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MCHIP YEAR ONE 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]
ACNM	American College of Nurses and Midwives
AED	Academy for Educational Development
AFR/SD	USAID Africa Bureau, Office of Sustainable Development
AIDS	Acquired Immune Deficiency Syndrome
AMTSL	Active management of the third stage of labor
ANC	Antenatal care
BASICS	Basic Support for Institutionalizing Child Survival
CBMNI	Community-based management of neonatal infection
CCM	Community case management
CDC	U.S. Centers for Disease Control and Prevention
CHW	Community health worker
CI	Catalytic Initiative
CIDA	Canadian International Development Agency
cMYP	Comprehensive multi-year plan
CSHGP	Child Survival and Health Grants Program
CSTS+	Child Survival and Technical Support Plus
CYP	Couple Years Protection
DHS	Demographic Health Surveys
DRC	Democratic Republic of the Congo
EmONC	Emergency obstetric and newborn care
ENC	Essential newborn care
FANC	Focused antenatal care
FIGO	International Federation of Gynecology and Obstetrics
FP	Family planning
GAPPS	Global Alliance for Prevention of Prematurity and Stillbirths
GAVI	GAVI Alliance (formerly the Global Alliance for Vaccines and Immunization)
HBB	Helping Babies Breathe
HIV	Human Immunodeficiency Virus
iCCM	Integrated community case management
ICM	International Confederation of Midwives
IIP	Institute of International Programs
IMCI	Integrated management of childhood illness
IMMbasics	IMMUNIZATIONbasics
ITN	Insecticide-treated net
JHU	Johns Hopkins University

JSI	John Snow, Inc.
KMC	Kangaroo Mother Care
LAC	Latin America and the Caribbean
LAM	Lactational Amenorrhea Method
LiST	Lives Saved Tool
LGA	Local Government Area
MaMoni	Integrated Safe Motherhood, Newborn Care and Family Planning Project
MCHIP	Maternal and Child Health Integrated Program
MCP	Malaria Communities Program
MIP	Malaria in pregnancy
MNC	Maternal and newborn care
MNCH	Maternal, newborn and child health
MNH	Maternal and newborn health
MOH	Ministry of Health
MOHFW	Ministry of Health and Family Welfare
M&E	Monitoring and evaluation
NGO	Nongovernmental organization
PAC	Postabortion care
PATH	Program for Appropriate Technology in Health
PE/E	Pre-eclampsia/eclampsia
PMI	U.S. President's Malaria Initiative
PMNCH	Partnership for Maternal, Newborn and Child Health
PMTCT	Prevention of mother-to-child transmission of HIV
PNC	Postnatal care
PNLP	National Malaria Control Program
POPPHI	Prevention of Postpartum Hemorrhage Initiative
PPC	Postpartum care
PPFP	Postpartum family planning
PPH	Postpartum hemorrhage
PSI	Population Services International
PVO	Private voluntary organization
QI	Quality improvement
QOC	Quality of care
RED	Reaching Every District
RH	Reproductive health
SC	Save the Children
SNL	Saving Newborn Lives
TA	Technical assistance
TAG	Technical advisory group
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
USG	United States Government
VIA	Visual inspection of the cervix with acetic acid
VPPAG	Vaccine Presentation and Packaging Advisory Group
WHO	World Health Organization
WHO/AFRO	World Health Organization/Regional Office for Africa

Summary of Major Achievements

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). Since it began in October 2008, MCHIP has received \$10.41 million (as of September 30, 2009)—\$5.51 million in total core obligations and \$4.9 million in field support (see Annex B).

MCHIP's Year 1 was envisioned as a transition year, with a focus on ensuring continuity of projects that ended in conjunction with MCHIP start-up (i.e., Child Survival and Technical Support Plus [CSTS+]), while providing a transitional bridge between the final year of other projects and MCHIP's first year (i.e., ACCESS, BASICS, IMMUNIZATIONbasics and POPPHI). To build consensus around the MCHIP strategy, Year 1 featured rigorous discussions with USAID staff and other key stakeholders, while simultaneously launching work at the country level.

Also in Year 1, MCHIP worked with core and/or field funds in 13 countries: Bangladesh, Burkina Faso, Democratic Republic of the Congo (DRC), Ghana, India, Kenya, Malawi, Mali, Mozambique, Nigeria, S. Sudan, Swaziland and South Africa. In some countries, such as DRC, Mali, Nigeria and S. Sudan, this work continues and is a transition from previous work by ACCESS, BASICS, IMMUNIZATIONbasics and POPPHI, respectively. In Kenya, MCHIP is building upon and expanding previous work in maternal health to provide technical assistance (TA) on supportive supervision and on monitoring and evaluation (M&E) within additional divisions of the Ministry of Health (MOH).

On August 3, 2009, MCHIP received the MaMoni (Integrated Safe Motherhood, Newborn Care and Family Planning Project) Associate Award for Bangladesh. The goal of the MaMoni Project is to improve maternal and neonatal health outcomes in Sylhet and Habiganj Districts by increasing the practice of healthy maternal and neonatal behaviors during the antenatal, delivery and postnatal periods. MaMoni builds on the work of the ACCESS Program, although the project shifts the approach from working with nongovernmental organizations (NGOs) to working through the public sector.

Additional MCHIP country programs are currently under development in: Benin, Bolivia, Burkina Faso, Dominican Republic, Indonesia, Lesotho, Liberia, Madagascar, Malawi, Nepal, Paraguay, Rwanda, South Africa and Tanzania. Also in Year 1, the private voluntary organization (PVO)/NGO components supported 66 grants in 29 countries.¹

This report presents MCHIP program results and activities organized by USAID Results Pathways², and covers the period from October 1, 2008 to September 30, 2009.

¹ CSHGP has 53 active grants in 26 countries. MCP has 13 grants in eight countries, and five of those countries overlap with CSHGP countries. At least two CSHGP grants are operating in each of the proposed Phase 1 countries, with three grants in Kenya and four in Malawi.

² Table 1 organizes MCHIP Technical Areas by HIDN Results Pathways

Table 1. USAID Results Pathways and MCHIP Technical Areas

USAID Result Pathway	MCHIP Technical Area
Skilled Care at Delivery	
Prevention & Treatment of Postpartum Hemorrhage	Maternal Health
Eclampsia	Maternal Health
Newborn Care	Maternal Health & Newborn Health
Immunization	Immunization
Acute Respiratory Infections	Child Health
Oral Rehydration Therapy	Child Health
Zinc	Child Health
HIV Integration	PMTCT/Pediatric HIV-MNCH Integration
Nutrition	Crosscutting: Nutrition
Hygiene Improvement	Water Sanitation and Hygiene Improvement
Urban Health	Crosscutting: Urban Health
PVO/NGO Strengthening	PVO/NGO Strengthening
Polio	Immunization
	Family Planning
	Malaria

YEAR 1: STRATEGIC PLANNING FOR IMPACT AT SCALE

During this first year, MCHIP worked closely with USAID colleagues to better define the five-year strategic plan for the Program. Several strategic meetings on results pathways and overall programming were held, and, subsequently, it was determined that MCHIP will support high-impact interventions that: 1) have a demonstrable impact on mortality, 2) have shown an increase in coverage, and 3) hold the greatest promise for scale-up.

MCHIP will work toward ensuring that the appropriate interventions are highlighted across the household-to-facility continuum of care, including addressing the health system strengthening needs at the community or facility level. Targeting interventions to different epidemiologic and socioeconomic scenarios for improved program efficiency and effectiveness is necessary to achieve the appropriate mix of household/community- and facility-based services. Equity and health strengthening systems are key lenses through which programming will occur.

MCHIP will influence both USAID’s priority maternal and child health (MCH) countries and the 68 Countdown countries with the highest burden of maternal and child mortality—both directly and indirectly through three distinct strategies. Although the intensive focus countries represent the greatest opportunity to achieve impact at scale, all 30 MCH priority countries will receive MCHIP support, depending on where they are operating within USAID’s Acceleration Framework.

Intensive Focus Countries

MCHIP and USAID have agreed that MCHIP will have six to eight focus countries. If core and field resources and interventions are strategically focused and continue for at least three to five years, these countries have the potential to achieve measurable impact on maternal, newborn and child mortality at the national level by the end of the MCHIP implementation period. These MCHIP programs will have integrated maternal, newborn and child health (MNCH) activities across the household-to-hospital continuum of care. Through a participatory process with USAID Washington, D.C., the USAID mission and the government, MCHIP will develop for each focus country a clear pathway for achieving this vision through systematic assessment and analysis of the enabling environment,

stakeholder implementation capacities, and challenges related to supply and demand for high-quality MNCH services.

Second Phase Countries

MCHIP will also work catalytically in other countries to expand high-impact MNCH interventions. In these “second phase” countries, MCHIP will strategically use more limited core and/or field funding in partnership with other USAID-funded programs or partners, such as UNICEF, World Health Organization (WHO), Partnership for Maternal Newborn and Child Health (PMNCH) and the Catalytic Initiative, among others, to leverage these programs to expand high-impact MNCH interventions. As a result of limited funding and role in country, MCHIP will have restricted control over programs, but will strategically use technical assistance (TA) support to influence government programs and policies. In these second phase countries, MCHIP will encourage and galvanize MCHIP involvement, with the intent of facilitating the transition of some second phase countries to focus countries.

Third Phase Countries

In the remaining “third phase” countries, MCHIP’s role will be more indirect and will advance the dissemination of evidence-based best practices. This advancement will occur through influencing the agenda of global partners, timely and actionable dissemination of common protocols, standardized indicators and measurement tools, and information about proven interventions.

Table 1. MCHIP’s Approach to Reaching Every Country

	MCHIP Level of Engagement	Countries ³
Intensive Focus Countries	<ul style="list-style-type: none"> ▪ Multi-year core and field funds ▪ Integrated MNCH work ▪ Close partnership with USAID Mission, bilateral projects, MOH and other key partners ▪ Demonstrable change in coverage of package of interventions ▪ Significant scope (either directly or through partners) to impact national outcomes (or state outcomes if a large country) ▪ Strong evaluation component 	Bangladesh, DRC, India, Kenya, Malawi and potentially Indonesia, Mali, Mozambique, Nepal and Rwanda
2nd Phase Countries	<ul style="list-style-type: none"> ▪ Limited core or field funding; limited timeframe ▪ One or two interventions only ▪ Targeted TA to support USAID bilateral or other partner programs ▪ Assessment, policy, strategy and plan development, including program reviews and evaluations ▪ Dissemination of common protocols, and standardized indicators and measurement tools ▪ Sharing information about proven interventions ▪ MCHIP/USAID to galvanize support to facilitate movement of some countries to focus country status 	Benin, Bolivia, Burkina Faso, Ethiopia, Liberia, Nigeria and Madagascar
3rd Phase Countries	<ul style="list-style-type: none"> ▪ Program learning or focus to influence the national agenda on MNCH ▪ One-off technical assistance or support for events ▪ Dissemination of common protocols, and standardized indicators and measurement tools ▪ Sharing information about proven interventions 	Afghanistan, Azerbaijan, Cambodia, Dominican Republic, Ghana, Guatemala, Haiti, Lesotho, Nicaragua, Pakistan, Paraguay, Peru, Philippines, Rwanda, Senegal, S. Sudan, Tajikistan, Tanzania, Uganda, Zambia

³ These countries may shift categories over the course of MCHIP as field funding is received.

YEAR 1: ACHIEVEMENTS

SKILLED CARE AT DELIVERY

Core Funded

- Expanded AMTSL activities in the **Democratic Republic of the Congo**. This included conducting a formal assessment of the combined AMTSL/Essential Newborn Care (ENC) training package which was introduced by BASICS and POPPHI in late 2008, and has now been rolled out to 43 of the 57 health zones that are targeted for this activity. MCHIP provides the technical assistance for this effort, which is implemented by the USAID bilateral health project (AXxes), UNICEF and the Ministry of Health.
- Developed a study protocol and package of MNH Quality of Care (QOC) facility assessment tools, which included the use of AMTSL, partograph, PE/E, essential newborn care (ENC) and infection prevention. Preparations were completed for a QOC Assessment Tool pilot test in **Ethiopia** and **Kenya**.

Field Funded

- Supporting eight facilities in four provinces in **Mozambique** to become “Model Maternities” in both emergency maternal and newborn care (EMNC) and emergency obstetric newborn care (EmONC) service provision, as well as clinical training. The Model Maternity Initiative is a national program and MCHIP-supported facilities were identified by the MOH for support in quality improvement (QI), humanization of care, and prevention and control of infections. These sites will also be used for pre-service clinical training and will spearhead the nationwide dissemination of the Initiative.
- Four provinces in **Mozambique** now have master trainers in EMNC, EmONC and QI for MNH services.. Further, 11 provincial EMNC and EmONC training centers were equipped with training materials, including anatomic models.
- Between January 2006 and September 2009, ACCESS/MCHIP **Nigeria** scaled up EmONC services from 17 health facilities in four local government authorities (LGAs) in two states to 48 health facilities in 22 LGAs in three states to provide high-quality MNC services.. By June 2009, the trained skilled birth attendants had managed 332,308 antenatal care (ANC) visits, attended 62,306 deliveries), provided AMTSL to 50,242 women (92% of vaginal deliveries), used the partograph for 36% of deliveries and provided ENC to 66% of newborns
- See Newborn Health, Field Funded for results on the MaMoni Project in **Bangladesh**.

PREVENTION & TREATMENT OF POSTPARTUM HEMHORRAGE

Core Funded

- Developed MCHIP strategy for accelerating scale-up of interventions to prevent and treat postpartum hemorrhage (PPH) in order to sustain and expand gains made in PPH prevention by USAID partners. The strategy includes a transition plan to integrate POPPHI and ACCESS activities with MCHIP work, encompassing country-level active management of the third stage of labor (AMTSL) work in the **Democratic Republic of the Congo**, **Mali** and **Latin America**; in collaboration with International Federation

of Gynecology and Obstetrics (FIGO), the International Confederation of Midwives (ICM) and the UNFPA/ICM midwifery capacity-building initiative.

ECLAMPSIA

Core Funded

- Advanced knowledge of the prevention and treatment of pre-eclampsia/eclampsia (PE/E) and PPH in collaboration with WHO, FIGO, ICM, the Maternal Health Task Force and others. A Technical Working Group and task forces for PE/E were formed during a stakeholder meeting.

MATERNAL HEALTH (OTHER)

Core Funded

- Drafted MCHIP facility- and community-based guidelines for postpartum care (PPC)/ postnatal care (PNC) based on the WHO/UNICEF joint statement and existing WHO maternal and newborn care (MNC) guidelines. These guidelines will be utilized by MCHIP programs and others, as applicable, until revised WHO guidelines are made available.
- Identified two countries where national-level, maternal anemia control consultations could be held and where strategic plans to address anemia could be developed; there is Mission interest in Bangladesh and Indonesia.
- Developed key policies and guidelines in **Mozambique** including: 1) National Plan for the Humanization of Health Care, including the Model Maternity Initiative, and 2) Guidelines for Maternal and Neonatal Audit Committees. Technical quality standards were also developed to improve MCH services as part of the Model Maternity Initiative in the area of humanistic management of MCH services, which included: 1) information and M&E; 2) human, infrastructure and material resources; 3) humanization and safety of the work environment; 4) health education and community involvement; 5) humanistic antenatal and postnatal care for the woman and child; 6) reanimation of the newborn and management of main obstetric complications; and 7) teaching.

NEWBORN CARE

Core Funded

- Supported the **Global Alliance for the Prevention of Prematurity and Stillbirth** (GAPPS) international conference on prematurity and stillbirths, and provided technical input into the deliberations during the conference. MCHIP reviewed its interventions against those recommended by the conference and found that most of the facility- and community-based interventions are already in our package of services, with the exception of antenatal steroids for women who experience preterm labor. Discussions are ongoing on how to integrate this with our focused antenatal care (FANC) package.
- With the release of the UNICEF/WHO joint statement on PNC home visits, MCHIP held discussions with WHO, UNICEF and USAID, and agreed on a plan to disseminate the statement. At the country level, MCHIP will work with UNICEF, WHO, USAID and other stakeholders to support national forums for disseminating and discussing the

policy and program implications of the joint statement. MCHIP will also collaborate with WHO and UNICEF at regional meetings to disseminate the statement.

- MCHIP worked closely with American Association of Pediatrics (AAP) in selecting additional countries, **Bangladesh** and **Kenya**, to undertake studies of the effectiveness of the Helping Babies Breathe (HBB) training manual on providing the appropriate set of competencies needed for neonatal resuscitation. MCHIP is finalizing the subgrants for the countries. (This activity is being supported by core and field funds.)
- Through a series of meetings on newborn health with a variety of stakeholders—including USAID, BASICS, JHU and Saving Newborn Lives (SNL)—MCHIP reached a consensus on the key newborn interventions ready for scale-up, and identified interventions with significant knowledge/operational gaps that could be addressed through strong program M&E.
- Established Technical Working Groups (TWGs) on Kangaroo Mother Care (KMC) and management of neonatal infections. The KMC TWG reviewed current KMC programs and subsequently made recommendations for strengthening ongoing and future programs. Through this review, the KMC TWG also revised a list of KMC indicators to incorporate with community KMC programs to ensure adequate information that will inform program learning.
- The Neonatal Infection Management Working Group, which was established in collaboration with SNL, identified the development of “program implementation guidance”—based on the lessons learned from the community-based management of neonatal infection (CBMNI) research—as its priority.
- Expanded ENC activities in the **Democratic Republic of the Congo**, conducting a formal assessment of the combined AMTSL/Essential Newborn Care (ENC) training package which was introduced by BASICS and POPPHI in late 2008, and has now been rolled out to 43 of the 57 health zones that are targeted for this activity.
- In **India**, conducted a desk review of the current national situation on maternal and newborn health, and MCHIP participated in a USAID-led MNH assessment.

Field Funded

- MaMoni **Bangladesh** is already actively linked with and participating in ongoing initiatives, such as the strategic planning process of White Ribbon Alliance, operational planning for Neonatal Sepsis Operations Research (MOHFW and joint UN program, MNCs) and the MNH action plan formation process led by the directorate general of health services.

ARI/PNEUMONIA⁴

Core Funded

- Participated with global partners in the CCM Task Force/CCM.org on the development of common metrics for the assessment and evaluation of integrated community case management (iCCM) including ARI/Pneumonia.
- Developed a matrix of countries that shows the status, interest and number of implementing partners supporting CCM implementation.

⁴ Because MCHIP works on all three diseases (pneumonia, diarrheal disease, and malaria) simultaneously at 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.

- Together with partners, MCHIP drafted a strategic paper recommending areas for future USAID investment in CCM.
- Advocated for CCM introduction in **Mali** during two national planning workshops; MCHIP facilitated the second workshop, limited to a country task force, which addressed issues raised during the first workshop in order to pave the way for authorization to implement CCM .
- Initiated documentation of an iCCM case study in **Senegal**, which is to be one of three country case studies and; Developed a concept paper to guide CCM documentation.
- In **DRC**, iCCM was expanded to an additional province (Katanga), bringing coverage to 10 of the 11 provinces. A total of 94 new iCCM sites were added with 189 new community health workers (CHWs). Nearly all the new sites and volunteers were from areas supported by the USAID bilateral health project (AXxes).
- In **DRC**, MCHIP provided guidance for an integrated Management of Childhood Illness (IMCI) assessment, including iCCM..

ORT/ZINC

Core Funded

- Trained a total of 384 health professionals from 36 hospitals located across three provinces on the use of zinc in the treatment of diarrheal disease in **DRC**. The trainees included 191 medical doctors, 191 nurses and two pharmacists. MCHIP contributed to advocacy efforts that resulted in the purchase and distribution of zinc tablets to all provincial medical stores.
- MCHIP assisted three working groups that are collaborating to plan a national launch of the revitalization of diarrheal disease case management in **DRC**, including the introduction of zinc in diarrheal disease case management.

CHILD HEALTH (OTHER)

Field Funded

- In **Kenya**, MCHIP participated in Malezi Bora national steering committee meetings. (Malezi Bora is a national campaign for improving the health of children that is held in May and November of each year.) MCHIP is a member of the M&E subcommittee of Malezi Bora and has provided TA for data collection as well as a supervision tool.

IMMUNIZATION

During this transition year, the immunization activities and results below were supported jointly by IMMUNIZATIONbasics and MCHIP and with different combinations of core and field support.

Core Funded

- Contributed to global and regional technical advisory groups, task teams and working groups, including GAVI CSO Task Team, the Measles Initiative, the new vaccine communication advocacy group, WHO SAGE and TLAC:
- As a member of the Vaccine Presentation and Packaging Advisory Group (VPPAG), MCHIP contributed to the development of: Generic Presentation and Packaging Product

profiles to be used by industry stakeholders and WHO for designing vaccines suitable for use in public sector programs in developing countries; Target Product Profile for pneumococcal vaccines suitable for procurement through GAVI; and Target Product Profile for HPV vaccine.

- As a member of the GAVI Civil Society Task Team, MCHIP contributed to the development of GAVI Strategy to establish a civil society constituency for immunization.
- Working with USG and USAID partners, MCHIP assisted with the translation of *Immunization Essentials* into Spanish and the revision of immunization indicators/analysis for Demographic Health Surveys (DHS).
- Developed tools with and for WHO including a Mid-Level Managers Module on community engagement, which was published in October 2009; a post-introduction evaluation (PIE) tool for new vaccines; and a District-Level Measles Outbreak Risk Assessment Tool for WHO/AFRO. In addition, MCHIP helped revise the WHO/UNICEF methodology for measuring national immunization coverage, provided technical support for the development of comprehensive multi-year plans (cMYP) for immunization and authored the WHO Aide Memoire, *Sustaining the Gains against Measles*.
- Disseminated revised Reaching Every District (RED) guide and monitoring tools in English, French and Portuguese, and conducted a regional RED adaptation workshop with World Health Organization/Regional Office for Africa (WHO/AFRO).⁵
- Assisted four high-burden countries (**India**, **Nigeria**, **S. Sudan** and **Timore-Leste**) and one country with low-performing regions (**Madagascar**) in applying RED or RED-like strategies.
- Provided technical guidance during the planning and analysis of a national EPI review and coverage survey in **Benin**. The results of the review are being used to advocate with decision makers and program managers to improve routine immunization services and increase coverage.
- Provided support to the introduction of the pneumonia vaccine in **Rwanda**, the first country in Africa to introduce the vaccine. Minimal core funds were used and leveraged with field support (see below). Project staff worked closely with the Rwandan government to analyze the impact of PCV-7 on Rwanda's cold chain, which resulted in USAID investing more than USD 500,000 to expand the cold chain's storage capacity. ..
- Initiated/contributed to a number of studies and evaluations, including:
 - A WHO plan to analyze gender/sex issues in immunization as a member of a WHO Technical Advisory Group (TAG); a paper with WHO on Periodic Intensification of Routine Immunization (PIRI) (author); a programmatic "companion piece" (as author) with WHO to help national managers operationalize/interpret WHO's consolidated immunization schedules; a paper (as author) on epidemiology of the unimmunized (review of the gray literature); and a peer-reviewed article on routine immunization in Africa in the Bulletin of WHO (as an author) and on "Reaching every district (RED) approach to strengthen routine immunization services: evaluation in the African region" with WHO and CDC, published in *The Journal of Public Health* in June 2009.
 - A review of grey literature and preparation of a document on the epidemiology of non-immunized women and children under IMMUNIZATIONbasics, which will be continued by MCHIP during its second project year.

⁵ These achievements are shared by both MCHIP and IMMUNIZATIONbasics.

- Development of GAVI reviews of progress toward engaging civil society within GAVI governance and country implementation.
- USG/USAID papers on “Using Data to Guide Action in Polio Health Communications: Experience from the Polio Eradication Initiative (PEI)” and “Communication for Polio Eradication: Improving the Quality of Communication Programming through Real-time Monitoring and Evaluation” (co-author for both) under peer-review for planned publication in 2010 in the *Journal of Health Communication*.
- Contributed to the Alliance for Malaria Prevention’s toolkit for developing integrated campaigns to encourage the distribution of long-lasting insecticide-treated nets.
- Provided 2–3 page country summaries that include an analysis of coverage trends and program indicators to selected Missions and partners working in priority countries.

Field Funded

- Assisted five high-burden countries (**India, DRC, Nigeria, Timor Leste and S. Sudan**) and one country with low-performing regions (**Madagascar**) in applying RED or RED-like strategies. (Combination of IMMUNIZATIONbasics and MCHIP core and field support.)
- Worked with partners to develop and obtain the government of **S. Sudan’s** endorsement for a new national immunization policy. Also drafted guidelines for RED introduction and set of EPI training modules for the national immunization program.
- Planned with USAID Missions and partners for follow-up of IMMUNIZATIONbasics work in **DRC, Benin, India and S. Sudan** during the transition to MCHIP.
- Provided support to the introduction of the pneumonia vaccine in **Rwanda**.
- Conducted rapid immunization assessment and supervised measles campaigns in two provinces in **Kenya**.
- IMMUNIZATIONbasics and MCHIP staff contributed to the International Conference on Global Health, presenting on the use of PDAs for field health supervision in **Madagascar** and a computerized planning tool for routine immunization in **India**.

MALARIA

Core Funded

- Malaria in Pregnancy (MIP) Implementation and Malaria Resource Package disseminated to PMI country teams. These tools provide relevant and important programming, training and reference resources to support countries in their efforts to scale up MIP programming in malaria-endemic areas.
- Collaborated with Global MCH and the U.S. President’s Malaria Initiative (PMI) to develop a community case management (CCM) pathway and framework, identify components and benchmarks and compile CMM tools.
- Participated in the Roll Back Malaria MIP Working Group (Manila, Philippines, October 2008). This participation led to the development of an initial strategy and prioritization of efforts within the Asia region to accelerate MIP prevention and control efforts.
- In collaboration with PMI, addressed start-up of documentation of best practices, lessons learned and bottlenecks in **Zambia**. This documentation will be completed in

MCHIP Year 2 and will yield greater insight to successful MIP programming throughout the region.

- MIP bottlenecks addressed in **Nigeria**. MCHIP provided technical guidance and support to help Nigeria address bottlenecks hindering implementation of Global Fund-supported MIP activities; specifically, this included meetings in four states (Zamfara, Kano, Bauchi and Niger) to disseminate national MIP strategies and guidelines. State policymakers were oriented to MIP issues, and guidelines were distributed for dissemination to secondary and primary health care facilities. (This effort was co-funded through the ACCESS Program.)
- Provided on-site technical assistance to Malaria Communities Program (MCP) grantees in **Tanzania, Ghana** and **Angola**.
- Organized and attended a national workshop in **Benin**, which was designed to strengthen the dialogue among partners, actors and stakeholders involved in community-based interventions against malaria.
- MCHIP participated at the country level in **DRC** in preparations for a research project on malaria CCM, funded by the Canadian International Development Agency (CIDA). During the project presentation to the malaria task for adoption, new members were briefed on CCM. The overall project has a budget of \$17.9 million for four countries: **DRC, Malawi, Cameroun** and **Mali**. MCHIP advocated for an integrated approach in **DRC**, also adopted by **Malawi, Cameroun** and **Mali** will cover only malaria.

Field Funded

- In **Rwanda**, MCHIP coordinated closely with the National Malaria Control Program (PNLP) and PMI to outline support that will be carried out in Year 2 of the program. MCHIP will build on efforts carried out through the ACCESS Program to accelerate and scale up MIP programming in **Rwanda** as well as expand efforts to iCCM. These efforts will: contribute to the delivery of this integrated package of services at all levels, motivate pregnant women to attend ANC clinics and encourage prompt treatment of children under five years.
- Provided technical guidance and programmatic support to initiate a **Burkina Faso** Malaria Program. This program will be implemented with USAID FY09 malaria funds. The program is designed to support implementation of MIP, case management, and diagnostics for malaria prevention and control.

FAMILY PLANNING

Core Funded

- Initiated **Ghana** MCHIP pre-service midwifery education with a focus on postpartum family planning (PPFP).
- Developed training materials in PPFP that were used in an IntraHealth FP update for a training of trainers (TOT).
- Successfully submitted two concept papers to USAID for **Malawi** and **Ghana** on pre-service strengthening of FP through PPFP and postabortion care (PAC). Additionally, MCHIP's concept paper on an integrated package of postpartum and postnatal care to include AMSTL, ENC and PPFP in **Mali** has been accepted.

Field Funded

- National FP Strategy developed with MCHIP support in **Mozambique**.
- Nine health care facilities in **Mozambique** now have the capacity to screen and treat precancerous cervical lesions, and provide counseling to eligible women coming for FP, therefore giving a new sense to the concept of integrated reproductive health (RH). A total of 24 trained professionals will lead the process of change to comprehensive RH care with the introduction of screening, treatment and counseling for cervical cancer. In addition, those facilities were provided visual inspection of the cervix with acetic acid (VIA) and cryotherapy equipment acquired by UNFPA.
- Nine health care facilities in **Mozambique** have improved supervision.
- In **Nigeria**, from January 2009–September 2009, ACCESS/MCHIP-supported providers counseled 70,958 individuals on FP, resulting in 31,259 couple years of protection (CYP).
- See Newborn Health, Field Funded for results on the MaMoni Project in **Bangladesh**.

HIV INTEGRATION

Core Funded

- Hosted prevention of mother-to-child transmission of HIV (PMTCT)/MNCH/FP Integration meeting with more than 30 participants from USAID and collaborating partners.

URBAN HEALTH

Core Funded

- MCHIPsupported the African Population and Health Research Center to support the organization of a one-day Urban Health Champion Forum in **Kenya**.

HYGIENE IMPROVEMENT

Core Funded

- Led the development of an MOU between USAID W and Unilever for handwashing for newborn health.
- Worked with USAID Washington, D.C. and USAID India to collaborate with HIP, USAID India's market-based partnership bilateral project, and Unilever to initiate the development of a handwashing for newborn survival activity in **India**.

PVO/NGO SUPPORT

Core Funded

- Child Survival and Health Grants Program (CSHGP) projects ending in 2008 saved an estimated 7,200 lives of children under five through MCHIP-supported interventions, with 5,800 of those occurring in MCH priority countries.

- MCHIP provided program design and M&E planning support to eight new CSHGP grantees, six of whom are innovation grantees with an operations research component that will contribute to the MCHIP Learning Agenda.
- MCHIP convened a virtual technical advisory process on equity for the purpose of informing guidelines to be developed in Year 2, which can inform equity-driven program design, M&E in MCHIP country programs and CSHGP grantees.
- Strengthened CSHGP Evaluation Guidance and provided input on strengthening future program guidelines to more strongly align CSHGP and MCHIP priority directions.

AFRICA/SD

- Co-funded all child health (CCM, ORT/zinc), immunization, and AMTSL/ENC work carried out in the **DRC** during this reporting period (see above)
- Disseminated revised Reaching Every District (RED) guide and monitoring tools in English, French and Portuguese and co-facilitated a subregional RED adaptation workshop with World Health Organization/Regional Office for Africa (WHO/AFRO).
- Assisted three high-burden countries in the Africa Region (**DRC, Nigeria and S. Sudan**) and one country with low-performing regions (**Madagascar**) in applying RED or RED-like strategies. (Combination of IMMUNIZATIONbasics and MCHIP core, AFR SD and field support funding.)
- Provided technical guidance during the planning and analysis of a national EPI review and coverage survey in **Benin**.

LAC

- Participated as a member of the Neonatal Alliance for Latin America and the Caribbean, and assisted with planning the Technical Forum: Advancing Neonatal Health through Partnerships (Lima, Peru, September 15–16, 2009).

Challenges and Opportunities

CHALLENGES

- MCHIP Year One was anticipated as a transition year where MCHIP gathered inputs and lessons learned from existing programs in their last year of implementation. Most staff on MCHIP straddled two programs. However, the demands of the MCHIP program were more than anticipated in terms of limited core funding, administrative and contractual requirements and in building a unified vision of the MCHIP program. Despite these challenges, MCHIP accomplished several results as is evident from the annual report.
- The MCHIP team was scattered across various partner offices, and individuals had very little time available on the MCHIP program resulting in many start up challenges. This made it difficult for MCHIP to function as a team across the various technical interventions. Being housed together on a more consistent basis has helped tremendously in functioning better as a team.
- Moving from a temporary to a permanent office mid-year. The original planned office did not work functionally for MCHIP. Jhpiego made a decision to procure a larger space that was more conducive to meetings and hosting all the MCHIP staff

OPPORTUNITIES

- In Year 1, MCHIP worked with core/and or field funds in 13 countries. MCHIP is meeting the needs of the Missions in the areas of maternal, newborn, child health , family planning and HIV/AIDS. This provides MCHIP with a great opportunity to utilize these platforms to document the role of integrating selective interventions based on the country context.
- Huge increase in field funding in Year 2. Year one started with field funding from 3 countries and at the beginning of year 2, MCHIP has field funding from over 20 countries.
- During this year MCHIP and USAID worked closely to build a unified strategic vision for the long term goal of the program. This now serves as the foundation for all future programming.
- Selection of Focus Countries: MCHIP and USAID /W in dialogue with Missions have selected 4-5 countries that will remain the focus of greater attention, integrated programming, stronger documentation and higher resource investment from MCHIP. MCHIP will document major results in these countries.
- MCHIP has the opportunity of joint assessment visits in several countries that allows for designing strategic programs that are aligned with Mission and MCHIP goals.

Annex A: Core Activity Matrix

	ACTIVITY TITLE	LEAD *and others who may be involved	EXPECTED RESULTS 1 October 2008 – 30 September 2009	KEY TASKS	ACHIEVEMENTS	COMMENTS (Explain any delays)
MATERNAL AND CHILD HEALTH						
1. Global Leadership and Learning						
1.1	Five-year strategy development	LEAD: Koki, Pat D. Others: Full CMT, with Technical Team Leaders and USAID CTOs and interested parties	MCHIP 5-year strategy, including knowledge management, developed.	Conduct strategic planning meeting with MCHIP and USAID. MCHIP to develop overall 5-year strategy as well as specific strategies for each technical area and Results Pathway	MCHIP and USAID conducted a strategic planning process that created a shared understanding of what may realistically be achieved on the ground in Year 1, and how to build on this foundation for Year 2; and clarified and streamlined how USAID and MCHIP communicate and make decisions together to speed program implementation and increase efficiency of planning and management. The outcomes of this meeting have shaped the work planning process—both long-term and for Year 2—MCHIP has an approved Year 2 work plan which includes 46 countries where MCHIP will focus integrated MNCH programs aimed at impact at scale.	
1.2	Participate in global/regional advocacy and planning with USAID to mobilize resources and coordinate partner support for implementation for all technical areas.	LEAD: EACH PATHWAY OR MAJOR STRATEGY HAS A GLOBAL LEAD IN ADDITION, IIP (JENNIFER) WILL WORK DIRECTLY WITH "COUNTDOWN TO THE MGDS"	Details on MCHIP's global Leadership activities are included in each technical component: Activities 2.1, 3.1, 4.1.1, 4.1.2, 4.1.3 and 7.1.	Work with the "Countdown to the MDGs."		
1.3	Consultation with key stakeholders to define MCHIP research and evaluation process to support achievement of MDGs 4 and 5.	LEAD: IIP (JENNIFER) Others: Mary C., Barbara R., Jennifer L., and technical team leaders (Patricia, Joseph, Robert, Emmanuel, Rae, Rena, others)	1. Expert consultation with USAID and partners on a common implementation research and evaluation agenda. 2. Plan for strategy to document in Yr 2 identification of "best bet" opportunities for achieving high, sustained and equitable coverage for proven interventions across the continuum of care, from pre-pregnancy through early childhood, from community to referral-facility levels.	1. Conduct planning meeting with USAID in preparation for stakeholder meeting in Task 2. 2. Meeting with USAID and other stakeholders to review background documents and agree on priority topics for implementation research and evaluation, and develop a common agenda. Agreement on tracking mechanism to monitor implementation of the common agenda. Prepare a report of the meeting. 3. As determined by planning meeting, plan and prepare for systematic desk review in Yr 2 of published and grey literature related to scaling-up MNCH interventions and combined delivery of interventions during contacts between mothers, children and the health system. 4. Consultative process with USAID and other technical partners to ensure the opportunities document is complete, correct and comprehensive.		

1.4	Improving evidence-based planning for MCH at national and district levels through use of the Lives Saved Tool (LiST).	LEAD: NEFF Others: Ingrid, Jim	<ol style="list-style-type: none"> 1. LiST results for 10 priority countries that reflect the reductions of under-five mortality that can be expected if national plans are fully implemented and coverage targets are met. 2. National plans in one priority country where MCHIP works reflect focus on high-impact interventions to reduce mortality and improve nutrition among mothers, newborns and children. 3. Documentation of applications of the LiST tool, resulting in recommendations for its improvement and guidelines for its application in different settings and for different uses. 	<ol style="list-style-type: none"> 1. Capacity building applying country-specific LiST results in ways that stimulate policy dialogue at country level. 2. LiST results for 10 priority countries that reflect the reductions of under-five mortality that can be expected if national plans are fully implemented and coverage targets are met. 3. Application of LiST in select MCHIP priority countries to inform policy and programs on high-impact interventions to reduce mortality and improve nutrition among mothers, newborns and children. 4. Documentation of applications of the LiST tool, resulting in recommendations for its improvement and guidelines for its application in different settings and for different uses. 	<ol style="list-style-type: none"> 1. JHU/IIP staff, supported by funds from both MCHIP and the Catalytic Initiative project, conducted LiST workshops related to national planning with Malawi and Mozambique. Remotely trained staff who have consequently run several training workshops in Bangladesh as part of the planning process for maternal and child health. <ul style="list-style-type: none"> - During the first year of the project we have held 8 seminars or training workshops with USAID or MCHIP organizations. 2. In September 2009, we developed estimates of maternal and child lives that could be saved under a set of scale up goals developed by USAID. This was done for all 68 Countdown priority countries and provided to USAID. 3. JHU/IIP staff, supported by funds from MCHIP and Catalytic Initiative project, prepared analysis of estimates of maternal and child lives saved as well as costs for various scale up approaches for Ghana, Nigeria, South Africa, and Uganda as part of the African Science Academy Development Initiative (ASADI). 4. Based on suggestions and feedback from USAID, IIP staff supported by funds from both MCHIP and the Catalytic Initiative Project, developed a simpler version of LiST that could be used for rapid testing of various scale up options. This embed version of the program is called <i>EasyLiST</i> and is now part of the standard release version of <i>LiST</i>. We have four papers in press that either document the process of using <i>LiST</i> at country level in Burkina Faso, Ghana and Malawi or use country study data to validate the LiST estimates. The results of these papers are being used to refine the <i>LiST</i> model. Drafts of these papers have been provided to USAID and have been presented in various workshops. 	
1.5	Contribute to global dialogue on program learning on community-based interventions, the role of community health worker (CHW) and CHW task-shifting.	LEAD: JOSEPH Others: Technical Leads (Patricia, Robert, Emmanuel, FP-TBD, HIV/AIDS-TBD, Rae, Michel P) Also: Lora Shimp, Michel O., and others from BASICS, ACCESS	<ol style="list-style-type: none"> 1. Tools and materials related to community-based MNCH and community health workers are compiled and available to MCHIP staff and partners. 2. MCHIP furthers learning on community-based MNCH and the "functional" community health worker. 	<ol style="list-style-type: none"> 1. Collaborate with key stakeholders to compile tools and materials on community-based MNCH on the Web (include SOTA tools and materials, guidelines, indicators, program experiences). 2. Compile tools and materials on community mobilization. 3. Collaborate with USAID, HCI and others key partners to discuss opportunities and approaches for community health workers in MNCH 4. Assure review of MCHIP country strategies and program for community-based work. 	The tools and program approaches of the MCHIP consortium partners were presented during brown bag lunches. Tools and approaches presented included LiST, RED, KMC, community mobilization, etc.; the tools and other materials will be put on the MCHIP Web site, which is currently under development.	
1.6	MCHIP Information Management System	LEAD: David Cantor Others: Dave Burrows, IM Working Group	<ol style="list-style-type: none"> 1. MCHIP.net Public Web site 2. MCHIP internal information management system 	<ol style="list-style-type: none"> 1. Identify priority functions and content for MCHIP internal information management system and external Web site. 2. Develop beta sites for review and feedback 3. Launch MCHIP public and internal sites. 	MCHIP external Web site launched. Content still being refined. Decision made to use Jhpiego's planned Results Information System for Excellence as MCHIP's internal information management system as it will have role-based access.	
2. Maternal Health						
2.1 Global Leadership for Maternal Health						
2.1.1	Participate in global/regional advocacy and planning with USAID to mobilize resources and coordinate partner support for implementation.	LEAD: Patricia	<ol style="list-style-type: none"> 1. Evidence-based input provided into global decisions on policies and practices in maternal and newborn health. 2. Collaboration with global bodies ensured to increase the impact of MCHIP activities at global, regional, and national levels through development of complementary strategies and synergies. 	<ol style="list-style-type: none"> 1. Participate in WHO technical consultations on PPC/PNC and other technical areas. 2. Participate in ICM/UNFPA technical meetings to advance access to midwifery care in key countries. 3. Participate in Maternal Health Task Force meetings to build synergies between MCHIP activities and global and country-level strategies emanating from the MHTF. 	MCHIP Staff participated in key technical meetings and consultations	

2.2 Skilled Birth Attendance						
2.2.1	Expert Review of Health Systems and Quality Improvement approaches to guide MCHIP's strategic approach to Maternal Health.	LEAD: Koki	1. Best practices in quality improvement identified. 2. Strategy for applying best practices at field level developed.	1. Convene meetings with other quality improvement programs.	A meeting was held with MCHIP, URC, USAID and other to review different quality improvement approaches.	
2.2.2	Expert review of IMMPACT tools and learning to guide MCHIP's strategic approach to Maternal Health.	LEAD: Patricia	1. Appropriate tools identified that can be applied in Y2 and beyond.	1. Convene meeting to share IMMPACT tools and learning from implementation of those tools. 2. Plan for application in Y2 using field funds.	MCHIP reviewed the tools for relevance to future MCHIP programming and assessment needs.	
2.2.3	Case studies documenting lessons learned on health systems elements that improve maternal and neonatal health.	LEAD: Rena Others: Linda B., M&E Working Group	1. Brief case studies analyzing 2-3 countries where maternal mortality has declined in conjunction with other global partners developed.	1. In collaboration with MH Task Force, identify 2-3 African countries where maternal mortality has declined identified. 2. Develop a framework that incorporates the elements of effective health systems that lead to reduced maternal mortality. 3. Review existing literature, assess frameworks and identify gaps. 4. Conduct key informant interviews. 5. Analyze success factors that have led to declines in maternal mortality in the high-performing outlier countries. 6. Identify priorities for further research. 7. Plan for application of lessons learned in Year 2.	Activity initiated. Will continue in Year 2.	
2.2.4	Develop Harmonized Postpartum/Postnatal Care - <i>linked with newborn activities.</i>	LEAD: Joseph or Patricia Others: Bacqui, Winnie, Cat	Postpartum/Postnatal Care (PP/PNC) package defined based on WHO guidelines.	1. Continue participation in WHO/MPS Department consultation process on defining PP/PNC. 2. Utilize MPS guidelines as well as WHO/CAH Department guidelines on community-based postnatal care to formulate package on PP/PNC for use in MCHIP interventions.	Also see item 3.2.2.	
2.3 Postpartum Hemorrhage						
2.3.1	Strategic preparations for MCHIP's PPH activities in Y2 and beyond	LEAD: Patricia Others: Deb A., Linda B.	1. Participate in PPH Working Group 2. Strategy for expansion of PPH prevention developed 3. Progress of PPH prevention in countries where POPPHI conducted baseline survey reviewed - linked with PE/E survey 4. WHO PPH treatment guidelines disseminated in 3 countries	1. Conduct survey of Maternal Complications - linked with PE/E survey (See Activity 2.4.2) 2. Convene half-day meetings in 3 countries to disseminate WHO PPH treatment guidelines (this task will take advantage of other planned MCHIP in-country to minimize costs 3. Convene series of meetings with ACCESS, POPPHI, and USAID to develop PPH strategic plan	Strategy for expansion of PPH prevention developed and circulated. Participated in PPH working group.	WHO PPH prevention and treatment guidelines have not been published yet. This activity will be done in Year 2 once they are available.

2.3.2	Support transition from POPPHI to ensure scale up of PPH prevention in Mali.	LEAD: Patricia Others: Deb A., Sushi E.	<ol style="list-style-type: none"> 1. National guidelines reviewed and revisions initiated as necessary to ensure that as many levels of providers as possible can perform AMTSL using oxytocin. 2. Successes and challenges of work to date assessed and documented. 3. Results of assessment used in formulation of scale up strategy by MOH and partners to ensure national-level coverage of AMTSL within 2 years. 	<ol style="list-style-type: none"> 1. Continue working with existing TWGs on prevention of PPH to update national guidelines as necessary for all levels of birth attendants. 2. Plan to implement in YR2 the new survey being developed on PPH, PE/E and care of complications in labor. 3. Design and carry out assessment of progress to date in training providers in AMTSL and systems strengthening, and scope of work remaining to be carried out. 4. Continue meetings with TWG consisting of MOH and other partners to formulate PPH prevention strategy for scale up, possibly using SAIN approach developed through ATN/POPPHI/Capacity Project. 5. Support ongoing efforts to include AMTSL in supervisory tools and as part of national-level indicators. 6. Support dissemination of revised guidelines and national strategy to pre-service and in-service programs, provincial and district levels through other partners working in the country. 7. Conduct on-going monitoring of sentinel sites to determine uptake of correct use of AMTSL. 8. Continue collaboration with Venture Strategies and SPS to introduce misoprostol into PPH prevention activities. 	Concept paper approved by Mission and work plan in progress.	Process of formulating, submitting and approval concept paper was time consuming.
2.4 Eclampsia						
2.4.1	Strategic preparations for MCHIP's pre-eclampsia/eclampsia activities in Y2 and beyond.	LEAD: Patricia or Linda B.	<ol style="list-style-type: none"> 1. State-of-the-art knowledge in prevention and treatment of PE/E identified. 2. Gaps in knowledge about approaches to prevent and treat PE/E identified in four countries. 3. MCHIP program strategy formulated to ascertain potential MCHIP contributions in the area of PE/E through action at the global level as well as programming and/or operations research in specific countries during the life of the program. 	<ol style="list-style-type: none"> 1. Convene expert panel from global and technical organizations (WHO, USAID, MCHIP partners, others) to determine present knowledge of and gaps in addressing PE/E in low-resource settings. 2. Identify specific countries where MCHIP or other partners can assist the MOH and other donors to build capacity in prevention and treatment of PE/E and evaluate effectiveness of approaches. 3. Begin work plan process for country-specific interventions. 	First Technical Working Group Meeting on Prevention and Treatment of Pre-eclampsia/Eclampsia: MCHIP's kick-off meeting to discuss efforts to target high impact interventions for reducing maternal mortality, specifically in the area of PE/E. Meeting report outlines what is known, key knowledge gaps, research and implementation, and potential ways to address gaps. As a result, five task forces have been set up and are developing terms of reference. Participation in PE/E Global WG, April 09; Presentation to WG on PE/E survey development; Co-Chair M, R&E working group for PE/E WG -	

2.4.2	Baseline survey on facility quality of care for prevention, screening and treatment of complications at the time of delivery: Ante/post partum hemorrhage, severe pre-eclampsia/eclampsia, obstructed labor and newborn care.	LEAD: Linda Other: Jim, Jennifer L.	<ol style="list-style-type: none"> 1. Study design developed with input from a small working group including partners from MCHIP and USAID. First meeting April, 2009. 2. Protocol submitted to JHU IRB. 3. One country identified with partners for field testing. 4. Survey protocol agreed upon with MOH and submitted to national IRB for approval. 	<ol style="list-style-type: none"> 1. Working group established with MCHIP, USAID and other partners to determine the scope of study, including the methods and place (ER and OB/Gyn wards) of data collection, and causes of complications for examination, including ante and post partum hemorrhage, severe pre-eclampsia/eclampsia, and obstructed labor. In addition, newborn resuscitation and essential newborn care. 2. Study protocol written, including: <ol style="list-style-type: none"> a) Indicators developed b) survey tools developed c) sampling plan developed 3. JHU IRB approval obtained. 4. Field visit to one test country done <ol style="list-style-type: none"> a) MoPH and other key stakeholders approval and collaboration obtained b) Research partners identified c) Country IRB initiated 	Working group established, draft tools and protocol reviewed with USAID Aug 6. Pilot testing planned for Ethiopia and Kenya. Substantial development work of new survey tool kit accomplished including protocol with sampling plan for various settings, budgets for various settings, and ten data collection tools. Field trips to plan pre-testing done in Ethiopia and Kenya. Agreement obtained from all stakeholders to conduct survey in both countries. In each country: Advisory committee formed of MOPH, professional societies and other major stakeholders; PI 's identified; research counter-parts identified; IRB process in country identified. In addition, expansion of use of this survey tool kit through collaboration with MACRO to include the QOC in L&D and management of PE/E components in Kenya SPA as a pilot test. If successful, possibly to be expanded to additional SPA countries in future.	Protocol not submitted to IRB in Yr 1 because field missions informed need for further sampling strategization, which was accomplished first week in October. JHU IRB submission in October, 2009.
3. Newborn Health						
3.1 Global Leadership for Newborn Health						
3.1.1	Participate in global/regional advocacy and planning with USAID to mobilize resources and coordinate partner support for implementation.	LEAD: Joseph Others: Bacqui, Pat, Saving Newborn Lives	<ol style="list-style-type: none"> 1. Collaboration with global and regional partners in neonatal infection, birth asphyxia, management of LBW babies (KMC) and postnatal care. 2. Global partners recognize MCHIP has a leader/convener for newborn health. 	<ol style="list-style-type: none"> 1. MCHIP has strategic engagement with global partners in newborn health, including PMNCH, GAPPS, WHO, UNICEF and others. 2. Collaborate with UNICEF-Catalytic Initiative, GAPP as well as USAID partners/partnerships such as BASICS, CORE/CSHGP, and SPS. 3. Exchange technical information, disseminate findings and/or develop joint action plans in identified countries. 	<ol style="list-style-type: none"> 1. MCHIP has been in discussions with UNICEF and WHO and agreed to collaborate on a number of activities including the dissemination of the joint UNICEF/WHO statement on PNC home visits, introduction of neonatal infection management in Nigeria, expansion of community-based ENC in India and other countries using an adapted version of the WHO/UNICEF community-based MNH training manual and associated tools . MCHIP is also working with IIP and other partners to update the LisT tool for maternal and newborn health. 2. MCHIP has encouraged its country programs to engage the Catalytic Initiative and other partners at country level to mobilize resources and coordinate the expansion of MNCH services in their respective countries. Participated in the BASICS end of project meeting on USAID/BASICS Global Symposium on Newborn Health ("From Advocacy to Scale") in Dakar, Senegal. Presented on evidence based research on community-based newborn health programs and met with BASICS staff to identify opportunities for transition of program work funded by BASICS on newborn health to MCHIP. 3. MCHIP has been asked to work in 10 countries⁶ to provide technical assistance on newborn health and has/will be developing workplans to meet these requests 	

⁶ These 10 countries are: Bangladesh, Dominican Republic, DRC, India, Indonesia, Kenya, Madagascar, Malawi, Nigeria, and Paraguay

3.2 Neonatal Care						
3.2.1	Moving implementation of KMC forward for LBW newborns.	LEAD: Joseph Others: Abdullah Baqui, Steve Wall,	<ol style="list-style-type: none"> 1. Assessment of USAID investments in country experiences in community KMC to date. 2. Gaps in knowledge on community KMC identified and a plan of action to define an evaluation strategy for community KMC developed. 3. Evaluation component of community KMC activities developed. 4. TA to two countries to begin to strengthen ongoing facility level KMC activities. 	<ol style="list-style-type: none"> 1. Technical document describing program experiences in community KMC prepared. 2. Technical document on monitoring and evaluation strategy for community KMC prepared. 3. Conduct consultation meeting with KMC partners (USAID, SNL, WHO, UNICEF, MCHIP partners) to review experience and develop a strategy to assess community KMC. 4. Agreement of key experts on quality and service indicators for community KMC. 5. TA to 1–2 countries for facility based KMC (Mali and TBD) Yr 2 activity. 6. Document results of community KMC based on strengthened M&E. 7. Introduce KMC into 1 additional MCHIP country. 	A review of the data from the two countries implementing community KMC was conducted and presented to the KMC technical working group (KMC TWG). The ACCESS/Bangladesh had the most data while the ACCES/Malawi program had very limited information because the integration of community KMC into the community-based MNH activity had only started. The Bangladesh activity was a universal promotion of community KMC without a facility component, and uptake of KMC was limited. MCHIP established a CKMC working group and the group has recommended that based on the lessons learned, MCHIP should not promote a stand alone community KMC but always have both facility and community components. The KMC TWG agreed on a set of indicators that should be collected for the community component of the KMC programs in Malawi, Bangladesh and all future KMC programs. These indicators will be incorporated in the Malawi and Bangladesh programs during the FY10 revision of program activities.	
3.2.2	Scaling-up essential newborn care	LEAD: Joseph	<ol style="list-style-type: none"> 1. Work with selected ongoing MNCH programs in 1–2 countries (Mali and 1 TBD) including USAID bilaterals, MOH and NGO to integrate evidence-based ENC elements in their programs. 2. In 1 to 2 countries (Mali and 1 TBD) where MCHIP is supporting introduction or expansion of ENC, including PNC, advocacy and coordinated actions by governments, donors and key stakeholders to support country adaptation of these recommendations for early home visits. 3. Contribute to the development of the WHO's evidence based postnatal care/postpartum care guidelines. 	<ol style="list-style-type: none"> 1. Compile a list of countries with USAID bilateral funded MNCH and central funded CS programs and share evidence base ENC materials. 2. Confirm Mali and (India and/or Nigeria) USAID missions interest and reach consensus on key tasks. 3. In 1–2 countries (Mali and TBD), MCHIP will work with the MOH and local partners to expand ENC, including home-based PNC. 4. Review policy on PNC package to identify gaps in ensuring PNC along the continuum – that women and newborns receive appropriate PNC at facility and home level with a focus on getting women who deliver at home to receive PNC within 2 days at the facility 5. In Mali, support a TIPs study on the feasibility and acceptability of PNC within the first week and use results to refine PNC package. 6. Establish linkage with the WHO /UNICEF PNC/PPC review team and provide technical input to draft PNC/PPC evidence document. <p>In Year 2</p> <ol style="list-style-type: none"> 7. Plan for evaluation of these efforts, evaluation to take place in year 2. 	MCHIP developed and submitted concept papers to assist Mali and India to strengthen and expand their ENC programs. In India MCHIP received the approval and completed a desk review on the national newborn situation, and also participated in a joint USAID/MCHIP MNH assessment. In Mali MCHIP has been in discussions with various stakeholders and USAID and the concept paper is still under discussion. • Drafted MCHIP PPC/PNC facility and community-based guidelines based on the WHO/UNICEF Joint Statement and existing WHO maternal and newborn care guidelines. These guidelines will be utilized by MCHIP programs and others, as applicable, until revised WHO guidelines are made available.	

3.2.3	Community-based infection management for newborn	LEAD: Joseph Others: David M, Mary C, Bacqui	1 Awareness of the evidence for community-based infection management for newborn (CBIMN) in 1-2 countries (India and Nigeria) created	1. Share evidence on CBIMN with managers/technical staff of ongoing USAID bilateral programs, MOH and NGO In Year 2: 2. CBIMN in 1-2 counties introduced	MCHIP collaborated with ACCESS to disseminate information on CBIMN through a review article written for the MotherNewBorNet newsletter. MCHIP also provided leadership for the technical update/advocacy workshop for local NGOs sponsored by PMNCH in Nigeria. Information was also shared at SNL funded launch of the Nigeria Situation of newborn health. This activity led to the expression of interest by the Nigeria Society for Neonatal Medicine to introduce community-based management of newborn infection in the country. MCHIP will support the Society in FY10 to initiate this activity.	
3.2.4	Prevention of preterm births	LEAD: Joseph Others: Patricia, Rae, Joseph	1. Key gaps in the prevention of preterm births identified. 2. Support further exploration of, or program to address identified gaps in 1 country.	1. Provide financial support to the GAPPS consultative meeting on preterm births. 2. Support 2 MCHIP staff to participate in the GAPPS organized meeting on preterm births. 3. Develop MCHIP's strategy for addressing selected gaps in the prevention of preterm births.	MCHIP supported the Global Alliance to Prevent Prematurity and Stillbirths meeting through funding of participants from Malawi and two MCHIP staff. MCHIP staff participated in the May 7-11th meeting in Seattle, which brought together participants from around the world and reviewed the landscape assessment of preterm births and stillbirths through a framework of discovery, development, delivery, advocacy, ethics and justice. Recommendations from the meeting will inform research and programmatic direction on this area. It was agreed that most of the recommended interventions are already part of its package so there was no need for a separate strategy but there was need to ensure that its interventions including screen and treatment for syphilis and reproductive tract infections should be strengthened, A major missing intervention in the current package is the use of antenatal steroids for women who experience premature labor. There is ongoing discussion on how MCHIP could integrate this intervention in its focus antenatal package, A final decision is yet to be made.	
3.2.5	Scaling-up newborn resuscitation	LEAD: Joseph Others: Pat, CC Lee	1. Contribute to the WHO led global training manuals on resuscitation 2. MCHIP strategy for scaling-up resuscitation developed	1. Provide technical input on the review of the 2 resuscitation training manuals and models being developed for health facility staff under WHO 2. Support the second consultative meeting on newborn resuscitation and develop MCHIP resuscitation strategy 3. Review and adopt/adapt the resuscitation component of the UNICEF home-based MNH training manual	MCHIP held numerous discussions with the American Academy of Pediatrics (AAP) to define the collaboration of the two organizations on this activity. MCHIP staff also attended and provided input on the Helping Babies Breathe training manual and associated materials. MCHIP with core and field support will be funding two countries, Kenya and Bangladesh, to study the effectiveness of the HBB manuals in training service providers.	
3.2.6	Assessing readiness for newborn care	LEAD: Linda B. Others: Joseph	This activity linked to PE/E survey in Activity 2.4.2	1. Support/review newborn care component of the survey	Working group established, draft tools and protocol developed for review with USAID Aug 6, JHU IRB submission by mid-August. Pilot testing being planned for Ethiopia and Kenya. Missions to prepare for pilot in Ethiopia and Kenya in Sept.	
3.2.7	Handwashing for newborn survival	LEAD: Dan Abbott Others: Pat, Joseph, Koki, PSI???	Link with activity 5.1.2		See 5.1.2.	

4. CHILD HEALTH						
4.1 Global Leadership for Child Health						
4.1.1	<i>Community-based Treatment of Pneumonia:</i> Participate in global/regional advocacy and planning with USAID to mobilize resources and coordinate partner support for implementation.	LEAD: Emmanuel Others: Mary C., Michel P., David M., Salim S Penny D.	1. Resources for CB-pneumonia identified 2. Coordinated planning with partners	1. Collaborate with UNICEF-Catalytic Initiative, GAPP as well as USAID partners/partnerships such as BASICS, CORE/CSHGP, and SPS. 2. Exchange technical information, disseminate findings and/or develop joint action plans in identified countries. 3. Maintain roles on CCM Task Force and CCM OR group of partner representatives.	*Maintained contact with UNICEF. Continued work initiated under BASICS, to develop with Africa 2010 and Africa bureau a strategic paper recommending areas for future USAID investment in CCM; a draft was completed; *Established a CCM working group and developed a matrix of countries showing the status of interest of, and number of implementing partners support for CCM implementation and partners in activities, The purpose of the matrix was to identify opportunities for MCHIP.	
4.1.2	<i>ORT Revitalization:</i> Participate in global/regional advocacy and planning with USAID to mobilize resources and coordinate partner support for implementation.	LEAD: Mary Others: Marcelo C., Emmanuel, Michel P.	1. Resources for ORT- identified 2. Coordinated planning with partners	1. Collaborate with UNICEF-Catalytic Initiative, WHO, CIFF and USAID partners/partnerships such as BASICS/CSHGP/Africa 2010 2. Exchange technical information, disseminate findings or develop joint action plans in identified countries	Met with DD/ORT partners in Kenya. Also see 4.4.1	
4.1.3	<i>Immunization:</i> Participate in global/regional advocacy and planning with USAID to mobilize resources and coordinate partner support for implementation at country level.	LEAD: Robert Others: Jenny, Lora, Michel	1. Global policies on new vaccine presentation, packaging, and financing reflect country needs 2. USAID immunization support to countries leveraged and well coordinated 3. CSO participation increased in GAVI decision-making and in national immunization programs 4. Increased Child Survival Grantee activities in support of immunization and related activities	1. Contribute to global and regional technical advisory groups, task teams and working groups, including GAVI CSO Task Team, WHO SAGE and TLAC 2. Participate with USAID in coordination and technical update meetings with WHO, CDC and others. 3. Participate in immunization partnership teleconferences and meetings (i.e., SAGE, GIM, TFI, WHO Regional WGs, GAVI technical WGs, TLAC) 4. Support CSHGP to identify opportunities for improving immunization as part of CSHGP activities	*With IMMbasics, participated in several advisory group meetings (e.g. participation in SAGE, TLAC (RS), pneumo (RS, MO), new vaccine communication advisory group (LS) and provided input to global immunization and new vaccine planning); *Input provided to USAID 2009 grant to WHO/AFRO. +CDC +TFI. In addition, provided technical support to 5 new and IMMbasics transition countries (Benin, DRC, India, Kenya, Southern Sudan); Participation in meetings of the GAVI Civil Society Task Team (CSTT), WHO TLAC (as sub-group chair), meeting on Introduction of New and Underutilized Vaccines, first meeting of ad hoc Advisory Committee on IVR Project on Gender and Immunization, SAGE; Participation in WHO/PATH Project Optimize Program Advisory Group meetings; Participation in meeting on USA National Vaccine Plan (including Institute of Medicine review of the plan); Participated in the Global Immunization Meeting, presented and co-facilitated the Inter-Agency Task Force on Communication for Immunization and Polio Eradication, a roundtable on Experience from US and International Immunization Communication Efforts, Health Communication: Polio Lessons meeting and Measles Initiative telecons, Participated with AFRO on RED adaptation, the Task Force on Immunization, and the 2009 Annual GHC conference; *Active in getting GAVI to invest in CSOs working in immunization	

4.2 Community-based Treatment of Pneumonia						
4.2.1	Implement strategies in select MCH countries to intro/expand community treatment of pneumonia.	LEAD: Emmanuel Others: Mary C., Michel P., David M., Salim S, Penny D., Joseph	1. CB-pneumonia treatment introduced in 1-2 new countries. 2. Efforts advanced in 2-3 countries transitioning from BASICS support.	1. Based on the analyses below, identify 1-2 new countries with USAID to initiate activities. 2. Identify work with SPS in 1-2 new countries to strengthen drug logistics and availability in support of community treatment programs 3. Participate in program review in 2- 3 existing program countries transitioning from BASICS technical support e.g. Rwanda, Madagascar and/or DRC (with possible GH core 'bridge' funds) In Year 2, begin implementation of country-specific interventions	Advocated continuously for CCM introduction in Mali and DRC. Discussions included strategies to address issues raised by key MOH officials opposed to CCM and some personal communications. In Mali, MCHIP participated in 2 national workshops on CCM and presented and facilitated some sessions during the first with international participants to advocate for CCM. MCHIP facilitated the second workshop limited to a country task force that was addressing issues raised during the big workshop in order to pave the way for an authorization to implement CCM	
4.2.2	Conduct analyses/ implementation research to build evidence base for implementation and scale up for community case management of childhood pneumonia and malaria.	LEAD: Kate Gilroy Others: Salim, David M, Emmanuel, Mary, Michel, Jim	1. Existing analyses/assessments of CB-pneumonia treatment reviewed. 2. Future assessments and program documentation identified that are needed to advance evidence base.	1. Review of existing literature/studies/analyses to identify lessons learned and needs for additional analyses. 2. Design further analyses needed that could be co-funded with other partners to address identified gaps in program assessment and documentation.	1 Draft review completed; discussions with UNICEF and MCHIP partners underway for date to review findings and finalize recommendations. 2. MCHIP developed a concept paper for the CCM documentation proposed for 2 countries A preliminary trip to Senegal to discuss with CCM key stakeholders and lay some ground work for the exercise. Some approaches and documentation of CCM. A tentative period was set and a number of measures	
4.3 ORT in Diarrhea Case Management						
4.3.1	Desk analyses to identify factors contributing to low or declining ORT use.	LEAD: Marcelo Others: Katherine F., Kate G., Mary, Jim, Michel	1. Existing analyses/assessments reviewed. 2. Additional needed analyses designed (that could be co-funded with above partners). 3. LiST applied to 30 priority countries to determine potential mortality impact of improving diarrhea disease control.	1. Review existing literature, analyze and assessments for lessons learned including WHO AFRO and AFRICA 2010 joint analyses of determinants of ORT use/non-use, previous BASICS and A2Z Zinc/ORT assessments, CDC/Kemri analyses in Kenya, DHS analyses, etc. 2. Based on above, design additional in-country analyses as needed, utilizing other partner resources where feasible 3. Use LiST to provide input to analyses to determine potential mortality impact of improving diarrhea related indicators in 30 MCH priority countries	Literature review initiated and meetings held with Africa 2010. The results of the LIST tool analysis that is being prepared for all MCH priority countries and the full range of MNCH interventions will include this diarrheal disease/ORT/zinc analysis. This activity will only proceed once Africa 2010 finishes its country assessments. At that point, MCHIP will prepare of synthesis of the Africa 2010 and other ORT/zinc assessment findings and look for opportunities to assist with supplemental in-country assessments.	
4.3.2	Implement strategies in select MCH priority countries to revitalize ORT at country level.	LEAD: Marcelo Others: Mary, Emmanuel, Michel P., Jim R.	1. ORT revitalization efforts initiated in 1-2 new countries. 2. ORT revitalization advanced in 2-3 existing countries transitioning from BASICS.	1. Based on the analyses above, initiate activities in 1 - 2 new countries (leveraging Catalytic Initiative, CIFF and local resources committed to this effort together with USAID core funds + available field support e.g. Kenya) 2. Build upon efforts in 2 - 3 existing program countries transitioning from BASICS technical support e.g. Rwanda, Madagascar and/or DRC.	Advocacy to expand ORT through the use of CHWs in Kenya and Mali. MCHIP is working with Mali to introduce iCCM. This will be an opportunity to support revitalization of DD cases management at all levels. Kenya has requested a pilot CCM of CHW that will both improve CHWs capacity to assess and manage diarrhea including the use of zinc. DD Revitalization activities continued in DRC including the training of more HW and CHWs in correct assessment, classification and treatment of DD to prevent and or correct dehydration. 3 Commissions were created in country to prepare for a national day to launch a multimedia campaign on DD. The event is scheduled for the financial year 2009-10	

4.4 Zinc in Diarrhea Case Management						
4.4.1	Integrate zinc in revitalization of ORT and CCM efforts cited above.	LEAD: Mary	1. Zinc included in revitalization of ORT efforts at global, regional and country levels, described above	1. Participate in discussions/key forums (e.g., Zinc Task Force) to identify program gaps/needs and opportunities for strengthening implementation at country level.	Discussions with Africa 2010 held.	
4.4.2	Implement strategies in select MCH priority countries to introduce or expand zinc in case management of diarrhea+A111.	In conjunction with 4.3.2 above LEAD: Marcelo Others: Mary, Emmanuel, Michel P., Jim R. Salim	1. Zinc incorporated into ORT activities in 3-4	1. Initiate activities in 1 – 2 new countries ((leveraging Catalytic Initiative, CIFF and local resources committed to this effort together with USAID core funds + available field support). 2. Build upon efforts in 2 – 3 existing program countries transitioning from BASICS technical support e.g. Rwanda, Madagascar and/or DRC	MCHIP collaborated with three working groups that are collaborating to plan a national launch of the revitalization of diarrheal disease case management in DRC, including the introduction of zinc in diarrheal disease case management. Expansion of training of HWs and CHWs in the use of zinc in the treatment of diarrhea in DRC. Clinicians in health facilities including major hospitals and pharmacists were trained. MCHIP participated in effort to make zinc available in the regional central medical store. More details are provided in the DRC report. Kenya has accepted to pilot in the financial year 09-10 the use of CHWs to treat Diarrhea with zinc in his work plan with MCHIP. MCHIP is assisting Mali initiate a national CCM intervention that will include zinc in the mgmt of DD disease.	

4.5 Crosscutting Child Health						
4.5.1	Democratic Republic of Congo	<p>LEAD: Emmanuel/Pat T.</p> <p>Others: Indira, Sushi E.</p>	<ol style="list-style-type: none"> 1. Expansion of high-quality CCM activities completed in 100 districts with AXxes, UNICEF and other partners 2. Necessary policies, strategies and training capacity in place to continue CCM expansion 3. ORT revitalization campaign launched successfully with UNICEF and other partners 4. Assessment of AMSTL/Newborn training and supervision completed. 5. A plan for further expanding and improving the results of AMSTL/Newborn interventions developed and being implemented 4. National EPI review completed (IMMbasics) and findings disseminated (MCHIP) and used in planning. 5. EPI Review recommendations implemented with MCHIP technical support. 6. Annual MOU for the national immunization program defining government and donor commitments 	<ol style="list-style-type: none"> 1. Transition CCM in-country work of BASICS to MCHIP 2. CCM: <ul style="list-style-type: none"> – Provide technical support and leverage support for the expansion of CCM – Lobby and take other steps to ensure that CCM policies and resources are in place – Monitor the progress and quality of CCM training and expansion – Document CCM results – Develop a plan for institutionalizing CCM training capacity – Leverage support to carry it out 3. ORT revitalization <ul style="list-style-type: none"> • Support final preparations/materials for the launch • Provide partial support 4. AMSTL/Newborn <ul style="list-style-type: none"> – Continue support to AXxes for training and support supervision – Conduct an assessment of the introductory phase – With MOH and partners, develop and support the implementation of a plan to improve quality and effectiveness of the intervention – Lobby for policy change if that is required – Disseminate the results of the introductory phase and facilitate planning for scale up 5. Immunization 	<p>Concept paper prepared and approved by USAID/Kinshasa and AOTR team end of Qtr 2; transition of staff and office to MCHIP, as planned, April 1; detailed work plan developed and submitted for approval late April; Mission comments received late May; revision delayed; planned resubmission in July. , Work in country continues with bilateral partner, MOH and other partners. Technical areas being supported include CCM (malaria, pneumonia, diarrhea), ORT revitalization, immunization, postpartum hemorrhage prevention, and newborn health.</p> <p>Provided some guidance for the programming of funds allocated by WHO for a country IMCI assessment including iCCM. In preparation for the review slated for October, more than 5,000 CCM individual patient forms were collected from some health zones for analysis</p> <p>From the period spanning from April 1st until September 30, iCCM was expanded to a new province (Katanga) bringing the presence of iCCM in 10 of 11 provinces. Some 11 new health zones were added raising the total to 78 health zones. 94 new iCCM sites were added manned by 189 new CHWs for a total of (total 716 communities covered by 1358 volunteers. Nearly all the new sites and volunteers were from the bilateral supported areas. However, just about half of the CHWs were followed up as recommended</p> <p>MCHIP participated in the ongoing preparation for a research project on malaria CCM funded by CIDA . During the project presentation to the malaria task for adoption, new members were briefed on CCM. The overall project has a budget of 17.900.000 \$ for 4 countries (DRC, Malawi, Cameroun, Mali). MCHIP strongly advocated for an integrated approach in DRC also adopted by Malawi. Cameroon and Mali will cover only malaria. TOT is planned for November 09. There will be 8 intervention and 8 control areas during Year 1. Both will have treatment in the second year.</p> <p>Post training support activities carried out for workers trained in ENC and AMTSL</p> <p>Some 384 professionals in 36 hospital of 3 provinces were briefed on the use of zinc in the treatment for DD. They included 191 MDs, 191 nurses and 2 pharmacists. MSHIP contributed to an advocacy that resulted in positioning zinc tablets in all the provincial medical stores. UNICEF alone had purchased 25 millions tablets of zinc.</p> <p>Three working groups have been preparing a national day for the launching of DD revitalization activities including the introduction of zinc in the treatment of DD.</p>	

4.6 Immunization						
4.6.1	Conduct strategic review of immunization program status to identify gaps in 30 USAID MCH priority countries	LEAD: Robert Others: Jenny, Lora, Michel, Pat T.	<ol style="list-style-type: none"> 1. Report on epidemiology of non-immunized from grey literature (started under IMMbasics, may be completed under MCHIP) 2. Analysis of coverage trends and other EPI indicators in 30 MCH Priority Countries 3. Recommendations to guide USAID advocacy with Mission and partners and future country programming 	<ol style="list-style-type: none"> 1. Review of grey literature and preparation of a document on the epidemiology of non-immunized women and children (IMMbasics funded as part of broader WHO-led effort; may be completed under MCHIP) 2. Prepare an analysis of coverage and EPI program trends in the 30 MCH priority countries, using official country estimates, WHO/UNICEF estimates, JRFs, Annual Progress Reports to GAVI and population-based survey data 3. Convene a virtual working group to determine the strategy for approaching missions and partners in high-burden and/or low-performing priority countries 4. Provide 2 page summary and analysis of coverage trends and program indicators to Missions and partners working in priority countries 	<p>Review was completed and a PowerPoint presentation was sent to WHO. India conducted analysis of NFHS 3 data on unimmunized.</p> <p>A 30 country analysis was conducted and summary documents for Benin, Kenya and Liberia have been prepared and submitted to the respective Missions⁷. Data has been analyzed across all priority countries and will be used for developing additional summary country documents in project year 2</p>	
4.6.2	In MCH priority countries with fragile or ineffective immunization systems, support the development and implementation of strategies to reach unimmunized and partially immunized children with life-saving vaccines	LEAD: Robert Others: Jenny, Lora, Michel O., Ousmane, Pat T.	<ol style="list-style-type: none"> 1. Plan developed to continue and/or expand work in 2-3 IMMbasics transition countries 2. At least one country completes a formal assessment, review or planning exercise with MCHIP input 3. Activities in 1-2 new countries (e.g., Kenya, S Sudan) using core and available field support 	<ol style="list-style-type: none"> 1. Planning with USAID Missions and partners in 2-3 countries for follow-up of IMMbasics work (most will be conducted with IMMbasics funding in FY'09, but this could include continued support to DRC, Benin, Madagascar, Nigeria and India during the transition to MCHIP and other USAID TA mechanisms) 2. Couple Field Support and Global MCH funding for innovation, advocacy, leveraging, and expansion of proven approaches, including RED and other RED-like approaches in 1-2 new countries. 3. As required, provide technical support to these countries for coverage surveys,; multi-country EPI reviews; rapid cold chain, vaccine management, immunization program and data quality assessments; comprehensive Multi-Year Planning; annual work planning; and operational studies to uncover the causes of low coverage and ineffective programs. 	<p>DRC, Benin, India, South Sudan. Madagascar was also discussed, but immunization activities are on-hold until suspension is lifted.</p> <p>Benin, Kenya, South Sudan; Planning was begun with Benin, but did not begin until the end of the year</p> <p>Kenya (rapid cold chain assessment) and DRC and Kenya for multi-agency review; technical discussions held with DVI and partners in Kenya on immunization review; rapid assessment conducted with provincial and select district teams in 2 provinces (Sept)</p>	
4.6.3	Support for the introduction of new vaccines and the improved planning and management of routine immunization services (after the end of IMMbasics)	LEAD: Robert Others: Michel O., Ousmane	<ol style="list-style-type: none"> 1. At least one country completes a GAVI application with MCHIP support or is assisted during planning and preparations for new vaccine introduction 	<ol style="list-style-type: none"> 1. Provide technical support to countries for the preparation of plans and applications to GAVI for new vaccine introduction and other forms of GAVI and government support (i.e., HSS, ISS) 2. Provide technical support to same countries for multi-country EPI reviews; cold chain assessments; comprehensive Multi-Year Planning, and the monitoring/evaluation of vaccine introduction. 	<p>Planned for DRC and Kenya (pneumo introduction delayed until 2010 or 2011). Was planned for Madagascar, but suspended due to political situation; using IMMbasics funding, pneumo introduction activities also carried out in Rwanda; reviewed GAVI CSO applications from countries; Rwanda for multi-agency review and M&E of vaccine introduction (provided support to WHO HQ on the post-introduction evaluation methodology)</p>	

⁷ We are in the process of finalizing the India, Ethiopia, Madagascar, and Zimbabwe summaries.

4.6.4	Use the routine immunization platform to add selective MCH/FP interventions and expand the RED approach	LEAD: Jenny Others: Pat T., Robert, Lora, Michel, also CH, MH, NH, Nutrition technical officers	<ol style="list-style-type: none"> 1. Report on past experiences with integrated outreach completed (IMMbasics) 2. Joint work plan with WHO and UNICEF completed 3. Expansion of RED guidelines and tools in process with partners for use in countries in Year 2 4. Countries confirmed and funding secured for design and implementation of integration trials in Year 2 	<ol style="list-style-type: none"> 1. Literature review and key informant interviews by phone and during 2009 EPI Managers meetings in the Africa Region (IMMbasics) 2. Form MCHIP working group to review findings and develop conceptual framework for designing and testing integrated outreach on immunization platform 3. Meet with WHO/AFRO and UNICEF in the Africa region for joint work planning, country selection and initial work on expansion of RED guide and tools 4. Adapt the RED guide and tools for use in countries 5. Leverage funding from USAID Missions, WHO, UNICEF and others for country trials in Year 2 	<ol style="list-style-type: none"> 1. Literature review begun and ongoing (IMMbasics funded); 2. Planning began, particularly the integration of FP and immunization during routine outreach; 3. MCHIP Staff co-facilitated the RED Guide adaptation workshop for 4 countries in Central Africa (including DRC), organized by the WHO/C. Africa IST in Kinshasa in July. Further country and AFRO regional adaptation was discussed with WHO/AFRO and WHO/DRC. RED Guide adaptation was also discussed with partners in Madagascar and Kenya during a visit in Sept . 4. RED Guide revised and finalized in English and French with IMMbasics assistance. 5. Not yet implemented 	
4.6.5	Use immunization contacts to promote birth spacing and increase access to FP services.	LEAD: Robert (immunization). Holly (FP) Others: Jenny, Lora (Immunization);new FP Officer (FP)	<p>This activity is the same as FP Activity 7.5.</p> <ol style="list-style-type: none"> 1. Literature review and key informant interviews used to produce summary document 2. Analytic or conceptual framework developed to guide design of interventions 3. Plan for developing and testing immunization/FP interventions with countries in place 	<ol style="list-style-type: none"> 1. Co-host a consultative meeting with ACCESS/FP, to include CAs and other agencies and NGO partners to share implementation experience to date on integrating FP with immunization 2. Prepare a document analyzing and reviewing experience in linking FP and immunization services including programmatic tools 3. Select sites for pilot implementation and make site visits 4. Secure funding and obtain agreement from MOHs and partner agencies to participate in implementation in Year 2 	<ol style="list-style-type: none"> 1. Some technical discussions via email have begun. This activity has been shifted into Year 2. 2-3. not yet begun; 4. Discussions initiated with UNICEF 	
5. Crosscutting Interventions						
5.1 Water, Sanitation and Hygiene Improvement (WASH)						
5.1.1	Hygiene improvement for prevention of diarrhea	LEAD: Mary Others: Marcelo	Use MCH platform to initiate hygiene improvement activities in 1-2 countries	<ol style="list-style-type: none"> 1. Meet with HIP to review their hygiene improvement messages, methods, tools and experience and brainstorm the possible strategic integration with ORT. 2. Identify target countries for collaboration with HIP 3. Identify focal point for ORT/Hygiene Improvement in each country 4. Develop BCC strategy for integration of handwashing/hygiene into ORT in all appropriate settings. 	<p>Meeting held with HIP on handwashing around newborn health. Met with CTO for HIP on various occasions during workplanning</p> <p>Created Child Health working group that includes members with water, hygiene and sanitation expertise and developed a comprehensive MCHIP diarrhea control strategy</p> <p>Held discussions with MOH and APHIA partners in Kenya and formulated set of comprehensive ORT/Zinc and diarrhea control activities that have recently been added to the Kenya workplan. Recruitment of a Child Health consultant who will act as the MCHIP ORT/Hygiene improvement focal point and counterpart to the MOH/DCAH is underway.</p> <p>MCHIP exploring the strengthening of hygiene improvement messaging in conjunction with DRC's ORT/zinc revitalization and CCM efforts.</p>	

5.1.2	Handwashing for newborn survival	LEAD: Dan Abbot, Others: Pat, Koki, Joseph,	<ol style="list-style-type: none"> 1. Strategic approach developed for MCHIP work in handwashing. 2. Assessment of handwashing for newborn survival in 1-2 countries (India and Bangladesh) 3. MCHIP identifies opportunities for public-private partnership strategy for scaling-up handwashing 4. Partner with soap manufacturers and government in 1-2 countries (India and Bangladesh) to introduce handwashing for newborn survival 	<ol style="list-style-type: none"> 1. Hold consultative meeting with key stakeholders to develop strategic approach for handwashing for newborn health. 2. Review and adopt/adapt existing handwashing assessment tool 3. Assess handwashing for practices as it relates to the newborn in 1-2 countries (India and Bangladesh) 4. Conduct meeting with leaders of the Public-Private Partnership for Handwashing (PPPHW) to strategize incorporating handwashing for newborn survival in their mandate 5. Dialogues started with multinational soap companies at country level to develop a private-public strategy on handwashing for newborn survival in one country 6. Support the design of integrating handwashing for newborn survival in India. 	<p>(-) Concept note outlining strategic approach for Handwashing for newborn survival completed and approved by USAID. Consultative meeting to be held by March 2010 for additional input into technical approach.</p> <p>(-) Concept note for HW for newborn survival submitted to India Mission. Visit to India completed. Consultative meeting held with Government of India, Unilever, MCHIP, MBP and other stakeholders regarding programming on newborn handwashing and its link to National HW Alliance.</p> <p>(-) Global Vision Statement for partnership between Unilever's Lifebuoy brand and USAID / MCHIP drafted and nearing approval. Statement outlines partnership for handwashing for newborn survival in India, Bangladesh and Indonesia with potential for further expansion.</p> <p>(-) HW research tools reviewed and plan for formative research in India developed. Formative Research in India not yet complete, it has been put on hold until completion of Vision Statement with Unilever.</p> <p>(-) Discussions with members of PPPHW have taken place to raise awareness of HW for newborn survival. Further discussions with PPPHW leadership will take place during consultative meeting to be held by March 2010.</p>	
5.1.3	Hygiene improvement for HIV/PMTCT-MNCH Integration	LEAD: David Burrows Others: Koki, Pat D. Tambu Rashidi (Jhpiego Malawi CD)	1. IEC hygiene improvements incorporated into ACCESS and BASICS-led HIV/PMTCT-MNCH Integration activities in Malawi	1. Provide IEC hygiene materials to providers and mothers targeted by ACCESS and BASICS	IEC hygiene materials provided to mothers in Malawi.	
5.2 PMTCT/Pediatric HIV-MNCH Integration						
5.2.1	Ensure Prevention, Care and Treatment for Mothers with HIV and their Infants	LEAD: JSI Others: Gloria E. (PATH)	<ol style="list-style-type: none"> 1. Desk review of pediatric HIV evidence, guidance, promising practices and materials posted on the Web and accessible to MCHIP staff, partners and countries. 2. UNICEF/WHO PMTCT IATT products produced with MCHIP input 3. MCHIP capacity improved to design programs that integrate HIV and MNCH interventions 	<ol style="list-style-type: none"> 1. Convene consultative meeting with USAID and other partners to explore integration approaches 2. Produce a desk review pediatric HIV evidence, guidance, promising practices and materials (include data, state-of-the-art tools, guidelines, indicators, and training materials related to HIV in mother-infant pairs) 3. Participate in the UNICEF/WHO PMTCT Interagency Task Team's (IATT) pediatric working group and provide input to its products (i.e., HIV standards of care and guidance on counseling and testing) 4. Carry out capacity building activities with MCHIP HQ staff to ensure knowledge of current recommendations and approaches to prevention, care and treatment of HIV positive mothers and exposed and infected infants and children. 	<p>PMTCT-MNCH consultative meeting held at MCHIP with experts from USAID, CDC and USAID projects.</p> <p>Pediatric HIV expert contributed to development of the workplan and contributed to the UNICEF/WHO PMTCT Interagency Task Team's (IATT) pediatric working group and its products, including the HIV standards of care and guidance on counseling and testing.</p> <p>Desk review of pediatric HIV evidence determined with USAID to be low priority given funding available.</p> <p>Discussions held with USAID/GHB Child Health Advisor to define future activities. Agreement has been reached on a consultative meeting once the new guidelines for pediatric HIV treatment are released and on the selection of one country for testing of the RED+ approach and other strategies for integrating MNCH and the four pillars of PMTCT care.</p> <p>Capacity building with MCHIP staff delayed until the new PMTCT/pediatric HIV guidelines are released.</p>	

5.3 Maternal Anemia						
5.3.1	Maternal Anemia Control	LEAD: Rae	<ol style="list-style-type: none"> 1. An international consultation on maternal anemia resulting in a plan of action to address anemia. 2. A national consultation in one country to identify country-level barriers and facilitators for a successful maternal anemia control program. 3. A strategic plan for addressing maternal anemia in one country. 4. Introduce new or strengthened maternal anemia control activities in one country. 	<ol style="list-style-type: none"> 1. Meet with the A2Z Project to plan the international consultation. 2. Hold the international consultation. 3. Convene a consultation in at least one country (e.g., India, Kenya, Mali, Nigeria) to identify barriers and facilitators for a successful maternal anemia control package and develop a strategic plan for addressing maternal anemia in that country. 4. Identify and implement activities to improve maternal anemia control activities in one country. 	<p>MCHIP and A2Z met to discuss putting maternal anemia control on the international agenda and jointly held a brown bag presentation at MCHIP on maternal anemia control; *The international consultation was discussed but not organized for this year. Discussions with A2Z are planned in Year 2 for putting maternal anemia control on the international agenda with key stakeholders; *Countries were discussed as ideal places to hold national level consultations and work on developing strategic plans to address anemia, although actual consultations were not held. There is Mission interest from Bangladesh and Indonesia. Malawi was also discussed within MCHIP as a country technical assistance on maternal anemia could be provided; * It was proposed to start work to improve maternal anemia control activities using MCHIP investment funds by first conducting a situational analysis of the maternal anemia control program in Indonesia where the country has made an investment in the past to improve its anemia control program; *In addition, MCHIP Director Koki Agarwal presented at meeting on the Hill on Maternal and Child Nutrition.</p>	<p>The proposal to the MCH Investment Funds was late and did not get funded. However, a situational analysis of the maternal anemia control program in Indonesia is still of interest since that country made progress in the 1990s in improving its program and lessons learned from that experience will help in moving forward to nationalize those lessons.</p>
6. PVO/NGO Strengthening						
6.1	Support to existing CSHGP Management Systems	LEAD: Leo Others:	<ol style="list-style-type: none"> 1. Efficient management of annual Program Cycle for the CSHGP; 2. Important learning from CSHGP Portfolio feeds into MCHIP knowledge management system and informs MCHIP SO1 and SO2 activities; 3. CSHGP Team has access to portfolio-level information on its grantees in order to respond to requests about the program from partners 4. Summary report from report reviews activity that includes a mapping of key elements of the portfolio, and identification of relevant achievements of grantees in MCH priority countries 5. Updated guidance for evaluators conducting MTE and FEs in 2009, to ensure reporting on priority MCH technical and cross-cutting areas. 6. Modified CSHGP public and private information systems 7. CSHGP Technical Reference Materials updated/revised, including family planning and reproductive health module (integrated into MNC module); pneumonia case management; malaria; health systems strengthening; behavior change interventions; tuberculosis; and control of diarrheal disease 8. Design in place for an FY10 OR Support Event for CSHGP Grantees 9. CORE Web site and listserves maintained on Macro International web server 	<ol style="list-style-type: none"> 1. CSHGP Report Review 2. Minor updates to core CSHGP Tools including KPC and RHFA 3. Maintain and Monitor Quality of Grantee Project Data 4. Respond to Ad Hoc Requests for data on the CSHGP and its portfolio of active grants 5. Simplify and Align Annual CSHGP Program Cycle and Related Requirements 6. Technical Advisory Group Meeting to update Evaluation Guidance 7. Provide Management Support throughout CSHGP Program Cycle 8. Update CSHGP Technical Reference Materials (TRMs) 9. Design and plan for an October 2009 OR Support Workshop for CSHGP Grantees 10. Quarterly coordination meetings with CORE, SO3, and CSHGP teams 11. Continue to host CORE listserves and website 	<ol style="list-style-type: none"> 1. Provided technical review and analysis for 10 final evaluation reports and 15 MTE reports, generating 16 individual results highlights for projects to be posted on web. 2. No significant feedback from grantee community on KPC and RHFA tools; they remained unchanged. 3. Grantee Data Quality Matrix updated and submitted to CSHGP quarterly 4. Responded to an average of 3 ad hoc requests per month from CSHGP team and other BGH personnel for information from CSHGP portfolio. 5. Recommendations for aligning CSHGP RFA with MCHIP priority areas submitted to CSHGP in June 2009; DIP and Evaluation guidelines updated. 6. Final and MTE Evaluation Guidance updated based on input from Technical Advisory Group consisting of evaluators, MCHIP consortia reps, and grantees. 7. CSHGP online Management Information System reviewed; revisions to system 75% complete by Sept 2009 8. Malaria, FPRH, MNH TRM modules updated 9. Planning for OR support workshop led to decision to hold 1 day New Grantee Orientation instead. 10. Coordination meetings with CORE and CSHGP held on Feb 19 and June 15, with several meetings and discussions held in August/September to coordinate joint MCHIP work plan activities for PY2. 11. CORE listserves and website hosted throughout year 1, with transition of these functions completely over to CORE initiated in June. Public website and CORE listserves are now managed completely by CORE, with some aspects of present CORE site continuing to point to old site on Macro server until transition process is completed in FY10. 	<p>Lives Saved analysis from Fes to be complete by end of October 2009. MIS, including public website as well as CSHGP intranet, to be operational in QTR 1 of PY2 PCM, BCI, CDD updates submitted to reviewers in Year 1, but will be finalized in late October; HSS TRM still to be updated by mid November 2009; TB module to be updated in Year 2. 9. OR Support Workshop now planned for Feb/March 2010 TA to Concern Burundi scheduled for November 2009.</p>
6.2	Technical Support to Active Portfolio of CSHGP Grantees	LEAD: Leo	<ol style="list-style-type: none"> 1. Clearly articulated detailed implementation plans (DIPs) for 8 newly-funded projects 	<ol style="list-style-type: none"> 1. DIP Backstop Support and Support to DIP Reviews 2. Technical Support to CSHGP New Partners 	<ol style="list-style-type: none"> 1. Provided DIP backstop Support and coordinated DIP review support for 8 CSHGP grantees in Burundi, Nicaragua, Nepal, Pakistan, Afghanistan, Liberia, and Uganda, and India. PPT presentation 	

		Others:	<p>2. Strong operations research/program learning designs for DIP writers in the "innovation" category</p> <p>3. Grantees have access to up-to-date technical and design resources completed at the close of the CSTS project.</p>	<p>3. Operations Research/Program Learning Support to Grantees</p> <p>4. Targeted Field Visits in coordination with other MCHIP partners (up to 2)</p> <p>5. Diffuse Tools/ Resources Completed at Close of CSTS+:</p> <ul style="list-style-type: none"> - FY09 Rapid CATCH Tool - MNC KPC Module - Sustainability Planning User's Guide - Innovations Framework <p>6. Respond to ad-hoc requests for technical input from grantees</p>	<p>2. Provided ongoing technical support to 9 New Partner grantees in the active CSHGP portfolio in the areas of DIP development, M&E systems issues, and program implementation.</p> <p>3. Provided technical input to Operations Research Designs for 6 CSHGP Innovation grantees, and provided ongoing support to strengthen overall designs post DIP approval.</p> <p>4. MCHIP Staff member attended International Health Facility Assessment Network Meeting in Geneva</p> <p>5. FY09 Rapid CATCH tool, MNC KPC Module, Sustainability Planning User's Guide posted at www.childsurvival.com in October 2008; Innovations Framework document submitted in June 2009 and is undergoing final review with CSHP.</p> <p>6. Responded to grantee requests throughout the year for assistance with M&E and program implementation issues.</p>	
6.3	Assistance to leverage linkages between CSHGP, MCHIP SO1 and MCHIP SO2.	<p>LEAD: Leo</p> <p>Others:</p>	<p>1. Summary Report on Status of CSHGP Innovations and their potential contributions to SO1 and SO2 activities</p> <p>2. Report with recommendations for enhancing CSHGP focus on equity</p> <p>3. Summary report on lessons learned from NGO experiences with C-IMCI, to inform NGO dialogue with governments on community-based health</p> <p>4. Published paper on Community-based Primary Health Care</p> <p>5. Published paper on Evidence for the contribution of integrated community-oriented NGO programming in accelerating progress toward MDG 4</p> <p>6. CORE Spring/Fall meetings informed by MCHIP activities and staff</p>	<p>1. Summarize CSHGP innovations along innovations tracking matrix; align innovations tracking with USAID RTU framework</p> <p>2. Convene a Technical Advisory Panel to identify options for strengthening CSHGP contributions to equity.</p> <p>3. Participate in planning/session development for CORE Fall/Spring Meetings</p> <p>4. Partner with CORE to organize Technical Advisory Group meeting on Community-IMCI.</p> <p>5. Participate in CORE PD Hearth Technical Advisory Group meeting</p> <p>6. Support completion of paper on Community-Based Primary Health Care, presently in development by Dr. Henry Perry with support from other donors.</p> <p>7. Refine and submit for publication: Evidence for the contribution of integrated community-oriented NGO programming in accelerating progress toward MDG 4</p> <p>8. Provide information to MCHIP SO1 and SO2 teams on relevant CSHGP grantee experience as requested to inform SO1 and SO2 activities.</p>	<p>1. Summary of CSHGP innovations and alignment with RTU framework built into Innovations Framework paper presently under review by CSHGP</p> <p>2. Equity TAG convened and results presented at CORE Fall Meeting (Oct. 7 & 8)</p> <p>3. Participated in planning for CORE Spring/Fall meetings. At Spring meeting, led session introducing MCHIP to grantees; at Fall meeting, MCHIP staff led session on CCM, equity, a M-health lunch session, and introduction to MCHIP booth at the resource fair.</p> <p>4. MCHIP Staff member participated in the PD Hearth TAG</p> <p>5. SO3 team mapped CSHGP portfolio against MCHIP priority areas to inform Year 2 workplanning; R-HFA tool developed through CSHGP informed PE/E survey developed in Year 1; SO3 team members participated in MCHIP technical working groups to ensure CSHGP experience informed larger MCHIP activities.</p>	<p>4. C-IMCI TAG meeting delayed until MCHIP Year 2 6. Final Global Policy Brief derived from Dr. Perry's paper delayed to November 2010 7. Final Submission of Paper "Evidence..." delayed to November 2010</p>

7. FAMILY PLANNING						
7.1	Global Leadership and Program Learning	LEAD: Koki Others: Cat, new FP-TBD	<ol style="list-style-type: none"> 1. Consultative meeting on EBF-LAM 2. Desk review of FP-MNCH integration literature conducted. 3. Preparations for Y2 to write lessons learned document on FP-MNCH integration 4. PAC curriculum finalized 	<ol style="list-style-type: none"> 1. Convene EBF-LAM Technical consultation meeting 2. Conduct desk review of current FP-MNCH integration literature 3. Final comments incorporated in PAC curriculum 	<ol style="list-style-type: none"> 2. Shared ACCESS-FP/MCHIP staff conducted desk review in preparation for its study of MNCH-FP integrated services in Northern Nigeria, Afghanistan and Bangladesh. The report on Nigeria was completed by a shared ACCESS-FP/MCHIP staff member in April 2009. 3. The PAC Curriculum has been completed by shared ACCESS/MCHIP staff. 	<ol style="list-style-type: none"> 1. A consultative meeting on EBF-LAM among partners was not done in the first year but is planned in the second with ACCESS-FP
7.2	Postpartum/Interconceptional FP Program in Mali (or a PRH Tier 1 country)	LEAD: FP-TBD Others: Patricia, Cat	<ol style="list-style-type: none"> 1. Current norms /protocols/guidelines and service delivery practices, with critical gaps assessed and opportunities for PP/IC FP programming identified. 2. An essential package of community-based clinic to household interventions defined to increase use of PP/IC FP services. 3. Districts identified where existing community-based PFP activities can be strengthened to increase demand for FP services; and where FP services can be integrated into facility-based MNCH services <p>Year 2</p> <ol style="list-style-type: none"> 4. Norms/protocols/ guidelines modified to ensure PP/IC FP is appropriately integrated 5. Service delivery approaches modified from ACCESS-FP countries and adapted for Mali. 6. Communities and providers engaged as full partners in planning, implementation and evaluation 	<ol style="list-style-type: none"> 1. Form TWG that includes a variety of stakeholders in maternal, newborn, child, reproductive and community based health interventions; review assessments conducted by bilateral projects; include NGO/PVO/FBO sector to carry out any additional formative research and assessments that may be needed 2. Conduct formative research to inform design of community component 3. With MOH and existing implementing partners, define the contents of an essential postpartum /interconceptional package for strengthening PP/IC interventions through their programs 4. With MOH and existing implementing partners, gain agreement on service delivery modalities (i.e. community-based and facility-based, and link with ANC, AMTSL/SBA, NB/Infant/Child visits, Nutrition/weaning/complementary feeding, Vit A, Immunization, CSCOM routine services, relays outreach, etc.) <ul style="list-style-type: none"> – Identify districts to implement activities – Identify existing community-based interventions on which PP/IP FP can be integrated – Identify facilities where existing MNCH activities can be strengthened to include provision of FP counseling and services 5. Identify technical assistance needs of existing implementing partners and develop joint plans 	The Senior Advisor RH/FP for MCHIP and the Director of ACCESS-FP initiated MCHIP in Mali at the end of the first year and met with partners, bilaterals, and assessed the PFP status in Mali.	The project in Mali was on hold while waiting for the new team leader from Ghana USAID to move to the mission in August

7.3	Strengthening Family Planning Content in Midwifery Pre-service Education in Malawi and Ghana.	LEAD: Patricia Others: David Burrows, Tambu Rashidi, Udaya Thomas	<ol style="list-style-type: none"> 1. Pre-service midwifery education curricula assessed and gaps in teaching FP knowledge and skills identified In postpartum/PAC/interconceptional periods 2. Capacity of core group of midwifery tutors and clinical preceptors strengthened to teach FP counseling and service provision <p>Year 2</p> <ol style="list-style-type: none"> 2. National guidelines revised as appropriate to ensure that midwives are empowered to provide all methods of FP, including IUD and implants. 3. Syllabus revised as appropriate to ensure competency of graduates in counseling and provision of FP services, including immediate postpartum and postabortion periods and interval IUD insertion and insertion of implants 4. At least one clinical site per school strengthened* to ensure that midwifery students have the opportunity to integrate FP into all services that they provide <p>* site strengthening includes reorganization of services, training /updating staff in FP counseling and skills and ensuring that they are fully implementing integrated FP/MH services</p>	<ol style="list-style-type: none"> 1. Form TWG that includes maternal, reproductive, newborn, and child health experts and midwifery leaders to carry out assessments, formulate guidelines, and revise curricula 2. Carry out technical update, clinical skills standardization, and TOT for core group of tutors and clinical preceptors in provision of FP services. 3. Strengthen clinical site 4. Begin teaching updated knowledge and skills to midwifery students 	ACCESS-FP Director initiated MCHIP in Ghana by supporting program staff who developed a work plan to assess pre-service curricula on FP knowledge particularly related to postpartum and postabortion care.	
7.4	Integration of FP into the CSHGP	LEAD: Michel P. Others: FP-TBD	<ol style="list-style-type: none"> 1. Review of FP integration in the Active Portfolio of CSHG grants 2. CSHG TRM module(s) updated to include strategies for community-based FP (i.e., mobile outreach services, depots, CBD workers, CBD of Depo Provera, referrals for LAPMs, etc.). 3. FP integrated further into CSHGP 	<ol style="list-style-type: none"> 1, Review active portfolio to identify the extent to which the grantees are addressing the PRH TP and GLPs 2. Convene CSHG and PRH teams to clarify focus of TRM updates and opportunities for integration of FP into CSHGP 3. Update Technical Reference Materials 4. Explore opportunities to integrate FP more clearly into CSHGP program guidelines, including the RFA, DIP Guidelines, and annual reporting guidelines. 	<ol style="list-style-type: none"> 1. About 42% of the CSHGP have plans to integrate FP/HTSP or already have at the community level. 2. Planning an FP/immunization integration meeting with FHI and other bilaterals and USAID in mid December 2009 3. The TRM have been updated 4. CSHGP is considering Creating an FP Integration category in the annual CSHGP RFA. MCHIP represented in PAC consortium at GHC and Senior Advisor RH/FP is co-chair of the FP task force 	

7.5	Using immunization contacts to promote birth spacing and increase access to FP services.	LEAD: Cat (FP), Robert (Immunization). Others: new FP Officer (FP); Jenny, Lora (Immunization)	1. Literature review and key informant interviews used to produce summary document 2. Analytic or conceptual framework developed to guide design of interventions 3. Plan for developing and testing immunization/FP interventions with countries in place	1. Co-host a consultative meeting with ACCESS/FP, to include CAs and other agencies and NGO partners to share implementation experience to date on integrating FP with immunization 2. Prepare a document analyzing and reviewing experience in linking FP and immunization services including programmatic tools 3. Select sites for pilot implementation and make site visits 4. Secure funding and obtain agreement from MOHs and partner agencies to participate in implementation in Year 2	MCHIP to look for synergies between FP and Immunization. A desk review of studies and projects has been initiated. MCHIP will plan a meeting among collaborating agencies, and global partners to develop a technical consultation during the second year. During the planning meeting the results of the lit review will be shared.	
7.6	Support PAC working group activities.	LEAD: Koki	1. Improve collaboration within CAs working on PAC 2. List of PAC messages that can be integrated into CSHGP program intervention areas	1. Provide facilitator for online forum on PAC training 2. Participate in USAID/PAC working group meetings 3. Develop PAC messages that can be integrated into CSHGP program activities	MCHIP was represented at semi-annual PAC Consortium meeting at GHI (5-09). Holly Blanchard agreed to be co-chair for the FPTF with Boniface Sebikali from Intrahealth. Together they developed a Postabortion Care Consortium Proposal to Form the Family Planning Task Force with specific objectives. The FPTF has 15 members	
7.7	Use the LiST tool to demonstrate the role of FP.	LEAD: IIP (Neff)	Better understanding of the contribution of FP of meeting MDGs 4 and 5	1. See activity description under 1.6: MCHIP will apply the evidence on birth spacing and mortality reduction to the List mortality calculations.	1. Worked with USAID to set up a meeting following the CHERG to review inputs related to neonatal and maternal health to ensure that LiST handles the inputs required for USAID and MCHIP. 2. Worked with USAID to produce a set of projections of the impact of scaled interventions on maternal and child mortality. 3. Conducted training sessions with USAID and MCHIP partners. See attached list of sheet 2. 4. Assisted in developing inputs related to modeling the impact of family planning on U5M	
7.8	Case studies documenting lessons learned on health systems elements that improve maternal and neonatal health.	LEAD: Rena			Rwanda has been selected as a case study country. A second country TBD.	
8. MALARIA						
8.1	Support to MCP Team	LEAD: Jennifer Y. Others: ???	1. PMI/MCP Team is supported in managing MCP portfolio. 2. Regional workshop organized 3. Basic knowledge management system created	1. Assist to update/develop reporting guidelines for grantees; 2. Review workplans and Annual Reports; 3. Provide input on MCP contributions to GH Portfolio Review Processes 4. Disseminate RFA 5. Organize regional workshop for grantees 6. Ad-hoc support to orient potential applicants to MCP 7. Create basic knowledge management system	1. Reporting guidance updated. 2. Workplans and annual reports reviewed. 3. PMI did not ask us to contribute to the GH Portfolio Review process. 4. RFA disseminated. 5. Regional workshop organized. 6. We were not contacted by any potential applicants last year. 7. PMI asked us to remove the KM system development from our workplan.	

8.2	Support to MCP Grantees	LEAD: Jennifer Y. Others: ???	<ol style="list-style-type: none"> 1. Grantees receive quality feedback on workplans and reports and receive TA when needed. 2. Grantees implement high quality community-based malaria programs and document their results. 	<ol style="list-style-type: none"> 1. Document grantee requests for support, and meet with grantees to discuss options for support. 2. Develop TA plans with grantees; 3. Provide technical support to grantees as requested (may include field visits) 4. Revise Malaria TRM 5. Create and deliver Elluminate course on Sustainability Planning for Community-based Malaria Projects 	<ol style="list-style-type: none"> 1. Each grantee was provided technical support. Specific ad-hoc requests were documented and submitted to PMI/MCP monthly. 2. TA plans were under discussion with three grantees. Two plans were developed (ASPI and LWR). 3. Each grantee received technical support. Grantees in Angola, Ghana and Tanzania (5 total organizations) were visited. 4. Malaria TRM revised and posted. 5. Elluminate course created and delivered, now posted on CORE website. 	
8.3	Support to In-country PMI teams	LEAD: Jennifer Y. Others: ???	<ol style="list-style-type: none"> 1. 2-3 national workshops co-organized (with CORE Group) 2. PMI in-country teams are supported to assist MCP grantees 	<ol style="list-style-type: none"> 1. Co-organize 2-3 National Partner Workshops 2. Ad-hoc support to country teams to orient potential applicants to MCP 3. Support to disseminate RFA, as requested 4. Coordinate grantee TA plans with in-country PMI activities 	<ol style="list-style-type: none"> 1. National workshop organized in Benin. MCHIP contributed to national workshop in Angola and provided input to workshop in Uganda. 2. There were no requests from country teams to assist with orienting potential applicants this year. 3. There were no requests from country teams to assist with disseminating the RFA this year. 4. Grantee TA plans were coordinated with in-country PMI activities, as appropriate. 	
8.4	Malaria in Pregnancy	LEAD: Elaine Roman Others: ???	<ol style="list-style-type: none"> 1. MIP service delivery bottlenecks reduced in up to 2 countries. 2. Global MIP resources/materials- MIP Implementation Guide and Malaria Resource Package- disseminated at one regional and/or global MIP meeting. 3. Global MIP resources/materials- MIP Implementation Guide and Malaria Resource Package- disseminated at 1-2 country level MIP meetings. 4. Technical guidance for MIP acceleration promoted through participation in at least one regional or global malaria control and prevention meeting 5. Development of up to two country-level lessons learned and best practices programming briefs. 	<ol style="list-style-type: none"> 1. Targeted Technical Assistance to Address Country Bottlenecks 2. Dissemination of Lessons Learned and Key Materials. 3. Participation in Global and/or Regional Events 4. Documentation of Lessons Learned and Best Practices 	<ul style="list-style-type: none"> ▪ MIP Implementation and Malaria Resource Package disseminated to PMI country teams. These tools provide relevant and important programming, training and reference resources to support countries in their efforts to scale up MIP programming in malaria endemic areas. ▪ Participated in the Roll Back Malaria MIP working group; Manila, Philippines- Oct. 2008. This led to the development of an initial strategy and prioritization of efforts within the Asia region to accelerate MIP prevention and control efforts. ▪ In collaboration with PMI, start up of documentation of best practices, lessons learned and bottlenecks addressed in Zambia. This documentation will be completed in MCHIP Year 2 and will yield greater insight to successful MIP programming throughout the region. ▪ MIP bottlenecks addressed in Nigeria. MCHIP provided technical guidance and support to help Nigeria address bottlenecks hindering implementation of Global Fund-supported MIP activities; specifically, this included meetings in four states (Zamfara, Kano, Bauchi and Niger) to disseminate national MIP strategies and guidelines. State policy makers were oriented to MIP issues and guidelines were distributed for dissemination to secondary and primary health care facilities. This effort was co-funded through the ACCESS Program. 	

8.5	Community Case Management (Malaria)	LEAD: Emmanuel Others: Mary C., Michel P., Jennifer Y., D. Marsh	See also Activity 4.2.1 Community case management of malaria introduced in 1-2 new countries (See Child Health sections above-Community Case Management of malaria is an integral part of package that includes pneumonia and diarrhea case management at community level.)	<ol style="list-style-type: none"> 1. Actively participate in global and regional policy and program discussions on home and community management of malaria (CCM) including GAPP, CCM Task Force and CCM.ORG 2. Transition selected CCM countries supported under BASICS to MCHIP assistance to continue to address issues of scale-up and sustainability. 3. Assist in the data-gathering and analysis by PMI country of CCM status (policy, geographic coverage, definition of CHW, etc) 4. Collaborate with other USAID funded health systems projects involved in malaria issues such as DELIVER, SPS, IMaD and HCI 5. Refine CCM training and supervisory guidelines and tools to include indicators of quality 6. Introduce CCM in 1-2 non-PMI new countries. 7. Increase community mobilization and participation to prevent malaria by the appropriate use of ITNs by pregnant women and under five children 	Worked with Global MCH and PMI to develop to develop a CCM pathway and components/benchmark and compile CCM tools. This is part of an effort to look for opportunities to collaborate for increased efficiency in the field. See also reporting under Activity 4.2.1	
9. Monitoring and Evaluation						
9.1	Develop M&E plans, conceptual models and guidance.	LEAD: Barbara Others: M&E Working Group	<ol style="list-style-type: none"> 1. Common understanding of MCHIP expected results and M&E approach 2. Common understanding of how MCHIP will document its results over the life of the program. Results reports submitted by MCHIP meet stakeholders needs 3. Improved understanding for the pathways to reducing maternal and newborn mortality 4. Standardized approach to M&E applied across MCHIP country programs. High quality data provided to USAID and other program stakeholders to understand program results and inform program implementation 5. M&E capacity of field-based M&E and program staff increased, with programs able to implement M&E plans and provide quality data to inform program implementation and for reporting to donors. M&E needs of MCHIP country programs met 	<ol style="list-style-type: none"> 1. Finalize the performance monitoring plan for MCHIP 2. Develop documentation plan and results reporting formats/templates for global reports to be submitted to USAID/Washington with input from MCHIP CTOs 3. Collaborate with MCHIP Research, Analysis and Evaluation team and stakeholders to develop a MCH-specific conceptual framework as part of the Common Evaluation Framework for the Scale-up to Achieve the Health MDGs 4. Create M&E guidance for country programs that buy into MCHIP with field support funds including: M&E plan template; expectations for M&E workplan and budgeting based on program size and scope; and guidance on data quality control and M&E capacity assessments 5. Develop a plan for providing M&E capacity building and other M&E technical assistance to MCHIP staff and partners as needed 	MCHIP PMP finalized and approved. Templates for quarterly and annual reports developed and approved. M&E guidance for country programs and plan for capacity building/technical assistance initiated. Reviewed common evaluation framework indicators and made recommendations for additional indicators/changes.	

9.2	Review and revise MNCH indicators and tools.	LEAD: Barbara Others: M&E Working Group, Rena, Jennifer	1. MNCH indicators reviewed and recommendations made for modifications and field testing. A new menu of MNCH indicators for use in performance based incentive programs developed, which are more clearly linked to the provision of high quality and high impact maternal, newborn and child services 2. Standardized data collection tools tailored to MCHIP program needs available and used by country programs (both MCHIP led and others) to generate standardized high quality data for program planning and reporting	1. Participate in ongoing efforts to review MNCH indicators (pneumonia/CCM, water and sanitation, pay for performance-related, etc.) and help provide recommendations for improving them and testing them as appropriate 2. Review standardized MCH data collection tools developed by Macro International and other organizations and adapt to MCHIP's needs	Met with Hygiene Improvement Project (HIP) to review WASH indicators and identify relevant indicators for newborn handwashing. Reviewed Rapid Health Facility Assessment and Jhpiego/AMDD EMOC tools and adapted elements for use in quality of care MNC/PE/E survey.	
9.3	Prepare results reports for USAID Washington and USAID Missions.	LEAD: Barbara Others: Activity and Country Program Managers	1. MCHIP program results synthesized and disseminated to stakeholders	1. Prepare quarterly, semi-annual and/or annual results reports as needed	Prepared and submitted two quarterly reports and began preparation of annual report.	
9.4	Participate in M&E working groups.	LEAD: Barbara Others: Jennifer L. and other Wrkg Grp members, as appropriate	1. Standardized approach to M&E ensured across MCHIP S.O.s and implementing partners. Operations research questions for MCHIP identified. MCHIP aware of, applying and disseminating M&E best practices	1. Attend key M&E working group meetings and help shape OR agenda for MCHIP (including the USAID/MEASURE Evaluation CA M&E working group, and the CORE Group M&E working group).	M&E staff participated in CORE group M&E working group, USAID's Global Bureau of Health M&E working group steering committee meeting and working group meeting.	
9.5	Help create MCHIP data management and reporting system.	LEAD: David K./Barbara Others: Dave Burrows, M&E and IM Working Groups	1. Framework, indicator/data entry forms and reports for M&E data system developed. Quality MCHIP program data available in a centralized data system, updated on a routine basis, and captured in standardized format	1. Work with MCHIP Information Management team to develop a M&E data system for tracking and reporting MCHIP results to USAID that is available on the MCHIP Portal	Decision made to use Jhpiego's planned Results Information System for Excellence.	
9.6	Provide M&E technical assistance, including capacity building, to core-funded MCHIP country programs and CSHGP grantees.	LEAD: Barbara Others: Jennifer L. and other Wrkg Grp members, as appropriate	1. M&E capacity of field-based M&E and program staff increased, with programs able to implement M&E plans and provide quality data to inform program implementation and for reporting to donors. M&E needs of MCHIP country programs met 2. M&E needs of country programs met. Quality data	1. Assist MCHIP country programs and grantees with design and implementation of their M&E plans 2. Help build the capacity of MCHIP staff, partners and consultants.	Ongoing technical assistance provided for M&E to grantees and MCHIP country programs funded under core. M&E capacity building activities carried out in Nigeria with field support funds. Also, sessions conducted at Jhpiego's country director meeting in June 2009.	

10. Africa/SD					
10.1	Build on training of tutors in FP carried out by Africa's Health in 2010.	LEAD: Patricia Others: ?	1. Plan developed for PY 2 to build on training of tutors in FP carried out in 2008 in Kenya, Tanzania, and Uganda supported by ECSA-HC with collaboration by AH 2010 and the Capacity Project.	1. In collaboration with AH 2010 and their partners discuss the recommendations made after their follow up of tutors trained in TZ in 2008 and establish priorities and detailed workplan for the coming program year: <ul style="list-style-type: none"> - Continuing training of tutors in one or two countries where activities were conducted in conjunction with MAISHA and APHIAs (Kenya, Uganda and Tanzania) in order to ensure that at least one tutor/school is updated. - Establishing a regional training site where tutors can be updated on a continuous basis - Support of tutors in their schools with materials such as manuals, anatomic models, etc. 	This activity is now scheduled to take place in Year 2.

All other Africa SD-funded activities are in the CH and Immunization plans above

Annex C: Global Monitoring and Evaluation Framework for MCHIP with Results for Year One

Table 1: 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	DATA SOURCE/ COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	BASE- LINE ⁸	TARGET YEAR ONE	ACTUAL YEAR ONE
Goal: Measurable reductions in under-five and maternal mortality and morbidity						
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, 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.	DSS, DHS, census modeled methods, verbal autopsy, community-based vital events informants, Sampling at Service Sites method; and modeling with the LIST tool as appropriate.	Every 3 to 5 years	0	0	0
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, depending on the scale of MCHIP-supported interventions. The indicator will be disaggregated by newborn and under five. This includes contributions by CSHGP grantees.	DHS, MICS, MOH surveys, population-based survey by MCHIP if funded by USAID Mission(s); LIST Tool	Every 2 to 5 years	0	0	CSHGP: ⁹ 1 MCHIP Country ¹⁰ 8 ¹¹ (CSHGP Countries)

⁸ Baseline refers to October 2008. End of Project refers to September 2013.

⁹ CSHGP grants work at sub-national levels. Information from CSHGP for this report is from projects that finished in FY08.

¹⁰ India, which is both an MCHIP and a CSHGP country

¹¹ CSHGP grants in: Senegal, Uganda, India, Albania, Cambodia, Sierre Leon, Tajikistan, and Afghanistan.

INDICATOR	DEFINITION AND DISAGGREGATION	DATA SOURCE/ COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	BASE- LINE ⁸	TARGET YEAR ONE	ACTUAL YEAR ONE
3. Estimated number of lives saved among women of reproductive age in 20 focus countries ¹² as a result of MCHIP-supported interventions, including CSHGP grants in these countries. ¹³	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.	LiST tool	Every 2 to 5 years	0	0	0
4. Estimated number of lives saved ¹⁴ among children under five in 20 focus countries as a result of MCHIP-supported interventions, including CSHGP and MCP-supported grants in these countries. ¹⁵	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.	LiST tool	Every 2 to 5 years	0	0	CSHGP: 5,800 ¹⁶ (GH MCH priority countries) 7,200 ¹⁷ (All CSHGP grants)

¹² To calculate the targets for this indicator (C.) as well as (D.), the MCHIP selected 10 **illustrative** countries from a priority list of 32. Several criteria were considered during this selection: Availability of data; Population size; Geographic diversity; epidemiologic profile (mix of tiers); post conflict; mentioned in RFA; presence of partner programs. The countries selected include: Bangladesh, Afghanistan, Nigeria, Ethiopia, DR Congo, Tanzania, Indonesia, India, Malawi, Mozambique. Projections were made using the following algorithms 1) MDG4: If a country is on track for MDG4, then we will help meet the MDG early, by 2013; if a country is not on track, then we help to go halfway to MDG4 by 2013; 2) MDG 5: we will help reduce maternal deaths by 33%.

¹³ 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.

¹⁴ Lives saved were calculated using the 2009 version of the List Tool.

¹⁵ 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.

¹⁶ CSHGP grantees that finished in FY08 contribute lives saved in the following MCH priority countries: Senegal, Uganda, India, Cambodia, and Afghanistan.

¹⁷ Lives saved in entire portfolio of CSHGP grants that finished in FY08. They were in the following countries: Senegal, Uganda, India, Albania, Cambodia, Sierra Leon, Tajikistan, and Afghanistan.

INDICATOR	DEFINITION AND DISAGGREGATION	DATA SOURCE/ COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	BASE- LINE ⁸	TARGET YEAR ONE	ACTUAL YEAR ONE
Program Objective: Support the introduction, scale-up and further development of high-impact MCH interventions, including the program approaches to effectively deliver those interventions, to achieve measurable reductions in under-five and maternal mortality and morbidity						
5. Number of MCHIP countries demonstrating improvement in population coverage of high impact MNCH interventions since the last survey***	<p>High-impact MNCH intervention indicators to track will vary by country and will be selected largely from the MDG Countdown/Common Evaluation Framework core indicator list, which includes: ¹⁸</p> <ul style="list-style-type: none"> a. Exclusive breastfeeding (< 6 months) b. Breastfeeding plus complementary food (6-9 months) c. Vitamin A supplementation coverage d. Measles immunization coverage e. DPT3 immunization coverage f. HiB 3 g. Oral rehydration and continued feeding h. Insecticide-treated net coverage (children under five) i. Anti-malarial treatment for children < 5 j. Prevention of mother to child transmission of HIV transmission k. Careseeking for pneumonia l. Antibiotic treatment for pneumonia m. Contraceptive prevalence n. Unmet need for family planning o. Antenatal care (4 or more visits) p. Neonatal tetanus protection q. Intermittent preventive treatment r. Skilled attendance at delivery s. C-section rate t. Timely initiation of breastfeeding (within one hour) u. Postpartum care for mothers (within two days of birth) v. Postnatal care for newborns (within two days of birth) <p>Coverage of handwashing for the newborn will be measured with a proxy knowledge indicator:</p> <ul style="list-style-type: none"> w. % of recent mothers who know to use soap for handwashing at critical times x. % of recent mothers who live in households with 	DHS, MICS, MIS, SPA, population-based survey by MCHIP if funded by USAID Missions, CSHGP Rapid CATCH surveys	Every 2 to 5 years	0	0	1 (India under CSHGP) India demonstrated progress in indicators: b, d, g,o,p,v,x,cc

¹⁸ Calculated based on the following equivalent indicators from CSHGP grantee KPC surveys at baseline and final for grants that ended in FY08.

INDICATOR	DEFINITION AND DISAGGREGATION	DATA SOURCE/ COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	BASE- LINE ⁸	TARGET YEAR ONE	ACTUAL YEAR ONE
	<p>soap and water at the handwashing station commonly used by family members (static or mobile station)</p> <p>Other FP, ANC and malaria-related coverage indicators include:</p> <p>y. % of mothers with children under 24 months who are currently using FP</p> <p>z. % of postpartum women who intend to wait at least 2 years before becoming pregnant again</p> <p>aa. Insecticide-treated net coverage (pregnant women)</p> <p>bb. % of pregnant women who received two doses of tetanus toxoid</p> <p>cc. % of pregnant women who received iron/folate</p>					
6. Number of MCHIP countries demonstrating greater equity in use of high impact MNCH interventions since the last survey	<p>Select coverage of high impact MNCH intervention indicators (e.g., taken from the coverage indicators listed under indicator 5 above) will be disaggregated by wealth quintile in a small number of countries to examine equity in use of the interventions. Increased equity means an increase of at least 10% for the lowest two quintiles. This type of assessment will require larger sample sizes to permit quintile analysis and will likely require the use of field support funds. This indicator will be disaggregated to identify CSHGP contributions, if any.</p>	DHS, MICS, MIS, population-based survey by MCHIP if funded by USAID Missions, CSHGP Rapid CATCH surveys ¹⁹	Every 2 to 5 years	0	0	0

¹⁹ CSHGP grantees are not required to conduct equity analyses, as this requires a larger sample size than the typical KPC survey, but one grantee has done so to date and others may in future.

INDICATOR	DEFINITION AND DISAGGREGATION	DATA SOURCE/ COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	BASE- LINE ⁸	TARGET YEAR ONE	ACTUAL YEAR ONE
Sub-objective 1: Increased availability and use of appropriate high-impact maternal, neonatal and child health interventions, including supportive family planning interventions, through delivery approaches that fit the program and health system capabilities and based on the epidemiologic, cultural and geographic needs of each country.						
Health Policy and System Strengthening (training, HMIS/IS, logistics, and supervision systems)						
7. Number of (national) policies drafted with USG support*	This refers to the number of national laws, policies ²⁰ , 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.	Final policy document; program records	Annual	0	3 India, DRC, Mozambique (CxCa)	4 total: <ul style="list-style-type: none"> ▪ 3 in Mozambique ▪ 1 in DRC²¹
8. Number of MCHIP countries demonstrating improved use of data for decision-making/priority setting with MCHIP support	For example, this includes the use of the LiST to inform national or sub-national program planning. This may also include improved use of HMIS, supervision or quality assurance data for decision making.	Meeting minutes, policy documents, program records	Annual	0	2 India, DRC	2 India, DRC ²²
9. Number of MCHIP countries that have introduced innovative health financing schemes with MCHIP support	This includes performance-based incentive (PBI) schemes, pay for performance, franchising, vouchers, and insurance schemes at a national or sub-national level.	Program records	Semi-annual	0	0	0

²⁰ 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

²¹ The 3 national policies in Mozambique drafted with USG support are the National Plan for the Humanization of Healthcare, including the Model Maternity Initiative; Guidelines for Maternal and Neonatal Audit Committees; and National Family Planning Strategy. The national policy drafted in DRC with USG support is the National Newborn Policy.

²² For the integrated community case management, which is a national program, there are a set of forms for routine data collection which are analyzed to indicate the performance of individual relays (CHW) in order to target support. There also some "road map forms" to indicate implementation of recommended processes such as scheduled follow up and meetings. They are used to follow up the quality of implementation.

INDICATOR	DEFINITION AND DISAGGREGATION	DATA SOURCE/ COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	BASE- LINE ⁸	TARGET YEAR ONE	ACTUAL YEAR ONE
Capacity Building						
10. Number of people trained through USG -supported programs*	<p>This indicator will be disaggregated by training topic and for CSHGP and MCP contributions. Training topics include:</p> <ul style="list-style-type: none"> ▪ Number of people (health professionals, primary health care workers, community health workers, volunteers, non-health personnel) trained in maternal/newborn health through USG (MCHIP)-supported programs ▪ Number of people (health professionals, primary health care workers, community health workers, volunteers, non-health personnel) trained in child health and nutrition through USG (MCHIP)-supported programs ▪ Number of people (medical personnel, health workers, community workers, etc.) trained in malaria treatment or prevention through USG (MCHIP)-supported programs ▪ Number of people (health professionals, primary health care workers, community health workers, volunteers, non-health personnel) trained in FP/RH (including training in service delivery, communication, policy and systems, research, etc.) through USG (MCHIP)-supported programs ▪ Number of health workers trained in PMTCT or other HIV/AIDS-related service provision (e.g., male circumcision) according to national and international standards ▪ Number of people trained in monitoring and evaluation/operational research 	Pre-service education school records; Training information monitoring system	Quarterly	0	Core-150 Core-150 TBD Kenya, B.F. TBD, Mali TBD TBD 17 (CSHGP, Kenya)	April-Sept' 09- Nigeria 154 Nurses/midwives and NYSc Doctors were trained in MNH and 77 in FP/RH while 217 volunteers including Male motivators were also trained Mozambique: <ul style="list-style-type: none"> ▪ 89 in M&E, 29 in MNH and 38 in FP/RH DRC- <ul style="list-style-type: none"> ▪ child health/CCM: 189 CHW/ 42 HW ▪ child health/DD: 189 CHW/ 687 HW MNH-224 HW

INDICATOR	DEFINITION AND DISAGGREGATION	DATA SOURCE/ COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	BASE- LINE ⁸	TARGET YEAR ONE	ACTUAL YEAR ONE
11. Percent of skilled birth attendants who know how to manage severe preeclampsia/eclampsia	Number of skilled birth attendants who know how to manage severe preeclampsia/eclampsia/Total number of skilled birth attendants assessed	PE/E case study	Annual	TBD	TBD	N/A
12. Number of countries with pre-service education strengthened to improve skilled birth attendance**	This includes updating curricula and improving the skills of tutors. This indicator will be disaggregated by type of curriculum/cadre of provider., e.g. midwife, nurse, clinical officer, etc.	Program records	Annual	0	2 Malawi, Ghana	N/A
Service Delivery and Use						
13. Number of MCHIP-supported health facilities demonstrating compliance with clinical standards	Health facilities from countries receiving MCHIP assistance will receive independent assessments of compliance with at least one clinical standard issued by a national authority, during the previous 12 months. Sampling frame is the facilities where USG (MCHIP) provided assistance on improving health systems and which are feasible to visit.	Quality improvement assessment tool, Tracer condition assessment, health facility survey, supervision visit reports	Annual	0	TBD- Mali TBD- Mozambiq ue TBD- Nigeria	Mozambique-0

INDICATOR	DEFINITION AND DISAGGREGATION	DATA SOURCE/ COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	BASE- LINE ⁸	TARGET YEAR ONE	ACTUAL YEAR ONE
14. Number of countries with introduction of high impact MNCH interventions through MCHIP supported activities and CSHGP grants in MCHIP supported countries**	<p>This includes:</p> <ul style="list-style-type: none"> ▪ PPH prevention (at least 25% of facilities in one district)** ▪ PPH treatment (at least 25% of facilities in one district)** ▪ 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-based infection prevention management (integrated handwashing into their community-based newborn interventions in at least one district)** ▪ community-based treatment of pneumonia (children < 5)** ▪ management of asphxia in the newborn (home and facility settings)** <p>This information will be disaggregated by MCHIP supported activities and CSHGP grants.</p>		Annual	0	PPH/P- 3 Mali (core) Nigeria, DRC PPH/T-3 Mali (core) Nigeria, DRC Eclampsia- 1 PNC/ENC- 3 (Bang Mali India) KMC- 2(India, Mali) CB-IP-1 (India) CB-Pneu.-1 (Kenya) Asphxia-1 (Mali)	PPH/P-2 (Nigeria, DRC) PPH/T-2 (Nigeria, DRC) Eclampsia- 1 (Nigeria) PNC/ENC: 2 (Bang, AKF ²³ India under CSHGP) KMC-0 CB-IP-0 CB-Pneu: 2 (Kenya, Mali) Asphyxia-1 (Nigeria)

²³ Aga Khan Foundation (AKF) CSHGP project that ended in FY08

INDICATOR	DEFINITION AND DISAGGREGATION	DATA SOURCE/ COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	BASE- LINE ⁸	TARGET YEAR ONE	ACTUAL YEAR ONE
15. Number of countries with expansion of high-impact MNCH interventions through MCHIP-supported activities and CSHGP grants in MCHIP supported countries**	<p>This includes:</p> <ul style="list-style-type: none"> ▪ Essential obstetric care** ▪ PPH prevention** (at least 20% of facilities in the country)** ▪ PPH treatment (at least 20% of facilities in the country)** ▪ Postnatal and essential newborn care (3 or more districts) ▪ Kangaroo Mother Care (facility-based KMC services in 3 or more districts)** ▪ Integrated package of MNCH/FP interventions** ▪ community-based treatment of pneumonia (children < 5)** <p>This information will be disaggregated by MCHIP supported activities and CSHGP grants.</p>		Annual	0	EOC-2 Nigeria, Moz Eclampsia-0 PPH/P-0 PPH/T-0 PNC/ENC- Nigeria Int.-0 CB-IP-1 (India) Integrated-0 CB-Pneu.-1 (DRC)	EOC-2 (Nigeria, Moz.) CB-IP-0 CB-Pneu.-1 (DRC)
16. Number of countries with strengthened postpartum care linked to postnatal care**		Program records	Annual	0	2 Mali, Bang	1 Bangladesh
17. Number of countries with strategies to revitalize ORT use**		Program records	Annual	0	2 Kenya DRC	1-DRC
18. Number of clients attending essential MNCH services with integrated FP at MCHIP-supported facilities who received FP counseling	Essential MNCH services include ANC, postabortion care, postpartum care, well-baby/immunization services.	HMIS/service statistics	Quarterly	0	TBD	April-Sept in Nigeria 105,953 ANC clients and 25,527 postpartum care
19. 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). Targets will be set for core-funded work only.	HMIS/service statistics or population-based survey (numerator)	Quarterly	0	TBD	Nigeria total from April-Sept was 28,336

INDICATOR	DEFINITION AND DISAGGREGATION	DATA SOURCE/ COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	BASE- LINE ⁸	TARGET YEAR ONE	ACTUAL YEAR ONE
20. Number of women receiving active management of the third stage of labor (AMSTL) through USG-supported programs*	Number of women giving birth who received AMSTL through USG-supported programs. Targets will be set for core-funded work only.	HMIS/service statistics	Quarterly	0	TBD	In Nigeria total from April-Sept was 15,688
21. Number of newborns receiving antibiotic treatment for infection from appropriate health workers through USB-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. Targets will be set for core-funded work only.	HMIS/service statistics or population-based survey (numerator)	Quarterly	0	0	In Nigeria total from April-Sept was 2,668
22. Number of newborns receiving essential newborn care through USG-supported programs*	Number of newborn infants who receive essential newborn care (clean cord care, drying and wrapping, immediate breastfeeding) from trained facility, outreach or community health workers through USG-supported programs. Targets will be set for core-funded work only.	HMIS/service statistics or population-based survey (numerator)	Quarterly	0	TBD	In Nigeria total from April-Sept was 14,529
23. Number of postpartum/newborn visits within 3 days of birth in USG-assisted programs*	Number of postpartum/newborn visits within 3 days of birth (Includes all skilled attendant deliveries plus facility or outreach postpartum/newborn visits for mothers/newborns who did not have SBA delivery). Targets will be set for core-funded work only.	HMIS/service statistics or population-based survey (numerator)	Quarterly	0	TBD	In Nigeria total from April-Sept was 19,309
24. 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. Targets will be set for core-funded work only.	HMIS/service statistics or population-based survey (numerator)	Quarterly	0	TBD	N/A

INDICATOR	DEFINITION AND DISAGGREGATION	DATA SOURCE/ COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	BASE- LINE ⁸	TARGET YEAR ONE	ACTUAL YEAR ONE
25. Number of cases of child diarrhea treated in USAID-assisted programs* (group by newborn, child health)	Number of cases of child diarrhea treated through USG-supported programs with: a) oral rehydration therapy (ORT), b) zinc supplements. Targets will be set for core-funded work only.	HMIS/service statistics or population-based survey (numerator)	Quarterly	0	Core-3600	DRC: 1595 children <5 received zinc or ORS
26. 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. Targets will be set for core-funded work only.	HMIS/service statistics or population-based survey (numerator)	Quarterly	0	0	DRC-1167
Sub-objective 2: Support USAID's participation in global leadership in maternal, neonatal and child health, including further development and promotion of improved approaches to increase coverage of health, nutrition and supportive family planning interventions.						
27. Number of international policies, standards of care and strategies developed or revised to promote adoption of high-impact MCHIP-supported MCH interventions and approaches, including CSHGP-supported MCH interventions and approaches	This refers to the number of international policies/standards of care/strategies developed or revised by international leaders such as WHO, GAVI and other UN agencies to promote availability and use of high-impact MCHIP priority interventions and approaches, including FP.	Policy documents and program records	Annual	0	1 (GAPPS mtg. strategy)	3 <ul style="list-style-type: none"> ▪ GAPPS mtg. strategy ▪ joint statement on home-based PNC ▪ Helping Babies Breathe training package
28. Number of countries where increased resources for high-impact MNCH interventions were leveraged	This could include the MOH or other donors investing more towards, or scaling up, high-impact MNCH intervention supported by MCHIP.	Program records	Annual	0	0	0
29. Number of e-learning courses created or revised		Program records	Annual	0	0	0

INDICATOR	DEFINITION AND DISAGGREGATION	DATA SOURCE/ COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	BASE- LINE ⁸	TARGET YEAR ONE	ACTUAL YEAR ONE
30. Number of studies ²⁴	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.	Program records	Annual	0 (Y1-1 in Malawi)	34 India, PE/E, ORT/ORS analysis, Immunization analysis, and 30 CSHGP evaluations/OR studies	34 <ul style="list-style-type: none"> ▪ CSHGP: 25²⁵ ▪ 9 immunization-related²⁶

²⁴ 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.

²⁵ CSHGP: 10 Final Evaluations and 15 Mid-term evaluations

²⁶ **Immunization studies:**

Contributed to WHO in the development of:

- WHO plan to analyze gender/sex issues in immunization as a member of a WHO TAG
- Paper (as author) with WHO on Periodic Intensification of Routine Immunization (PIRI)
- Programmatic "companion piece" (as author) with WHO to help national managers operationalize/interpret WHO's consolidated immunization schedules
- review paper (as author) on Epidemiology of the Unimmunized (review of the gray literature)
- peer-reviewed article on routine immunization in Africa in the Bulletin of WHO (as an author)
- peer-reviewed article on "Reaching every district (RED) approach to strengthen routine immunization services: evaluation in the African region" with WHO and CDC published in Journal of Public Health in June 2009

Contributed as a member of the GAVI Civil Society Task Team to development of:

- GAVI reviews of progress of engaging civil society within GAVI governance and country implementation

Contributed to USG/USAID to:

- "Using Data to Guide Action in Polio Health Communications - experience from the Polio Eradication Initiative (PEI)" and "Communication for Polio Eradication: Improving the Quality of Communication Programming through Real-time Monitoring and Evaluation" (co-author for both) under peer-review for planned publication in 2010 in Journal of Health Communication.

INDICATOR	DEFINITION AND DISAGGREGATION	DATA SOURCE/ COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	BASE- LINE ⁸	TARGET YEAR ONE	ACTUAL YEAR ONE
31. Number of countries to which MNCH approaches, reference materials, guides and tools have been disseminated with MCHIP support	<p>Dissemination may take place through peer-reviewed journals, conferences, and/or other media. Examples include Newborn SOTA.</p> <p>For the CSHGP grantees, examples of tools and reference materials include: knowledge, practice and coverage survey (KPC); rapid health facility assessment (RHFA); Sustainability tool; MTE and FE guidelines; and technical reference materials (TRMs). Dissemination includes posting on the MCHIP Web site or presentation at meetings and conferences.</p>	Program records	Annual	0	15	19 ²⁷ <ul style="list-style-type: none"> ▪ 7 MCHIP Year 1 countries²⁸ ▪ Tanzania, Benin, Liberia, Madagascar, USA ▪ 8 by CSHGP²⁹

²⁷Disseminated immunization materials to:

- Benin
- DRC
- India
- Kenya
- Madagascar
- Nigeria
- Southern Sudan
- USA: draft USA National Vaccine Plan and presentation at an Institute of Medicine review of the plan;

²⁸ MCHIP year one countries in include India, Bangladesh, DRC, Kenya, Mozambique, S, Sudan and Nigeria.

²⁹ MNCH approaches, reference materials, guides and tools were disseminated to new CSHGP grants in the following countries: Afghanistan, Pakistan, Nepal, Nicaragua, Burundi, India, Uganda and Liberia .

INDICATOR	DEFINITION AND DISAGGREGATION	DATA SOURCE/ COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	BASE- LINE ⁸	TARGET YEAR ONE	ACTUAL YEAR ONE
32. Number of conferences and professional meetings that MCHIP staff contribute to at the country, regional and global levels		Program records	Semi-annual	0	Confs./mtgs.-4	26 total: <ul style="list-style-type: none"> ▪ GHC ▪ USAID mini U. ▪ Int'l conf. on prematurity and stillbirth ▪ WHO/GAVI new vaccine meeting ▪ 2 BASICS end of project meetings ▪ JHU Newborn care and data analysis ▪ 19³⁰
Sub-objective 3: Assist PVO/NGOs and their local partners supported by the CSHGP and PMI MCP programs to design, implement, monitor and evaluate innovative, effective, and scalable community-oriented strategies that deliver integrated high impact interventions to vulnerable populations.						

³⁰ **Immunization Conferences MCHIP contributed to:**

- Inter-country meeting on RED
- EPI Managers meetings in Africa (3 Central (Gabon), East (Kenya) and West (Burkina Faso))
- Task Force on Immunization Meeting
- WHO Review of the WHO/UNICEF Estimates of National Immunization Coverage
- WHO Technology and Logistics Advisory Committee (sub-group chair of this group)
- WHO/PATH Project Optimize Program Advisory Group meeting (member)
- WHO Meeting on Introduction of New and Underutilized Vaccines
- WHO First Meeting of the ad hoc Advisory Committee on IVR Project on Gender and Immunization (member)
- WHO Meeting on Introduction of New and Underutilized Vaccines
- WHO SAGE Meeting
- Meeting on USA National Vaccine Plan (including Institute of Medicine review of the plan)
- Meetings of the GAVI Civil Society Task Team (CSTT) (member)
- Global Immunization Meeting
- Inter-Agency Task Force on Communication for Immunization and Polio Eradication (organized by UNICEF and WHO) - presented and co-facilitated
- Roundtable on Experience from US and International Immunization Communication Efforts (presented and assisted with organizing) - polio-funded
- Health Communication: Polio Lessons meeting (presented and assisted with agenda; organized by USAID and CI) - polio funded
- Global Health Conference (staff presented on use of PDAs for field health supervision in Madagascar and computerized planning tool for routine immunization in India)

INDICATOR	DEFINITION AND DISAGGREGATION	DATA SOURCE/ COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	BASE- LINE ⁸	TARGET YEAR ONE	ACTUAL YEAR ONE
33. Number of innovations or promising practices of CSHGP grants documented and supported by SO3.	<p>Demonstration of innovations and promising practices includes:</p> <p>CSHGP Operations Research Studies supported through TA from MCHIP SO3;</p> <p>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;</p> <p>Documentation of successful projects</p>	Internal SO3 management information system and MCHIP management system	Annual	0	5	5 ³¹
34. Number of CSHGP grantee innovations or promising practices incorporated into MCHIP country programs.	<p>Demonstration of innovations and promising practices includes:</p> <p>CSHGP Operations Research Studies supported through TA from MCHIP SO3;</p> <p>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;</p> <p>SO3 organized TAG, for example on equity;</p> <p>Documentation of successful projects</p>	Internal SO3 management information system and MCHIP management system	Annual	0	0	0

³¹ Last year MCHIP PVO/NGO strengthening team supported 5 innovation grants to the following organizations: World Vision (Afghanistan); Helen Keller Institute (Nepal); Concern Worldwide (Burundi); Catholic Relief Services (Nicaragua); and Aga Khan Foundation (Pakistan).

INDICATOR	DEFINITION AND DISAGGREGATION	DATA SOURCE/ COLLECTION METHOD	FREQUENCY OF DATA COLLECTION	BASE- LINE ⁸	TARGET YEAR ONE	ACTUAL YEAR ONE
35. 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).	Internal SO3 management information system and MCHIP management system	Annual	0	0	1 ³²
36. Number of in-country ³³ malaria workshops organized		Internal SO3 management information system	Annual	0	1	2 ³⁴

³² The CSHGP developed Rapid Health Facility Assessment (RHFA) was used to inform the MCHIP Pre-Eclampsia/ Eclampsia study.

³³ MCP currently emphasizes in-country workshops with participants from various countries rather than national workshops with participation only from host country.

³⁴ Workshops held in Benin and Angola