survey delivered by caesarean section Denominator: Total number of live births to women aged 15–49 years in the 5 years prior to the survey	▪ Ethiopia – 1.0% (2005 DHS) o Urban: 9.4% o Rural: 0.3% ▪ Kenya – 4.0% (2003 DHS) o Urban: 9.4% o Rural: 4.0% ▪ Lesotho – 5.1% (2004 DHS) o Urban: 8% o Rural: 4.6% ▪ Liberia – 3.5% (2007 DHS) o Urban: 5.4% o Rural: 2.6% ▪ Madagascar – 1.0% (2003-04 DHS) o Urban: 2.2% o Rural: 0.8% ▪ Malawi – 3.1% (2004 DHS) o Urban: 4.4% o Rural: 2.9% ▪ Mozambique – 1.9% (2003 DHS) o Urban: 5.3% o Rural: 0.5% ▪ Nepal – 2.7% (2006 DHS) o Urban: 8.4% o Rural: 1.9% ▪ Nigeria –Kano-.6%, Katsina-.1%, Zamfara - 0.1% (2008 DHS) o Urban (nat'l): 3.7% o Rural (nat'l): 1% ▪ Rwanda – 2.9% (2007-08 Interim DHS) o Urban: n/a o Rural: n/a ▪ Zimbabwe – 4.8% (2005-06 DHS) o Urban: 8.7% o Rural: 3.2% **Note:** Data for MCHIP countries maternal health activities and population based surveys.	▪ Kenya – 6.2% (2008-09 DHS) o Urban: 11.3% o Rural: 5.1% ▪ Lesotho – 6.7% (2009 DHS) o Urban: 11.4% o Rural: 5.2% ▪ Madagascar – 1.5% (2008-09 DHS) o Urban: 5.7% o Rural: 0.9%	▪ Malawi – 4.6% (2010 DHS) o Urban: 8.3% o Rural: 4.2%	N/A

INDICATOR	DEFINITION AND DISAGGREGATION	BASELINE DATA (2008 OR EARLIER)	FY2009/PY1 DATA	FY2010/PY2 DATA	FY2011/PY3 DATA
12. Percentage of newborns put to the breast within one hour of birth	Numerator: Number of women with a live birth in the X years prior to the survey who put the newborn infant to the breast within 1 hour of birth Denominator: Total number of women with a live birth in the X years prior to the survey (Note: This reference period may differ between surveys.)	**Note:** Data not included for MCHIP countries due to limitations. Indicator definition is standard for MICS, but not DHS, which uses the denominator of children ever breastfed rather than all children: anticipate having updated MICS data from the current round of MICS surveys in PY4. ▪ India – 25% (CSHGP HOPEWW 2006-2010) ▪ Kenya – 20% (CSHGP, HealthRight 2006-2010) ▪ Liberia – 33.7% (CSHGP, MTI 2006-2010) ▪ Zambia – 43.8% (CSHGP, SAWSO, 2005-2010)		▪ India[21] – 34% (CSHGP HOPEWW 2006-2010) ▪ Kenya[22] – 66%* (CSHGP, HealthRight 2006-2010) ▪ Liberia[23] – 87.0%* (CSHGP, MTI 2006-2010) ▪ Zambia[24] – 71.6%* (CSHGP, SAWSO, 2005-2010)	N/A
13. Percentage of mothers who received postnatal care visit within two days of childbirth	Numerator: Number of women who received a postnatal care visit within two days of childbirth (regardless of place of delivery) Denominator: Total number of women aged 15–49 years with a last live birth in the 5 years prior to the survey (regardless of place of delivery)	▪ Bangladesh – 27% (DHS 2007) ▪ Dominican Republic –82.1% (2007 DHS) ▪ Ethiopia – 4.6% (2005 DHS) ▪ Kenya – 10.0% (2003 DHS)[25] ▪ Lesotho – 47.9% (2009 DHS) ▪ Madagascar – 32.1% (2003-04 DHS) ▪ Malawi – 20.6% (2004 DHS) ▪ Mozambique – 12.1% (2003 DHS) ▪ Nigeria – Kano-12.9%, Katsina-7.1%, Zamfara-13.7% (2008 DHS) ▪ Paraguay – n/a ▪ Zimbabwe – 30.3% (2005-06 DHS) **Note:** Data for MCHIP countries with population based surveys and newborn health activities. ▪ Kenya – 23% (CSHGP, AMREF 2005-2010)	▪ Kenya – 42.1% (2008-09 DHS) ▪ Lesotho – 47.9% (2009 DHS) ▪ Madagascar – 46.3% (2008-09 DHS) ▪ Kenya[26] – 58%* (CSHGP, AMREF 2005-2010)	Malawi – 43% (2010 DHS)	N/A

[21] Percentage of newborns who were put to the breast within one hour of delivery
[22] Percentage of children aged 0–5 months who were exclusively breastfed within the first hour after birth
[23] Percentage of newborns who were put to the breast within one hour of delivery and did not receive prelactal feeds
[24] Percentage of children 0–23 months who were breastfed within one hour of birth
[25] Percent distribution of women who had a non-institutional live birth in the five years preceding the survey by timing of postnatal care for the most recent non-institutional birth
[26] Percentage of mothers 0-5 months who attend postnatal care within two days of delivery

INDICATOR	DEFINITION AND DISAGGREGATION	BASELINE DATA (2008 OR EARLIER)	FY2009/PY1 DATA	FY2010/PY2 DATA	FY2011/PY3 DATA
14. Percentage of babies who received a postnatal care visit within two days of birth.	Numerator: Number of babies who received a postnatal care visit within two days of birth (regardless of place of delivery) Denominator: Total number of last-born babies in the x years prior to the survey.	▪ Bangladesh- 27% (DHS 2007) ▪ Dominican Republic-82.1% (2007 DHS) **Note:** Data for other MCHIP countries from DHS not included due to limitations. Indicator definition is standard for MICS, but not older DHS: anticipate having updated MICS data from the current round of MICS surveys in PY4. ▪ Cambodia – 21.3% (CSHGP, IRD 2006-2010) ▪ India – 40.7% (CSHGP HOPEWW 2006-2010) ▪ Indonesia – 42.7% (CSHGP Mercy Corps 2006-2010) ▪ Kenya – 15.8% (CSHGP, HealthRight 2006-2010) ▪ Liberia – 7.0% (CSHGP, MTI 2006-2010)		▪ Cambodia[27] – 67.0%* (CSHGP, IRD 2006-2010) ▪ India[27] – 46.3% (CSHGP HOPEWW 2006-2010) ▪ Indonesia[27] – 43.0% (CSHGP Mercy Corps 2006-2010) ▪ Kenya[28] – 54.7%* (CSHGP, HealthRight 2006-2010) ▪ Liberia[27] – 40.3%* (CSHGP, MTI 2006-2010)	N/A
15. Percentage of mothers with children under 24 months who are currently using FP	Numerator: Number of mothers with children under 24 months who are currently using FP Denominator: Total number of mothers with children under 24 months *DATA for contraceptive prevalence rate from DHS uses this definition (percent married women 15-49 using any form of contraception at the time of the survey)* surveyed	▪ Bangladesh – 55.8% (DHS 2007) ▪ Ethiopia – 14.7% (2005 DHS) ▪ Guinea – 9.1% (2005 DHS) ▪ India – 56.3%; UP – 56.3%; Jharkhand [urban] – 60.0%, [rural] - 28.2% (2005-06 DHS) ▪ Kenya – 39.3% (2003 DHS) ▪ Malawi – 32.5% (2004 DHS) ▪ Mali – 8.2% (2006 DHS) ▪ Nepal – 48.0% (2006 DHS) ▪ Nigeria – 14.6% (2008 DHS) ▪ Rwanda – 36.4% (2007-08 Interim DHS) ▪ Zimbabwe – 60.2% (2005-06 DHS) **Note:** Data for MCHIP countries population based surveys and family planning activities.	▪ Kenya – 45.5% (2008-09 DHS)	▪ Malawi – 47.4% (2010 DHS) ▪ Rwanda – 52% (2010 Preliminary DHS) ▪ Zimbabwe – 58.5% (2010 Preliminary DHS)	▪ Ethiopia – 28.6% (2011 Preliminary DHS) ▪ Nepal – 49.7% (2011 Preliminary DHS)

[27] 2006 Rapid CATCH indicator definition: Percentage of children age 0–23 months who received a post-natal visit from an appropriately trained health worker within three days after birth
[28] Percentage of mothers of infants 0–5 months who received neonatal care within two days of delivery

INDICATOR	DEFINITION AND DISAGGREGATION	BASELINE DATA (2008 OR EARLIER)	FY2009/PY1 DATA	FY2010/PY2 DATA	FY2011/PY3 DATA
16. Percentage of women who received iron/folate during their last pregnancy	Numerator: Number of women who received iron/folate during their last pregnancy that led to a live birth Denominator: Total number of women surveyed who delivered a live baby within the last two years.	▪ Bangladesh – 57.2% (2007 DHS) ▪ Burkina Faso – 70.3% (2003 DHS) ▪ India – 64.8%; UP – 58.2%; Jharkhand – 49.5% (2005-06 DHS) ▪ Indonesia – 77.8% (2007 DHS) ▪ Kenya – 46.8% (2003 DHS) ▪ Lesotho – 37.8% (2004 DHS) ▪ Liberia – 87.4% (2007 DHS) ▪ Madagascar – 32.3% (2003-04 DHS) ▪ Malawi – 79.7% (2004 DHS) ▪ Mozambique – 59.7% (2003 DHS) ▪ Nepal – 62.8% (2006 DHS) ▪ Nigeria – 54.1%; North West Region – 30.6% (5yrs) (2008 DHS) ▪ Paraguay – n/a (2008 RHS) ▪ Rwanda – 41.7% (2007-08 Interim DHS) ▪ Zimbabwe – 41.4% (2005-06 DHS) **Note:** Data for MCHIP countries with population based surveys and maternal health activities.	▪ Lesotho – 46.5% (2009 DHS) ▪ Kenya – 69.6% (2008-09 DHS) ▪ Madagascar – 58.0% (2008-09 DHS)	▪ Malawi – 91.2% (2010 DHS)	N/A
17. Number of (national) policies drafted with USG support*	This refers to the number of national laws, policies[29], regulations, strategy documents, including national service delivery guidelines and performance standards, developed or revised with MCHIP support to improve access to and use of high impact MNCH services, including FP. The list of policies will be provided and disaggregated by country and technical area.	0	4	29	49 (See list of policies by country at the end of this matrix)

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

INDICATOR	DEFINITION AND DISAGGREGATION	BASELINE DATA (2008 OR EARLIER)	FY2009/PY1 DATA	FY2010/PY2 DATA	FY2011/PY3 DATA
18. Number of MCHIP countries that have introduced innovative health financing schemes/incentive mechanisms with MCHIP support	This includes performance-based incentive (PBI) schemes, pay for performance, client incentive mechanisms, franchising, vouchers, and insurance schemes at a national or sub-national level.	0	0	2	3 (Zimbabwe, Nigeria, India)
19. Number of people trained through USG - supported programs*	This indicator will be disaggregated by training topic and for CSHGP and MCP contributions as needed. Training topics include: MNH, child health and nutrition, malaria, FP/RH, HIV/AIDS (PMTCT, male circumcision), and M&E/operations research.	0	1935 (Note: These are training participants and not unique individuals)	23,348 (Note: These are training participants and not unique individuals)	69,273 MNH:29,680 (core: 3,843, field: 25,837) CH/N:3,843 (core: 261, field: 2822) Malaria:9083 (all field) FP/RH:25779 (all field) HIV/AIDS:985 (all field) MER: 544 (core: 13, field: 531) Other:119 (Note: These are training participants and not unique individuals)
20. Percent of facilities that offer delivery services with MgSO4 available in the delivery room	Number of facilities that offer delivery services with MgSO4 available in the delivery room/Total number of facilities that offer delivery services	0	New indicator for Year 3	New indicator for Year 3	Guinea- 87%

INDICATOR	DEFINITION AND DISAGGREGATION	BASELINE DATA (2008 OR EARLIER)	FY2009/PY1 DATA	FY2010/PY2 DATA	FY2011/PY3 DATA
21. Number of countries with preservice education strengthened to improve skilled birth attendance**	This includes updating curricula and improving the skills of tutors This indicator will be disaggregated by type of curriculum/cadre of provider, e.g. midwife, nurse, clinical officer, etc.	0	2 (Malawi, Ghana)	5 (DRC, India, Liberia, Malawi, Mozambique)	10 (DRC, Ethiopia, Ghana, Guinea, India, Malawi, Mozambique, Nigeria, Rwanda, Zimbabwe)
22. Number of MCHIP-supported health facilities demonstrating increased compliance with clinical standards over baseline	Number of MCHIP-supported facilities that are implementing a quality improvement approach, such as standards-based management and recognition that demonstrate increased compliance with standards over baseline. This will be disaggregated by country and type of facility (e.g., dispensary/health post, health center, hospital).	0	0	117	1990 (Bolivia, Burkina Faso, DRC, DR, Guinea, India, Indonesia, Kenya, Malawi, Mozambique, Nigeria)
23. Number of countries with introduction of high impact MNCH interventions through MCHIP supported activities and CSHGP grants in MCHIP supported countries**	This includes: ▪ Maternal anemia control ▪ PPH prevention (at least 25% of facilities that offer delivery services in one district)** ▪ PPH treatment (at least 25% of facilities that offer delivery services in one district)** ▪ Pre-eclampsia/Eclampsia programs (program model developed for prevention, detection, and treatment)** ▪ Postnatal and essential newborn care (less than 3 districts)** ▪ Kangaroo Mother care (facility-based KMC services in less than 3 districts)** ▪ Community Kangaroo	0	Mat. anemia - 0 PPH/P - 2 PPH/T – 2 PE/E – 0 PNC/ENC – 0 KMC -0 CKMC - 1 NB HW – 0 Asphyxia – 1 NB infect – 0 ORT/Zinc - 1 CCM/Pneu.. – 2 New vaccines - 0	Mat. anemia - 1 PPH/P - 7 PPH/T – 7 PE/E – 2 PNC/ENC – 5 KMC -7 (introduced/expanded) CKMC - 2 NB HW – 3 Asphyxia – 2 NB infect – 3 ORT/Zinc - 1 CCM/Pneu.. – 0 New vaccines - 1	Mat. anemia - 1 PPH/P - 2 PPH/T – 2 PE/E – 2 PNC/ENC – 3 KMC -8 (into./exp) CKMC - 2 NB HW – 1 Asphyxia – 14 NB infect..- 1 ORT/Zinc - 1 CCM/Pneu.. – 0 New vaccines – 5 (see the table following this matrix for the list of countries)

INDICATOR	DEFINITION AND DISAGGREGATION	BASELINE DATA (2008 OR EARLIER)	FY2009/PY1 DATA	FY2010/PY2 DATA	FY2011/PY3 DATA
	Mothercare ▪ Newborn handwashing promoted ▪ Management of asphxia in the newborn (home and facility settings)** ▪ Newborn infection management ▪ Oral rehydration therapy/zinc ▪ Community case management/pneumonia control ▪ New vaccines/innovative technologies				
24. Number of countries with expansion of high impact MNCH interventions through MCHIP supported activities and CSHGP grants in MCHIP supported countries**	This includes: ▪ Skilled birth attendance/ Essential obstetric care** ▪ PPH prevention** (at least 20% of facilities in the country that offer delivery services)** ▪ Postnatal and essential newborn care (3 or more districts) ▪ Kangaroo Mother care (facility-based KMC services in 3 or more districts)** ▪ Oral rehydration therapy/zinc ▪ Community case management/pneumonia control	0 (with MCHIP support)	SBA/EOC - 2 PPH/P - 2 PNC/ENC – 0 KMC -8 (into./exp) ORT/Zinc - 0 CCM/Pneu.. – 1	SBA/EOC - 8 PPH/P - 7 PNC/ENC – 2 KMC -8 (into./exp) ORT/Zinc - 1 CCM/Pneu.. – 1	SBA/EOC -1 PPH/P - 7 PNC/ENC – 9 KMC -8 (into./exp) ORT/Zinc - 2 CCM/Pneu.. – 1 (see the table following this matrix for the list of countries)
25. Number of countries with strategies to revitalize ORT use**	ORT/CDD revitalization strategy indicating explicit intent of MOH and partners to increase use of ORT	0	2	3	5 (DRC, Kenya, Malawi, Rwanda, Zimbabwe)

INDICATOR	DEFINITION AND DISAGGREGATION	BASELINE DATA (2008 OR EARLIER)	FY2009/PY1 DATA	FY2010/PY2 DATA	FY2011/PY3 DATA
26. Number of clients attending essential MNCH services with integrated FP at MCHIP-supported facilities who received FP counseling	Essential MNCH services include ANC, post-abortion care, postpartum care, well-baby/immunization services. Data will be disaggregated by country.	0	April–Sept in Nigeria 105,953 ANC clients and 25,527 postpartum care	1,077,640	1,049,817 (Bangladesh, DRC, Guinea, India, Malawi, Mozambique, Nigeria, Rwanda)
27. Couple years of protection	CYP is the estimated protection provided by contraceptive methods during a one-year period, based upon the volume of all contraceptives sold or distributed free of charge to clients during that period. CYP is calculated by multiplying the quantity of each method distributed to clients by a conversion factor, to yield an estimate of the duration of contraceptive protection provided per unit of that method. The CYP for each method is then summed for all methods to obtain a total CYP figure.[30]	0	New for Year 3	New for Year 3	404,807 (Bangladesh, Guinea, India, Malawi, Mozambique, Nigeria)
28. Number of deliveries with a skilled birth attendant (SBA) in USG-assisted programs*	Number of deliveries with a skilled birth attendant (SBA). SBA includes: ▪ medically trained doctor, nurse, or midwife. It does NOT include traditional birth ▪ attendants (TBA). Data will be disaggregated by country.	N/A	Nigeria total from April–Sept was 28,336	228,307	544,622 (Bangladesh, Bolivia, DRC, DR, India, Indonesia, Malawi, Mozambique, Nigeria, Paraguay, Rwanda, Zimbabwe)

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

INDICATOR	DEFINITION AND DISAGGREGATION	BASELINE DATA (2008 OR EARLIER)	FY2009/PY1 DATA	FY2010/PY2 DATA	FY2011/PY3 DATA
29. Number of women receiving active management of the third stage of labor (AMSTL) through USG-supported programs*	Number of women giving birth who received Active Management of the Third Stage of Labor (AMSTL) through USG-supported programs. Data will be disaggregated by country.	N/A (data not captured prior to program implementation)	15,688 (Nigeria)	108,873	469,654 (Bolivia, DRC, Guinea, Indonesia, Malawi, Mozambique, Nigeria, Paraguay, Rwanda)
30. Percent of women receiving a uterotonic immediately after birth		Baseline data not available	New for Year 3	New for Year 3	Bangladesh – 85% Guinea – 81% India – 81% Zimbabwe – 87%
31. Number of newborns receiving antibiotic treatment for infection from appropriate health workers through USG-supported programs*	Number of newborn infants (identified as having possible infection) who receive antibiotic treatment from appropriate trained facility, outreach or community health workers through USG-supported programs.	0 with MCHIP support	2,668	3,737	252,982 (DRC, Nigeria)
32. Percent of babies not breathing/crying at birth who were successfully resuscitated	This is one of the Helping Babies Breathe indicators.	Baseline data not available	New for Year 3	New for Year 3	
33. Number of children less than 12 months of age who received DPT3 from USG-supported programs*	Number of children less than 12 months who received DPT3 in a given year from USG supported programs..	0	N/A	10,024,409	25,786,000 (DRC, India, Rwanda, Zimbabwe)

INDICATOR	DEFINITION AND DISAGGREGATION	BASELINE DATA (2008 OR EARLIER)	FY2009/PY1 DATA	FY2010/PY2 DATA	FY2011/PY3 DATA
34. Number of cases of child diarrhea treated in USAID-assisted programs*	Number of cases of child diarrhea treated through USG-supported programs With oral rehydration therapy (ORT) or zinc supplements.	0	DRC: 1595 children <5 received zinc or ORS	55,742 ▪ Newborn cases: 1,889 ▪ Child cases: 49,854 ▪ Under five cases: ▪ 3999	521, 105 (DRC, Malawi, Rwanda, Zimbabwe)
35. Number of cases of child pneumonia treated with antibiotics by trained facility or community health workers in USG-supported programs*	Number of cases of child pneumonia treated with antibiotics by trained facility or community health workers in USAID supported programs	0	DRC- 1167	4,864	46,461 (DRC, Rwanda, Zimbabwe)
36. Number of countries accepting new MNCH indicators for national collection and routine reporting	This includes service use and quality of care indicators related to maternity services, postpartum care, community case management, etc.	0	New for Year 3	New for Year 3	5 (Bangladesh, DRC, Kenya, Malawi, Rwanda)
37. Number of countries piloting new MNCH indicators	This includes service use and quality of care indicators related to maternity services, postpartum care, community case management, etc.	0	New indicator for Year 3	New indicator for Year 3	4 (Bangladesh, DRC, Kenya, Malawi)

INDICATOR	DEFINITION AND DISAGGREGATION	BASELINE DATA (2008 OR EARLIER)	FY2009/PY1 DATA	FY2010/PY2 DATA	FY2011/PY3 DATA
38. Number of studies[31]	This includes special studies, baseline and feasibility studies and evaluations conducted with both core (SO2 and SO3) and field funds (under SO1), Special studies are analyses undertaken to gather information relevant for a particular program or activity in order to improve knowledge or understanding about the study subject. Special studies examine unique circumstances as opposed to an entire activity or program. A baseline study records the context of the host country working environment at that time. Such studies are generally carried out before program activities begin or during program start-up. A feasibility study examines the context in which an anticipated activity would be implemented as well as the viability and practicality or implementing the particular activity. This includes midterm and endline evaluations conducted by CSHGP grantees.	0	34	48 ▪ 22 CSHPG ▪ 10 Malaria Communities Program ▪ 16 MCHIP	46 ▪ 21 MCHIP ▪ 25 CSHGP (see the table following this matrix for a list of studies)

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

INDICATOR	DEFINITION AND DISAGGREGATION	BASELINE DATA (2008 OR EARLIER)	FY2009/PY1 DATA	FY2010/PY2 DATA	FY2011/PY3 DATA
39. Number of innovations or promising practices of CSHGP grants documented and supported by SO3.	Demonstration of innovations and promising practices includes: ▪ CSHGP Operations Research Studies supported through TA from MCHIP SO3; ▪ Special analyses conducted across the portfolio of CSHGP grants by MCHIP SO3, such as innovation tracking, Lives Saved calculations, and including possible themes of integration/integrated packages, cost, effective delivery modalities, analysis for scalable components, equity; ▪ Documentation of successful projects	0	5	11	6 (6 innovation grants started in YR3)
40. Number of CSHGP grantee innovations or promising practices incorporated into MCHIP country programs.	Demonstration of innovations and promising practices includes: ▪ CSHGP Operations Research Studies supported through TA from MCHIP SO3; ▪ Special analyses conducted across the portfolio of CSHGP grants by MCHIP SO3, such as innovation tracking, Lives Saved calculations, and including possible themes of integration/integrated packages, cost, effective delivery modalities, analysis for scalable components, equity; SO3 organized TAG, for example on equity; ▪ Documentation of successful projects	0	0	0	None

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

Table 6. Details for Indicators 17 and 38

Indicator 17: Number of national policies, guidelines and strategies developed using USG funds.		
Geographic Area	Number	Additional Notes
Bangladesh	2	1. Health Population Nutrition Sector Development Program (HPNSDP) 2011-2016. 2. Program Implementation Plan (PIP) of HPNSDP
Democratic Republic of the Congo	8	3 KMC training tools3 M&E tools2 Supervision check lists
Ethiopia	2	These are the financial and human resource manuals developed for Ethiopian Midwifery Association
Guinea	2	Tubal ligation curriculum and IUCD curriculum
India	4	
Kenya	17	School Health policy and guidelines; CS and Development Guidelines; DD policy; EPI MLM teaching modules; IYCF integrated guidelines orientation package; Diarrhea Communication Strategy; Guidelines for ORT corners; ENBC package; Food and Nutrition Security policy; National Nutrition Action Plan; IYCN Policy and Strategy Plan; Nutrition Surveillance Protocol; Rota Virus Vaccine Application; GAVI annual progress report; Concept paper for CLTS and cIMCI integrated materials; PPH community orientation package; PMTCT/MNCH Integrated services job Aid; MIYCN/FP integration materials; PCV10 Launch Materials
Liberia	1	Standards for Adolescent Sexual & Reproductive Health
Malawi	1	Revised CBMNH M&E system
Mozambique	3	National norms for care for normal delivery, newborn, and obstetric complications, national norms for family planning and management of infertility, national quality and performance standards for cervical and breast cancer
Paraguay	3	Manual de atencion neonatal, Manual de emergencias Obstetricas de atencion calificada del parto, cuadro de procedimientos del aiepi
Rwanda	2	Draft of MNH-BCC Sub-strategy and FP policy and its strategy
Zimbabwe	4	These are not policies but guidelines (EmONC, FANC, ENC/PNC and IMNCI guidelines)
Total	49	

Indicator 38: Number of special studies		
Geographic Area	Number	Additional Notes
Bangladesh	3	1. Role of community action groups in improving MNH situation. 2. Institutionalization of community action groups for improving MNH situation 3. Role of volunteers in improving MNH situation
Dominican Republic	1	
Ghana	1	Preservice assessment
Guyana	1	Guyana Process Evaluation
India	2	1. Assessment of PPIUCD services in India; 2. Evaluation of PPSS tool in Jharkhand, India
Kenya	5	Basic IT skills assessment of DFH staff; Nutritional Surveillance in Western and Nyanza Provinces; BFCI assessment in Western and Nyanza provinces; Assessment of MIYCN/FP integrated approach in Bondo district; Pilot of BFCI monitoring tool in Vihiga District;
Malawi	1	HBB Evaluation IRB protocol submitted; under review
Nepal	1	1. "Validation and District Pilot of a New Protein Self-Test for Early Detection of Pre-eclampsia"
Nigeria	1	Newborn sepsis assessment
Paraguay	1	Qualitative study of community maternal and newborn health.
Rwanda	2	PAC study and QOC study
Zimbabwe	2	Child Health Needs Assessment and Immunization Assessment
Total	21	

Table 7: Details for Indicators 23 and 24 (Number of Countries and Country Names)

	Year 1 Results	Year 2 Results	Year 3 Results	Year 4 Target	LOP Target
High Impact Maternal Health Interventions					
Maternal Anemia Control		1 Bangladesh or Indonesia	1 Rwanda	1 Zimbabwe	5
Skilled Attendance at Birth (Essential Obstetric Care)	2 Mozambique, Nigeria	8 Malawi, Kenya, Madagascar, India, Liberia, Mali, Lesotho, DRC	1 Zimbabwe	4 Ghana, Bangladesh, Afghanistan, Ethiopia	10
PE/E Prev./Treatment Introduced		2 Nepal Mozambique	2 Tanzania Zimbabwe	3 Bangladesh, Ethiopia, Indonesia	7

PPH Prevention Expanded	2 Mali, DRC	7 Kenya, Mozambique, Madagascar, Liberia, India, Nigeria, Malawi	7 Zimbabwe, Nepal, Rwanda, Paraguay, Indonesia, Ethiopia, Bangladesh	9 Guinea, South Sudan, Angola, Peru, Nicaragua, Guatemala, Honduras, Tanzania, Afghanistan	20
PPH Treatment Introduced	2 Nigeria, DRC	7 Mali, Kenya, Malawi, Mozambique, Madagascar, Liberia, India,	2 Zimbabwe, Nepal	2 Paraguay, Bolivia	15
	Year 1 Results	**Year 2 Results**	**Year 3 Results**	**Year 4 Target**	**LOP Target**
High Impact Newborn Health Interventions					
Management of asphyxia introduced	1 Nigeria	2 Kenya, Bangladesh	14 Azerbaijan, India, Ethiopia, Nigeria, Zimbabwe, Ghana, Dominican Republic, Nicaragua, Guatemala, El Salvador, Honduras, Panama, Belize, Bolivia	2 Tanzania, Malawi	8
Newborn handwashing promoted		3 Indonesia, Bangladesh, India	1 Kenya		8
Newborn infection management introduced		3 Bangladesh, Nigeria, Dominican Republic	1 Paraguay	1 Liberia	8
Community KMC	1 Bangladesh	2 Malawi Indonesia	2 Ethiopia, Mozambique,	0	8
KMC introduced/expanded		7 Malawi, Bangladesh, Nigeria, DRC, Mali, Dominican Republic, Nicaragua	8 Rwanda, Indonesia, Guatemala, Honduras, El Salvador, Paraguay, Zimbabwe Mozambique	0	15
PNC/ENC expanded		2 Bangladesh, DRC	9 India, Nigeria, Malawi, Ethiopia, Zimbabwe, Mozambique, Mali, Guinea Rwanda	0	10
PNC/ENC introduced		5 India, Malawi, Mali,	3 Azerbaijan,	3 Kenya, Tanzania,	15

		Nigeria, Dominican Republic	Indonesia, Paraguay	Colombia	
	Years 1-2 Results		**Year 3 Results**	**Year 4 Target**	**LOP Target**
High Impact Child Health Interventions					
Expansion of ORT/Zinc	1 Senegal		2 DRC, Rwanda	3 Kenya, Mali, Zimbabwe	6
Introduction of ORT/Zinc	2 Kenya, Mali		1 Zimbabwe	3 Guinea, Zambia	8
Expansion of CCM or Pneumonia Control	2 DRC, Senegal		1 Rwanda	2 Mali, Zambia	7
Intro. Of CCM or Pneumonia Control	2 Kenya, Mali		0	2 Guinea, TBD	5
	Years 1-2 Results		**Year 3 Results**	**Year 4 Target**	**LOP Target**
Immunization Interventions					
RI and Polio	3 DRC, India, Kenya		3 Nigeria Afghanistan, Pakistan	3 Ukraine, Kyrgyzstan, Tajikistan,	7
New vaccines/Innovative technologies	1 Rwanda		5 DRC, Kenya, Benin, Zimbabwe, Tanzania	3 Senegal, Malawi, Uganda	7
RED+ (RED plus MNCH/FP)	1 Liberia		3 Kenya,India, Zimbabwe	0	3
District RI planning/Management capacity	5 DRC, India, Kenya, Nigeria, South Sudan		2 Rwanda, Zimbabwe	3 Senegal, Malawi, Tanzania	8
Resources leveraged for RI	8 DRC, India, Kenya, Timor-Leste, Zimbabwe, Madagascar, Nigeria, South Sudan		1 Tanzania	3 Senegal, Malawi, Rwanda	6
One Year RI Coverage Increased	6 (Years 1 and 2: Rwanda, South Sudan, India, Madagascar, Nigeria, East Timor)		1 Kenya	5 DRC, Malawi, , Senegal, Tanzania, Zimbabwe, Ghana	7