



Maternal and Child Health Integrated Program (MCHIP)

YEAR THREE

ANNUAL IMPLEMENTATION PLAN

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ABBREVIATIONS AND ACRONYMS: TECHNICAL

ACT	Artemisinin Combination Therapy
AMTSL	Active Management of Third Stage of Labor
ANC	Antenatal Care
AOTR	Agreement Officer's Technical Representative
ARI	Acute Respiratory Infection
ART	Antiretroviral Treatment
ARV	Antiretroviral
BBL	Brown Bag Lunch
BEmONC	Basic Emergency Obstetric and Newborn Care
CB	Community-Based
CBIMNS	Community-Based Infection Management of Neonatal Sepsis
CCM	Community Case Management
CDD	Control of Diarrheal Disease
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CHW	Community Health Worker
CKMC	Community Kangaroo Mother Care
cMYP	Comprehensive Multi-Year Plans
CPG	Clinical Practice Guideline
CRT	Corporate Representative Team
DHMT	District Health Management Team
DHS	Demographic and Health Survey
DIP	Detailed Implementation Plan
DOTS	Directly Observed Treatment
EmONC	Emergency Obstetric and Newborn Care
EMT	Executive Management Team
ENC	Essential Newborn Care
FP	Family Planning
HCWM	Healthcare Waste Management
HF	Health Facility
HFS	Healthy Fertility Study
HMIS	Health Management Information System
HQ	Headquarters
HSS	Health Systems Strengthening
iCCM	Integrated Community Case Management
IEC	Information, Education and Communication
IPTi	Intermittent Preventive Treatment for Infants
IPTp	Intermittent Preventive Treatment for Pregnant Women
IRB	Institutional Review Board
IRS	Indoor Residual Spraying
ITN	Insecticide-Treated Bed Net
IYCF	Infant and Young Child Feeding
KM	Knowledge Management
KMC	Kangaroo Mother Care
LAC	Latin America and Caribbean
LBW	Low Birth Weight

LiST	Lives Saved Tool
LOP	Life of Program
MC	Male Circumcision
MCH	Maternal and Child Health
MC-MOVE	Models for Optimizing the Volume and Efficiency of MC Services
MC-UH	Maternal-Child Urban Health
MDG	Millennium Development Goal
MICS	Multiple-Indicator Cluster Survey
MIP	Malaria in Pregnancy
MIYCN	Maternal, Infant and Young Child Nutrition
MMR	Maternal Mortality Ratio
MNCH	Maternal, Newborn and Child Health
MOP	Malaria Operational Plan
MOU	Memorandum of Understanding
MTE	Mid-Term Evaluation
NICHD	National Institute of Child Health and Human Development
NMR	Newborn Mortality Rate
NPDA	Nutrition Program Design Assistant Tool
OPVO	Oral Polio Vaccine (partial vaccination)
OR	Operations Research
ORT	Oral Rehydration Treatment
PBI	Performance-Based Incentive
PDME	Program Design, Monitoring and Evaluation
PHCC	Primary Health Care Clinic
PMT	Partnership Management Team
PRH	Population and Reproductive Health
QoC	Quality of Care
PAC	Postabortion Care
PE/E	Pre-Eclampsia/Eclampsia
PMTCT	Prevention of Mother-to-Child Transmission of HIV
PPFP	Postpartum Family Planning
PPH	Postpartum Hemorrhage
PPIUCD	Postpartum Intrauterine Contraceptive Device
PSE	Pre-service Education
RDT	Rapid Diagnostic Test
RI	Routine Immunization
RISE	Results Information System for Excellence
SBA	Skilled Birth Attendance/Attendant
SBM-R	Standards-Based Management and Recognition
SOTA	State of the Art
SOW	Scope of Work
TA	Technical Assistance
TRM	Technical Reference Materials
TWG	Technical Working Group
VPD	Vaccine-Preventable Disease
WASH	Water, Sanitation and Hygiene

DONORS, PROGRAMS AND ORGANIZATIONS

AAP	American Academy of Pediatrics
ACCESS	Access to Clinical and Community Maternal, Neonatal and Women's Health Services Program
ARCI	International Advanced Research Centre
ASI	Accelerated Saturation Initiative
BASICS	Basic Support for Institutionalizing Child Survival
BMGF	Bill & Melinda Gates Foundation
CAMBIO	Changing AMTSL Behavior in Obstetrics
CATCH	Core Assessment Tool for Child Health
CI	Communications Initiative
CSHGP	USAID's Child Survival Health Grants Program
CSO	Civil Society Organization
ECSA-CON	East, Central and Southern Africa Health Secretariat
EPI	Extended Programme on Immunization
FIGO	International Federation of Gynecology and Obstetrics
GAPP	Global Action Plan for Prevention and Control of Pneumonia
GAPPS	Global Alliance for Prevention of Prematurity and Stillbirths
GAVI	GAVI Alliance (formerly the Global Alliance for Vaccines and Immunization)
GDA	Global Development Alliance
GHI	Global Health Initiative
GIM	Global Immunization Meeting
HBB	Helping Babies Breathe
HIDN	Health, Infectious Diseases and Nutrition
ICDDR,B	International Centre for Diarrhoeal Disease Research, Bangladesh
ICM	International Confederation of Midwives
IMMbasics	IMMUNIZATIONbasics
IPAC	Immunization Program Advisory Committee
IST	Inter-country Support Team
JHBSPH	Johns Hopkins Bloomberg School of Public Health
IKMCF	International KMC Foundation
MCC	Millennium Challenge Corporation
LSHTM	London School of Hygiene and Tropical Medicine
MCP	Malaria Communities Program
MOH	Ministry of Health
MVP	Meningitis Vaccine Program
NGO	Nongovernmental Organization
NUVI	New and Underutilized Vaccines Implementation
OHA	Office of HIV/AIDS (Global Health Bureau, USAID)
PAHO	Pan American Health Organization
PEI	Polio Eradication Initiative
P4P	Pay for Performance
PMI	President's Malaria Initiative
POPPHI	Prevention of Postpartum Hemorrhage Initiative
POUZN	Point of Use Water Disinfection and Zinc Treatment Project
PVO	Private Voluntary Organization
RCQHC	Regional Centre for Quality of Health Care

RED	Reaching Every District
SC4CCM	Supply Chain for Community Case Management of Pneumonia and Other Common Diseases of Childhood
SPS	Strengthening Pharmaceutical Systems
TAG	Technical Advisory Group
TFI	Task Force on Immunization
UHEP	Urban Health Extension Program
UNICEF	United Nations Children's Fund
URC	University Research Co.
USAID	U.S. Agency for International Development
USG	U.S. Government
WHO	World Health Organization
WHO/AFRO	World Health Organization/Regional Office for Africa
WHO/SAGE	World Health Organization/ Strategic Advisory Group of Experts

Introduction

This document represents the Annual Implementation Plan for the third Program Year of MCHIP: 1 October 2010–30 September 2011.¹ The previous program year was a period of significant growth and transition for MCHIP with the addition of 15 countries, replacement of three key personnel and recruitment of critical technical staff. Currently working in 37 countries, including all Global Health Initiative (GHI) Plus Phase 1 countries (Table 1), MCHIP is poised to build on the platform from prior program years to address strategic opportunities for integration and will continue to contribute to improved health outcomes for women, newborns and children.

This document begins with an overview of the MCHIP strategic approach. The approach highlights MCHIP's alignment with principles and components of the GHI, commitment to appropriate integration and use of the U.S. Agency for International Development (USAID) Acceleration Framework and modeling to prioritize interventions. This is followed by an overview of the cross-cutting and technical components of the workplan for core and regional bureau (AFR/SD and Latin America and Caribbean [LAC]) funded activities. Each technical section addresses global leadership, describes long-term strategy and outlines Year 3 expected results. Attachment 1 provides the MCHIP Year 3 Core Activity Matrix.

Table 1. MCHIP-Supported Countries (GHI Plus Phase 1 countries in bold)

AFRICA		LAC	ANE
Benin (bureau/core)	Mali	Bolivia	Bangladesh
Burkina Faso	Nigeria	Dominican Republic	India
DRC	Mozambique	Guatemala (bureau only)	Indonesia
Ethiopia	Rwanda	Guyana	Nepal
Ghana	Senegal (core only)	Honduras (bureau)	Timor Leste
Guinea	Sierra Leone	Nicaragua (bureau)	
Kenya	South Africa	Paraguay	E&E
Lesotho	Sudan	Peru (bureau)	Azerbaijan
Liberia	Swaziland		Ukraine
Madagascar	Tanzania		
Malawi	Zimbabwe		

MCHIP STRATEGIC APPROACH

MCHIP's strategic approach to reaching its projected end-of-program results is guided by five principles, as elaborated in our Program Year 2 workplan:

- Scaling up proven interventions (in the sense of geographic expansion and population coverage)
- Maximizing the use of core and mission resources to achieve integrated programming, where feasible and appropriate
- Building on existing efforts of bilaterals, national programs and global and regional partners
- Ensuring a focus on evidence generation through program learning and knowledge management (KM)
- Taking a global leadership role in areas where MCHIP occupies a unique niche in the global community.

Furthermore, MCHIP's work is fully aligned with the core principles and main implementation components outlined by the GHI. These will be referenced throughout this document (see Figure 1).

¹ Unless noted otherwise, work described in this document is funded through core and regional bureau funds.

Figure 1. Global Health Initiative: Core Principles and Main Implementation Components

Seven Core Principles

1. Women- and girl-centered approach
2. Strategic coordination and integration
3. Strengthen and leverage key multilaterals and other partners
4. Country-ownership
5. Sustainability through health systems strengthening (HSS)
6. Improve metrics, monitoring and evaluation
7. Promote research and innovation

Four Main Implementation Components

1. Do more of what works, promote proven approaches
2. Build on and expand existing platforms
3. Innovate for results
4. Collaborate for impact/promote country ownership

MCHIP is committed to working with partners to achieve impact at scale. This is accomplished as effective interventions are delivered at high population coverage. For key interventions that MCHIP is promoting, we will seek to systematically document implementation status across countries where MCHIP has a presence, GHI+ countries, and USAID MCH priority countries (to the extent that this is feasible). Where possible, this will be done using coverage data for the specific interventions; where this is not possible, we will use suitable benchmarks and proxies.

MCHIP will develop a detailed matrix covering each of the key interventions that we are focusing on. For each, we will elaborate appropriate benchmarks and coverage indicators (to the extent possible). We will then systematically characterize country-level progress using these benchmarks and indicators. First priority will be GHI+ countries and those where MCHIP has a presence for that particular technical area. We will also endeavor to collect such information across all 30 USAID priority MCH countries. Program activities supported by MCHIP (core and field support) will address key next steps to move these interventions forward to best ensure progress towards impact at scale.

MCHIP has established strong relationships with host-country governments as well as local, bilateral, multilateral and global partners to design and implement government-led, multi-partner plans consistent with broader national health strategies. As a project with more technical breadth than our predecessor projects, MCHIP is uniquely positioned to address barriers that have existed between vertical technical programs, with the potential of making investments more effective. The relationship among our Strategic Objectives is reflected in Figure 2 below.

Figure 2. MCHIP Approach to Supporting High impact Interventions



APPROPRIATE INTEGRATION

This Program Year 3 core workplan represents not only our efforts to move forward critical agendas within specific technical areas, but also to identify and address opportunities for strategic integration and global learning across the program. MCHIP will promote adoption of high-impact interventions with scope for significant impact on mortality across the life cycle from pregnancy to childhood. Approaches will be tailored to address the mortality burden and service delivery capacity and will be guided by 12 USAID results pathways.²

Consistent with the GHI principle of “strategic coordination and integration,” MCHIP is committed to *appropriate* integration. What that means is we recognize integration is not always the right answer. We seek opportunities to integrate in circumstances in which the result is expected to be higher coverage, better service quality and better health outcomes and when integrating does not produce better performance in one program or service at the expense of another.

Consistent with GHI Implementation Component 2, we look for opportunities to link or build on platforms, making use of existing contacts and cadres. Reviewing proposed technical interventions across a life cycle approach (Table 2) provides a framework through which MCHIP can determine if appropriate platforms for integration are being utilized, thus maximizing access, ultimately maximizing coverage and mortality impact.

Table 2. MCHIP Technical Interventions

	PRE-PREGNANCY	PREGNANCY	LABOR, DELIVERY AND IMMEDIATE NB CARE	NN/PP (UP TO 1 MONTH)	INFANCY/ LATE POSTPARTUM (1–12 MONTHS)	CHILD HEALTH
Household-community-hospital, referral linkages	FP Nutrition	Antenatal care (ANC) (including MIP, anemia)	SBA, EmONC, PPH, PE/E, NN resuscitation, ENC	ENC, LBWt (including KMC), PP-FP, MC	Routine immunization, new vaccine introduction, CCM, PP-FP, IYCN	CCM, ORT/ Zn, pediatric AIDS
	PMTCT, male circumcision, WASH, urban health					
	Integrated community-oriented CSHGP grants					
	HSS, policy and guideline development, community mobilization, strategic integration					

CROSS-CUTTING SUPPORT

Health Systems: The primary focus of MCHIP’s work is specific interventions addressing the principle causes of maternal, newborn and child deaths. In addition to contributing to advancing global best practices with regard to specific technical *interventions*, MCHIP expects to contribute helpful guidance on *implementation approaches* and principles that stand the best chance of accelerating health status improvements. Achieving population-level mortality impact requires that interventions be delivered at high coverage. This can only be accomplished with appropriate policies and functional *systems*.

Year 3 offers exciting opportunities to support and strengthen performance-based incentive pilots in Malawi and Tanzania, co-funded with field support. Building on the national policy decision to implement SBM-R to improve quality in all of Malawi’s hospitals and health centers,

² Maternal Health; SBA; Eclampsia; Prevention and Treatment of PPH, Newborn Health; Immunization; Polio, Acute Respiratory Infection (ARI); ORT; Nutrition; Water Supply, Sanitation and Hygiene; Maternal and Child Urban Health.

MCHIP will test linking improvements in the SBM-R score to payments in five districts in Malawi in collaboration with the governments of Germany and Norway. In Tanzania, we will provide technical assistance to the local team contracted by the Government of Norway to implement performance-based incentives in the Pwani region. In addition to the direct impact on improving utilization and quality of key maternal and child health services, these pilots will inform national scale-up and generate lessons to share with designers and implementers across the globe.

In addition to focusing on health systems and performance-based financing issues, the MCHIP health system approach includes what is done at the *community and primary health care levels* and how that integrates with and is supported by the formal health sector. It also includes—beyond the technical content—the factors determining *quality of care* and, more generally, *program or service performance* for health-facility-based care (including coverage, timeliness, equity, etc.). **We hold ourselves accountable not only for inputs but for sustained performance.** This requires effectively addressing systems factors that determine performance. MCHIP has documented the contribution of policy and systems factors to improved maternal-newborn program performance in Malawi. To understand further the contribution of health system inputs, MCHIP will document this in an additional country.

These considerations of community and quality/performance are fundamental to the impact MCHIP can achieve and, to ensure they are adequately taken into account in our work, we have formed cross-team working groups addressing these two areas.

- **Community.** Key to MCHIP's use of community strategies is that they be implemented in a way that they are complementary and not competitive with provision of services at the health facility level. **What we seek is maximum mortality reduction. This is achieved through high coverage of specific interventions that reduce mortality risk, however or wherever they are provided—be it in the community by a CHW or in a health facility by a physician or midwife.** Given that there is some skepticism about the role of service provision at the community and primary health care levels for maternal health, in particular, an MCHIP priority going into Year 3 is to rigorously document our community-based (CB) work, looking particularly at what effects—positive or negative—such peripheral-level provision of service has on use of health facility (HF)-based services and coverage for key interventions.

Our *Community Health Services* working group will focus particularly on characterizing the conditions necessary for CB service delivery that are effective, scalable, sustainable and complementary with, and indeed reinforcing of, service provision and use at the HF level. Without effective attention to such conditions, we cannot ensure the capacity for CB service delivery to contribute to population level health status improvements.

- **Performance/Quality Improvement.** Specific interventions promoted by MCHIP (e.g., active management of third stage of labor [AMTSL], neonatal resuscitation, CCM, immunization) require high coverage and adequate quality to achieve population-level impact, which, in turn, require functional and effective systems—health workers or CHWs must be available (at post), capable (having the needed knowledge and skills) motivated and enabled (with consumables in stock, the necessary equipment and physical setting, supervisory oversight and support). MCHIP is not mandated to focus on systems merely to strengthen systems, but we are mandated to contribute to mortality impact, which is unachievable without enabling systems conditions. It is the mandate of our second cross-cutting working group, *Quality/ Performance/ Systems*, to bring this broader perspective to bear, helping to ensure that our investments or program inputs are deployed strategically, recognizing the wider systems context in which we work. This is consistent with the emphasis to date, under MCHIP, on HSS.

Private Voluntary Organization/Nongovernmental Organization (PVO/NGO)

Contributions: Another element of MCHIP's cross-cutting work is provided by the PVO/NGO Support Team to USAID's Child Survival and Health Grants Program (CSHGP) and the PMI's Malaria Communities Program (MCP), helping to ensure a consistent level of quality across their portfolio of grants as they play a critical role in advancing USAID's maternal and child health (MCH) and malaria priorities. Consistent with the GHI commitment to promote research and innovation, these grantees serve as important learning labs that generate results and evidence for how to deliver community-oriented interventions, which can subsequently inform MCHIP efforts to implement similar interventions at scale through its country programs. Similarly, the Core Group will work through its membership and partners to support MCHIP to develop practical approaches and strategies for implementation of community-oriented health programs. A key strength of the Core Group is its focus on improving learning related to integration of health care delivery at the community level.

PRIORITIZATION OF INTERVENTIONS

MCHIP uses USAID's *Acceleration Framework* and available modeling tools, such as the Lives Saved Tool (LiST), to identify and prioritize interventions in the short, medium and long term. Particular attention is paid to sub-national data to inform service delivery and health system strengthening strategies. Building on the work completed during Program Year 2, MCHIP will continue to work on brief **country profiles on MNCH and family planning (FP)**, modeled in part on immunization profiles and including some elements of LiST tool analyses. These profiles are intended to be used primarily with USAID/W and Mission counterparts as an aid in planning and prioritization.

Consistent with the *Acceleration Framework*, in country settings where more sophisticated services are poorly developed (and that is the case in most countries where MCHIP is involved) achieving maximum mortality impact over the short to medium term will require mixed strategies that entail delivering simpler interventions through primary health care platforms while, at the same time, contributing to progressively strengthening capacity to deliver more definitive care.

For child and newborn health, there are quite a few potent interventions that can be delivered through primary health care or CB service delivery channels. Accordingly, in settings with weaker, less developed health services, there is scope for achieving high coverage for interventions potent in reducing mortality risk.

For maternal health, it has been assumed that nothing except relatively definitive emergency obstetrical care can significantly reduce mortality and that mortality reductions can only be expected when most deliveries occur with health workers able to provide such care. However, evidence is accruing for significant mortality reduction benefits with provision of simpler interventions, which, in principle, can be made available at high coverage in settings where a norm of definitive HF intrapartum care is still a long way off. This gives reason for hope for reducing maternal mortality even in more difficult circumstances. For example, MCHIP is continuing the work of the Prevention of Postpartum Hemorrhage Initiative (POPHI) to expand the use of AMTSL and, in settings with low skilled birth attendance (SBA) delivery coverage, is supporting CB or ANC-provided misoprostol in the context of operations research.

STRATEGIC CORE INVESTMENTS AT THE COUNTRY LEVEL

The previous sections have described how MCHIP identifies and prioritizes technical and programmatic needs. Another critical planning consideration focuses on how core and field

funding can be used to ensure maximum benefit. As a program designed to be 90% field supported, MCHIP receives a limited amount of core funding each year that can be directed to support country programs and global leadership activities. As defined through MCHIP level results, the majority of our activities are either directly or indirectly related to supporting country programs. The country funding matrix in Annex 2 tells only part of the story and does not include M&E support, technical assistance and country assessment visits. If we consider that communication, management and global leadership are the main areas that cannot be directly attributable to country support, we estimate that over 75% of core funds that MCHIP receives are directed toward technical assistance and country-level activities. In Year 3, MCHIP projects that it will be actively engaged in more than 35 country programs, which presents a challenge for identifying specific “priority countries” where the limited core funds can be best invested. Given these realities, MCHIP in Year 3 will shift the focus of its strategic core investments toward a set of guiding criteria, as opposed to a list of priority countries. Dedicated investments at the country level will be filtered through the criteria listed below, ensuring that the decision to use core funds is deliberate and targeted in nature. Although we anticipate that there may be an occasional “compelling exception” to these criteria in which there is a different motivation to invest core funding, as a normal course of business we will give greater weight to investments that meet a greater number of the criteria below:

Core funds should:

- Contribute to global program learning and include sufficient M&E/support for documentation.
- Make it possible for MCHIP to bring needed attention to a priority MNCH/FP intervention AND field resources for that intervention are not currently available.
- Be catalytic and leveraged. The resources should bring other stakeholders on board including USAID Mission, other donors or international agencies.
- Be directed to countries that are Health, Infectious Diseases and Nutrition (HIDN) priority countries³ and Population and Reproductive Health (PRH) first-tier countries⁴ to the extent possible.
- Not be used to expand geographically.
- Not be used in countries with absorptive capacity challenges (which may be characterized by a large pipeline).

The pre-conditions of this funding should include an assurance that the USAID Mission, MCHIP in-country team and the Ministry of Health MOH are receptive to being part of MCHIP global learning agenda AND are willing to accept technical guidance/involvement from MCHIP headquarters (HQ). MCHIP has a unique opportunity to build on over 30 field-funded programs to ensure impact at scale for some of the key high-impact interventions.

MCHIP’s program learning strategy will draw from critical activities across the MCHIP workplan to inform the global community on key unanswered questions and will serve as a legacy of MCHIP. Some of the ideas for program learning are discussed in the next section. Entering Year 3 in 2010 and working in more than 35 countries, MCHIP is well positioned to direct attention to key high-impact interventions at a country level that can be scaled up within

³ Africa Region: Benin, DR Congo, Ethiopia, Ghana, Kenya, Liberia, Madagascar, Malawi, Mali, Mozambique, Nigeria, Rwanda, Senegal, Sudan, Tanzania, Uganda, Zambia; Asia Region: Afghanistan, Azerbaijan, Bangladesh, Cambodia, Europe & Eurasia Region, India, Indonesia, Nepal, Pakistan, Philippines, Tajikistan; LAC Region: Bolivia, Guatemala, Haiti

⁴ Africa Region: DR Congo, Ethiopia, Ghana, Kenya, Liberia, Madagascar, Malawi, Mali, Mozambique, Nigeria, Rwanda, Senegal, Sudan, Tanzania, Uganda, Zambia; Asia Region: Afghanistan, Bangladesh, India, Nepal, Pakistan, Philippines, Yemen; LAC Region: Haiti

an individual country, but also serve as a potential cross learning for other countries. MCHIP will influence both the GHI Plus countries, USAID's priority MCH countries, the PRH first- and second-tier countries in addition to the 68 Countdown countries with the highest burden of maternal and child mortality—both directly and indirectly through the investment of core funds at the country level and through a solid KM and communication strategy.

HOW FIELD INVESTMENTS CONTRIBUTE TO MCHIP'S CORE STRATEGY

While core investments leverage scale-up at the field level; field support investments inform the core strategy and the global agenda. For example, MCHIP field support is promoting equity approaches in several countries by working with populations in hard to reach and underserved areas. The MCHIP program in Northern Nigeria focuses on three states with exceptionally poor maternal mortality and family planning indicators. In Indonesia, MCHIP's approach is to develop an integrated district model in three districts for scale-up in other remote areas. These efforts not only inform the national strategy at the country level but they also contribute to MCHIP's global equity strategy.

Successes of specific interventions at the field level can shape the global agenda. For example, MCHIP's highly successful MC campaign in Iringa, Tanzania, is now being touted as the model for other countries to replicate. Similarly, the innovative work in Nepal on prevention/detection of pre-eclampsia/eclampsia has the potential to guide the global agenda for this critical issue. Additionally, community KMC work in Ethiopia is a field funded activity that will shape the global agenda.

MCHIP field support is also leading the way in ensuring that investments—whether they are made at the district, regional or central levels—have a national impact. In almost every MCHIP country, direct investments are having a national impact by catalyzing action and resources among government, other donors and other implementing partners. For example, in Malawi, the Community Maternal and Newborn Health package, introduced by MCHIP and SNL in seven target districts, has been adopted by PMNCH and scaled up in 10 additional districts, extending coverage of this important intervention to 57% of all Malawi districts; in Liberia, MCHIP's efforts through collaboration with the RBHS bilateral is extending family planning services to 13 of 15 counties; in India, the pre-service ANM work is being scaled up through Government of India initiatives with limited MCHIP field support funds. In its third year, MCHIP will design a process for capturing and reporting on the broader impact of such catalytic efforts.

ANTICIPATED LIFE OF PROJECT RESULTS

The Life of Project (LOP) Results that MCHIP included in the Year 2 workplan are still relevant as the Program moves forward into Year 3. Those results include:

- Contribute to reductions in maternal and under-five child mortality in 20 countries.
- Contribute to an estimated 118,000 mothers and 7.2 million children under-five saved in 20 high-burden mortality countries.
- Assist 20 countries to demonstrate improved coverage of MNCH services, with five of these benefiting from an integrated package of high-impact MNCH interventions.
- Help five countries to demonstrate greater equity in coverage of MNCH services.
- Have all 68 MDG countdown countries benefiting from MCHIP-promoted learning tools and approaches.

The Year 2 MCHIP annual report will provide a detailed picture of the progress MCHIP has made toward these targets to date. An initial review of progress with respect to movement along

the HIDN Results Pathways indicates that MCHIP is on track to achieve LOP targets in all technical areas using a combination of core, bureau, and field support funds.

Program Learning and Knowledge Management

MCHIP's KM strategy builds upon USAID's overall approach to KM. With the benefit of broad and deep technical expertise and experience drawn from program activity in more than 35 countries, MCHIP is able to help improve the quality and effectiveness of on-the-ground program work, to bring useful influence to bear on national-level policy and program decision-making, and contribute to advancing global best practices. Our vision for KM is for key stakeholders in MCHIP at all levels—from country-level practitioners to USAID and other global actors—to access and put into use and disseminate MCHIP-generated learning on a routine basis.

MCHIP's KM strategy is based on the following key principles:

- Generation, documentation and sharing of knowledge about how to scale up, assess costs, set indicators and monitor scale-up progress;
- Harmonization of approaches using common protocols, standardized outcome indicators and measurement tools with appropriate country adaptations;
- Timely, accurate and actionable dissemination of information about proven interventions and lessons learned at the national and global levels; and
- Provision of opportunities for MCHIP country programs to share lessons learned, identify key missing interventions and develop plans to integrate high-impact interventions in their program of work.

In Year 2, MCHIP strengthened its KM systems to ensure a strong evidence base for results, and to provide the infrastructure for organizing and diffusing program learning during Years 3–5. The key systems that were further developed in Year 2 are outlined below.

Results Information Systems for Excellence (RISE)—during Year 2, this Web-based information system was developed by Voxiva for Jhpiego to guide data management and reporting for all of its programs, including MCHIP. This has meant cost savings for MCHIP, as we did not have to invest in a project-based results reporting database. MCHIP participated in identification of critical systems requirements to ensure that the system would generate relevant data and reports that can feed into MCHIP's overall KM strategy. This system will be operational in Year 3, and will house all the MCHIP global indicators as well as the country program indicators. These include indicators at the impact (mortality, lives saved), outcome (intervention coverage) and output (numbers trained, polices drafted, services provided, etc.) levels. This is discussed further in the M&E section.

MCHIP Communications—MCHIP is in the process of developing a strategic approach to communications that will highlight the investment of USAID in MNCH and increase visibility/brand of the program as a global leader within the global community. Communications will also ensure that learning emerging from MCHIP efforts are presented in fora that offer the best opportunities for influencing the global dialogue and policy in key areas, including proper dissemination and information sharing; and communicate the successes of scaling up proven interventions and integrated programming, drawing from the experience not only of MCHIP, but of other global leaders in MNCH. Communications will develop a strategy for best use of social media outlets, such as Facebook, YouTube, Twitter™ and blogs where MCHIP already has an active presence, to share learning with the widest possible audience in interactive and

dynamic forums. MCHIP will also routinely contribute success stories for the USAID Administrators weekly, Blog and Web site content.

With the CORE group taking on an expanded role as an MCHIP partner in Year 3, the project will also have access to diffusion mechanisms used by that organization to reach a wide range of CB health practitioners.

MCHIP.net—the functionality of MCHIP.net was expanded substantially in Year 2 and now provides a broader range of information on MCHIP programs, tools and resources, global leadership activities and technical areas of focus. The MCHIP Web site usage has gone from 700 unique visitors to more than 3,000 visitors in the last month.

Internal Communications. MCHIP SharePoint for internal use has expanded considerably and will look to expand the scope still further. MCHIP will make certain sites of the MCHIP SharePoint available to USAID for easy access to information at one site.

MCHIP has hosted a series of Brown Bag Lunches (BBLs) and seminars on state-of-the-art technical topics. Sharing of this knowledge has been mainly for internal purposes. In Year 3, MCHIP proposes to open up these BBLs and presentations to a broader group of participants from other partner agencies. To improve efficiency across the various offices, MCHIP installed video conferencing within the MCHIP office. Several of the MCHIP partners, UN organization and some country offices can now be directly linked with MCHIP during staff meetings or seminars. MCHIP also proposes to host several listservs and communities of practice that are described further in different technical sections.

MCHIP continued its efforts to document program learning from its core-funded and country-level programs. Among the highlights of Year 2, MCHIP created and implemented protocols for documenting/assessing malaria in pregnancy (MIP) programming, the contribution of health systems factors to maternal health program performance, CCM for childhood illness and generating practical information for use by policymakers and program planners in low-resource settings. These protocols were applied in the conduct of case studies on MIP programs in Senegal and Zambia as well as a health systems case study in Malawi. In Senegal, MCHIP documented the introduction and scale-up of CCM.

MCHIP is also a member of a multi-agency post-introduction evaluation of pneumococcal vaccine in Rwanda that is anticipated to generate much-needed evidence around the process and results of this type of intervention. An article authored by MCHIP staff was accepted in a peer-reviewed journal on the impact of national integrated “MCH weeks” on routine immunization (RI) in Madagascar. A retrospective analysis of the use of postpartum intrauterine contraceptive devices (PPIUCDs) in Paraguay, examining a PPIUCD insertion technique that has low expulsion rates was completed and will be shared at global fora and submitted for publication.

Over Year 2, the global health team leader had several papers published on CB service delivery, particularly of maternal newborn care (e.g., on community health workers [CHWs], use of chlorhexidine for newborn cord-stump care and use of misoprostol for the prevention of postpartum hemorrhage [PPH]).

With respect to operations research, CSHGP innovation grants focused on operations research of community-oriented service delivery. In fiscal year 2009 there were 11 innovation grants funded through USAID/W to PVOs/NGOs working in Afghanistan, Bangladesh, Burundi, Ecuador, Honduras, Nepal, Nicaragua, Niger, Pakistan and Zambia. MCHIP provided technical assistance (TA) to the grantees to develop rigorous operations research (OR) study designs and facilitate

submission to appropriate institutional review boards (IRBs). These grantees are exploring critical program learning questions related to how to inform MNCH program design and scale up. More specifically, the current portfolio of innovation grantees are carrying out OR to contribute to the following USAID GH priority focal areas: community-oriented MNC, CCM, CHW functionality, integration of MNC into other interventions and across other sectors, equity, gender equity and mobile health. MCHIP created guidance for development of OR concept papers by the grantees, in which globally recognized research standards are reinforced to ensure the conduct of quality research and stimulate the utilization at the national and global levels. MCHIP also held an OR development workshop for innovation grantees in April 2010.

In Malawi, MCHIP, in partnership with the MOH and Venture Strategies, completed the planning process for an OR study to test a comprehensive intervention for PPH, including provision of AMTSL for normal facility births and distribution of misoprostol through ANC services for use by women with home births.

PROVIDING GLOBAL LEADERSHIP WHERE MCHIP HAS A SPECIAL NICHE

With systems now firmly in place and program learning activities ongoing across technical areas and in country programs, MCHIP is well positioned to synthesize learning from across the project to inform larger questions. As mentioned previously, as a project with more technical breadth than our predecessor projects, MCHIP is uniquely positioned to bring global leadership to issues across the life cycle. In Year 2, MCHIP initiated processes for identifying additional opportunities for learning that might emerge by looking across the project, and we propose to formalize the development of a “learning agenda” for the project in Year 3 that will guide the documentation and diffusion of MCHIP learning through 2013. The key themes that we have already prioritized for focus in Year 3 include:

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

Continuity in important cross-project areas of learning that have been initiated during MCHIP’s first two years—including Health Systems Strengthening, PBF and Quality of Care—will be built into the learning agenda to be developed in Year 3; additional themes that will be considered for future program learning emphasis in Years 4 and 5 will include:

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

Documentation of any of these themes would provide an opportunity to demonstrate many of the core principles and implementation components of the GHI in action. In fact, many MCHIP country programs already have assessment activities under way with field support funds that will explore these themes. For example, the MaMoni associate award in Bangladesh is

measuring the performance of community health workers—both public sector and NGO-affiliated—with respect to delivery of MNH counseling services and referrals. MCHIP Malawi is evaluating the performance of health service assistants in delivering an integrated package of community-based MNH services. In Nigeria, a program evaluation is planned to assess the effectiveness of community mother volunteer peer educators and volunteer action groups in increasing demand for MNH services, as well as the process and results of integrating family planning services into MNH services. Innovative mHealth approaches are being implemented and monitored in Nigeria as well, where text messaging is being used to support transfer of learning on the job for health care providers after clinical training. In Nepal, MCHIP is conducting a cutting-edge pilot study on the effectiveness of distributing calcium to pregnant women through community health workers to prevent pre-eclampsia/eclampsia.

Inherent in the population groups MCHIP focuses on, programs are women-centered. MCHIP initiates programs with local engagement of national stakeholders, provides TA based on building local capacity, strengthens several elements of the health system including, developing human resources, improving quality of care, establishing supervision and referral systems, and strengthening monitoring and health information systems. As reflected in this workplan and our program learning and KM strategies, MCHIP places a strong emphasis on monitoring and evaluation. In Year 2, MCHIP staff (in discussion with USAID colleagues) prioritized certain high-impact MNCH interventions that need dedicated attention to help reach Millennium Development Goals (MDGs) 4 and 5. MCHIP will focus attention on these interventions and work with partners at global and country levels to dedicate special attention to these issues. For instance, in maternal health, preeclampsia and PPH will receive targeted attention. MCHIP will lead the way in building consensus around the interventions required to prevent deaths due to the second most important cause of maternal mortality in most of the developing world. MCHIP will also work with all partners and alliances, public and private, to mobilize commitment and rapidly scale up.

As MCHIP works to catalyze scale-up of the prioritized high-impact interventions in Year 3, the Program will place a strong emphasis on ensuring that these interventions are reaching the designated target populations in an equitable manner. MCHIP's approach to ensuring equitable programming and coverage will be strengthened in Year 3 and will be comprehensive in scope, including the program design phase, program monitoring and reporting. At the country program level, MCHIP already takes equity considerations into account when selecting geographic areas and populations for program implementation by consulting available data sources to determine where the most underserved groups are located. MCHIP also designs its interventions based on formative research findings and desk reviews that provide information on the local context and barriers to care, such as gender and social norms and financial and service availability constraints. Equity is an area for which MCHIP is well-positioned to contribute to the evidence base on what works. In MCHIP's Life of Program Results, the Program has committed to helping to achieve and measure greater equity in coverage of MNCH interventions in five countries. These countries will serve as equity learning labs for MCHIP. The new MCHIP Equity Guidelines developed in Year 2 will be further refined in Year 3 with the input of other key stakeholders, and applied in these five countries that have intensive efforts to reduce equity gaps in intervention coverage. In addition, in other countries where MCHIP works, the program will seek ways to reanalyze and present its monitoring and evaluation data using an equity lens. Select CSHGP grantees will also be testing the MCHIP Equity Guidelines, and their results will be synthesized and shared. Based on the program learning that emerges over the next year, MCHIP will revisit and revise the equity indicator currently included in the Program's global PMP.

MCHIP will also build on the initiative started in Year 2 on measurement of maternal health indicators. MCHIP is bringing together over 20 experts to discuss this issue in conjunction with the global maternal health meeting to be held in India in August 2010. MCHIP expects to

support a global review of benchmark maternal health indicators, complemented by testing and validating indicators (for example, to measure prevention of PPH and/or the content of postpartum/postnatal care) in at least one country, linking with and building on the core investment made in the MNC Quality of Care survey, which includes observation of active management of the third stage of labor, collection of service statistics related to PPH prevention and incidence, as well as immediate postpartum/postnatal care. In addition to testing selected maternal health quality of care indicators, MCHIP will select two-three child health indicators as well and conduct intensive monitoring of this small group of indicators in five MCHIP countries to provide a comprehensive picture of where these countries are in terms of intervention scale and quality of implementation.

In newborn health, MCHIP will collaborate with global partners to address birth asphyxia using the Helping Babies Breathe (HBB) curriculum. Similarly in child health, CCM is one of the focus areas for MCHIP leadership. MCHIP will facilitate the development of indicators, a toolkit on CCM and may serve as the secretariat for CCM if needed. With the formal addition of CORE to the partnership within MCHIP, the technical leadership within MCHIP can help translate global action around these selected interventions through the NGO partners and CSHGP.

At the same time as contributing to advancing best practices with regard to specific technical interventions, MCHIP tests, documents and promotes effective approaches to program implementation, from piloting potentially scaleable approaches, through introduction (and its related policy advocacy tasks), expansion, institutionalization and maintenance of performance at scale.

MCHIP partners are well-positioned to leverage non-USAID donor funds to enhance knowledge and learning in key areas of interest to MCHIP. For instance, JSI received a learning grant from the Bill & Melinda Gates Foundation (BMGF) to study evidence-based innovations and strategies for strengthening RI systems in the Africa region. Jhpiego enhances global learning on MIP through grants that they receive through corporate donors. MCHIP is working with the Maternal Health Taskforce to coordinate several activities and PATH received funding to advance PPH prevention through testing oxytocin in Uniject. Save the Children, through SNL, is advancing the field of newborn health in the management of low birth weight (LBW), birth asphyxia, and the management and treatment of neonatal infection.

Monitoring, Evaluation, Research and Information Systems

The M&E conceptual approach used by MCHIP aligns with the Common Evaluation Framework for the Scale up of Millennium Development Goals 4 and 5. This conceptual approach guides the work of countries and initiatives seeking to accelerate the achievement of MDGs 4 and 5 targets, and which has been adopted by the International Health Partnership, the Catalytic Initiative and others.

Documenting implementation processes and results of evidence-based maternal, newborn and child health (MNCH) care interventions at scale is central to the achievement of MCHIP objectives. MCHIP is measuring outcomes such as service utilization and coverage of high-impact MNCH interventions indirectly, by drawing on existing population-based surveys and through the M&E efforts of knowledge, practice and coverage (KPC) surveys conducted by PVO/NGO grantees operating in MCHIP priority countries. While MCHIP has a limited role in measuring mortality reductions in countries directly, the program uses the LiST to perform statistical modeling of mortality reductions based on increases in MNCH intervention coverage.

MONITORING AND EVALUATION PRINCIPLES

Monitoring and Evaluation under MCHIP will adhere to the following principles:

- **Collective action:** Primary focus on the contribution of collective efforts to scale up the health sector response in countries.
- **Alignment with country processes:** Build upon national processes countries have established to monitor and evaluate progress of implementation of national plans.
- **Balance between country participation and independence:** Driven by country needs but conducted to maintain independence of evaluation.
- **Harmonized approaches:** Common protocols and standardized outcome indicators and measurement tools, with appropriate country adaptations.
- **Capacity building and health information system strengthening:** Systematic involvement of country institutions.
- **Adequate funding:** Between 5% and 10% of the overall scale-up funds set aside for monitoring, performance, evaluation, and operational research and strengthening health information systems.

As the program underwent a period of remarkable growth, reaching over 35 countries to date, the M&E team at HQ and M&E Officers in the field worked to ensure that every MCHIP country program with at least \$500,000 of annual funding developed an M&E plan that reflects the M&E principles described above, and has program objectives, planned results and core indicators that are aligned with the local USAID Mission's Strategic Plan, MOH priorities and systems, and MCHIP global objectives and expected results. The intention is to ensure that country programs generate high-quality data to both inform programmatic decision-making and report to stakeholders and donors.

Given the size and scope of MCHIP, having a comprehensive program information system in place to capture, analyze and display M&E data is a top priority for the program. As mentioned in the previous section, significant progress was made in Year 2 with the development of a Web-based results information system, called the RISE. Jhpiego invested in this results information system and it will be available for MCHIP countries and global programs. A contract was awarded by Jhpiego (using non-MCHIP funding) to Voxiva to design the system, and MCHIP staff at HQ and in the field provided substantial input into the system requirements documentation. MCHIP staff who attended the Jhpiego regional country directors meeting in Rwanda May 2010 were oriented to the system and contributed ideas for making the system optimally useful in the field. Configuration of the system is now under way and it will be available for use by all MCHIP country programs in program Year 3. This system will enhance the ability of MCHIP to produce results reports and respond to information requests in a timely fashion with high-quality data. RISE will house all MCHIP program indicator data and will therefore include data from all the different data sources that MCHIP country programs draw upon to measure their results. These consist not only of national health management information system data, but also training data, data from evaluation studies, participatory community monitoring system data, etc. Data from RISE can also be easily exported to Excel and M.S. ACCESS formats so that it can be shared with program stakeholders in country. When shared in-country, these reports can be used to guide discussions and program decisions, and to support advocacy.

Looking forward to Year 3, MCHIP's core investments in M&E are designed to further efforts to improve measurement and communication of progress toward achieving MDGs 4 and 5 in USAID's 30 priority countries, and especially in the countries where MCHIP is working directly with partners to help scale up high-impact MNCH interventions. This work entails supporting the development and testing of improved MNCH indicators, data collection tools and data

collector training materials; supporting efforts to improve the quality of country and MCHIP M&E data; and building in-country capacity to use cutting-edge technologies (Smart Phones, cloud computing technology) to collect, analyze and disseminate results data more quickly, widely and easily.

GLOBAL LEADERSHIP

As part of its global leadership role in contributing to measurement of MNCH outcomes and coverage of MNCH interventions, MCHIP will continue to participate in ongoing efforts to review MNCH indicators used in nationally representative household surveys such as USAID's Demographic and Health Survey (DHS) and Malaria Indicator Survey (MIS) and the United Nations Children's Fund (UNICEF)-supported Multiple-Indicator Cluster Survey (MICS), and provide recommendations for improving them. MCHIP is leading a global effort to identify and test benchmark maternal health indicators (see Program Learning section). With respect to child health indicators, MCHIP will continue to work with USAID, UNICEF and others to update and revise indicators for CCM (see Child Health section for additional details). Once consensus is reached in key CCM indicators, MCHIP plans to apply them and incorporate them into the MCHIP country program PMPs for countries where CCM is part of the intervention portfolio, such as the DRC, Rwanda and Mali. MCHIP will also work to promote the use of these indicators globally by Ministries of Health, other projects and other donors in countries such as Malawi and Senegal. We anticipate that these CCM indicators will both inform the programming of and be diffused widely to CSHGP grantees and CORE members. Additional information has been included on this in the Child Health section as well.

With limited core investments, MCHIP will support broader application of the MNC Quality of Care (QoC) HF survey tools beyond the initial pilot countries of Kenya and Ethiopia (in an additional four countries for a total of six: Tanzania, Rwanda, Madagascar, and Zimbabwe; if funding is available, MCHIP will include potentially one country in Latin America) to assess the quality of ANC, delivery care, and especially care for pre-eclampsia/eclampsia (PE/E). We will also seek opportunities in countries where the survey is implemented to institutionalize ongoing monitoring of such measures, and where necessary developing new measurement strategies. This activity fills a widely recognized gap in available methodologies for monitoring and evaluating maternal and newborn quality of care, especially structured clinical observations. The survey tools and supporting documentation, including guidance on using smart phones for data collection, will be packaged into a comprehensive survey toolkit and disseminated. More information about this activity is available in the maternal health workplan narrative.

MONITORING AND EVALUATION

In the coming year, MCHIP will continue to conduct annual monitoring of the Program's contributions to advancing MNCH priorities along the relevant HIDN Results Pathways as well as monitor indicators associated with USAID/Washington's Operational Plan (OP) process—the *Investing in People* indicators (under the U.S. Foreign Assistance Framework). These indicators are designed to track output level results in a standardized way across countries and programs on an annual basis. MCHIP will select relevant *Investing in People* indicators for each country program. These indicators are being incorporated into the associated country program performance monitoring plans and data collection and reporting systems.

To ensure that high-quality data are generated and reported by the Program and that country programs understand and comply with MCHIP's and USAID's global M&E and research expectations, Jhpiego and MCHIP plan to hold an M&E workshop in an MCHIP-supported country to bring together U.S.-based and field-based M&E staff from Jhpiego and MCHIP country programs. The workshop will be funded primarily with Jhpiego corporate and non-

MCHIP program funds, while MCHIP will support the participation of key MCHIP staff. A primary focus of the workshop will be on approaches to improving M&E system and data quality, which is intended to benefit MCHIP's efforts to strengthen national M&E systems in the countries where the program works and to strengthen the Program's internal M&E systems. The workshop further will provide an opportunity to review standardized MNCH indicators, M&E best practices, data collection tools and MCHIP M&E country guidance. It will also provide field staff with a forum in which to share M&E resources, monitoring approaches and problem-solving strategies. MCHIP's research and evaluation requirements with respect to IRB review and approval and review and approval by USAID/Washington will be discussed. We will also orient staff on how to use RISE to house program data and enhance data quality, display and reporting.

Program evaluations will largely be conducted using field support funds in countries with larger-scale programs and where Missions are supportive of data collection efforts beyond routine monitoring. A small amount of core resources will be made available to support these evaluations in terms of TA from HQ-based M&E staff. MCHIP countries that have program evaluations planned or under way include Nigeria, Tanzania, Rwanda, Indonesia, Mozambique and Malawi.

INFORMATION SYSTEMS

Having a program-wide information system and relevant supporting information systems in place will be a major priority for MCHIP in Year 3. MCHIP M&E and information systems staff at HQ will be integrally involved in rolling out RISE to the MCHIP country programs—helping to orient country-level users to the system. As part of this process, MCHIP will devote significant time at the global M&E workshop to orient field-based M&E staff from MCHIP country programs to RISE and provide the opportunity for hands-on practice with data entry and use of the system to generate graphs, charts, reports and maps. This flexible and comprehensive system will allow MCHIP to easily incorporate any new indicators that may be relevant under the new GHI as more measurement guidance becomes available soon.

Another information system that will go live in Year 3 is a Web-based data management and dissemination system for the MNC Quality of Care survey results. In the data collection phase, raw data from QoC surveys is either transmitted via phone lines or hard-cabled and synchronized to the central server for each tool. A linked master database will be created for each QoC country. The QoC tabulation plan has already been established and programs will be written to display basic tables and indicators. Administrative templates will allow easy modification across countries of variables used to create composite indicators (such as Essential Obstetric Practices or Essential Newborn Care [ENC]). Since Geographic Information System coordinates have been captured for most facilities, it is anticipated that key results will also be mapped. All data will be password-protected and eventually available via the Web for MCHIP partners. This activity is also intended as a prototype to a larger MCHIP information management strategy of capturing community, facility and individual level data from various other MCHIP assessments (such as Standards-Based Management and Recognition [SBM-R]) for priority countries and storing it in online relational databases. In each of the countries implementing the Quality of Care survey, Ministry of Health staff are both co-implementers and information users. The main purpose of setting up such a system is to provide central data access to MCHIP partners, including Ministry of Health staff in the countries where the survey is being implemented, for ongoing data collection activities making selected information data query-accessible through a portal on the MCHIP public Web site and as a staging area for entry into the RISE information system. We will also build the capacity of in-country counterparts in the countries where MCHIP has applied the MNC Quality of Care Survey to use this type of

data management and dissemination approach so that it can be replicated for other country-based M&E activities beyond MCHIP.

MCHIP also plans to configure an additional information system to house and link SBM-R and performance-based incentives (PBIs) indicators, making use of cloud computing technology. Data capture will largely occur in health facilities and pre-service institutions in developing countries using tablet personal computers, smart phones and cell phones, and data analysis and report generation will largely occur at MCHIP, NGO and MOH offices in capital cities using laptops. This system will be partly funded with Malawi field support funds as they are implementing a PBI initiative there that will use SBM-R performance standards as a tool for benchmarking progress. Country programs that may be initiating PBI interventions that may apply this module include: Mozambique, Kenya and Tanzania, and MCHIP is exploring the possibility of joint work with HS2020 in Afghanistan. Other MCHIP and Jhpiego country programs that are implementing SBM-R but are not implementing PBI will also be able to utilize the module for housing, analyzing and presenting their SBM-R results. This module will be co-funded by MCHIP and Jhpiego since it will be useful to any country program implementing SBM-R.

OPERATIONS RESEARCH

To answer key program learning questions of interest to MCHIP globally (see program learning/KM strategy), core resources will be used in Year 3 to fund at least one OR study in a country with MCHIP field support. Core funds will be used in conjunction with field support funds to design a rigorous study that will be able to generate the type of evidence needed to inform program scale-up decisions. As with all research activities under MCHIP, the checklist for developing, reviewing and finalizing the research protocol with USAID will be followed.

YEAR 3 EXPECTED RESULTS

- MNCH indicators reviewed and recommendations made for modifications and field-testing.
- 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.
- MCHIP applying and disseminating M&E best practices.
- Improved indicators and information available to measure progress toward MDG 4 and/or 5 and to feed into LiST.
- Reporting under MCHIP is streamlined and timely.
- 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.
- MCHIP program results synthesized and disseminated to stakeholders.
- MNCH program learning generated by MCHIP disseminated and applied by others.
- High-quality training materials produced to improve the quality of observational HF survey data.
- Frameworks and indicator/data entry forms for MCHIP country programs created in RISE.
- Quality MCHIP program data available in an online results information system, updated on a routine basis and captured in standardized format.

- Web-based system for faster reporting and dissemination of QoC and other assessment results in operation.
- SBM-R tool streamlined and adapted for use to link payment to performance (SBM-R/PBI).
- Information system configured that enables faster reporting of SBM-R/RBF results and for program management and timely decision-making.
- SBM-R PBI programmed into a handheld data collection tool.
- SBM-R–PBI tool tested and revised in Malawi (link with field funding and coordination with Norway/KFW-funded pilot).
- Innovative approach to linking financial incentives with quality improvement available for global scale-up.
- High-quality evidence generated to inform MNCH program scale-up.

Introduction to Technical Sections

Given the programmatic and technical breadth of MCHIP, the next section of the workplan is divided into cross-cutting and specific technical elements followed by work supported through bureau funding (Africa and LAC). The organization of the sections that follow was guided by the USAID results pathways and by how MCHIP anticipates working with our various Agreement Officer's Technical Representative (AOTR) contacts to monitor progress throughout the program year. As many activities could appear in multiple places, we have made some choices of where specific efforts should be described and have attempted to ensure appropriate cross references as necessary.

CROSS CUTTING

- **PVO/NGO Support**—Support to the CSHGP, expand linkages to MCHIP country programs and expertise of MCHIP partnership
- **The CORE Group**—Diffusion of program learning, communities of practice, support to selected MNCH technical priorities

TECHNICAL ELEMENTS

- **Maternal Health:** with a particular focus on SBA, PPH and PE/E
- **Newborn Health:** sepsis management (and prevention), asphyxia management, care for newborns of LBW (including Kangaroo Mother Care [KMC]) and ENC (including handwashing)
- **Child Health:** primarily focusing on CCM (malaria, pneumonia and diarrhea), but also addressing diarrhea independently (oral rehydration treatment [ORT]/Zn)
- **Immunization:** primarily focusing on strengthened RI, but also including introduction of new vaccines
- **FP:** focusing mainly (but not exclusively) on postpartum family planning (PPFP), taking advantage of opportunities to integrate with other MNCH services
- **Malaria:** integrated within antenatal and CCM for childhood illness, but also including support to the Malaria Communities Program
- **HIV:** prevention of mother-to-child transmission of HIV (PMTCT), pediatric AIDS, integrated within MNCH

- **Water, sanitation and hygiene (WASH):** focusing on handwashing by those providing care for the newborn and appropriate integration within CCM and other diarrhea control work
- **Urban Health:** addressing the unique needs and conditions of urban populations to ensure access to MNCH services

BUREAU FUNDING

- **Africa Bureau:** MNCH including malaria and immunization
- **LAC Bureau:** maternal and newborn health

PVO/NGO Support

OVERVIEW

USAID's CSHGP presently consists of 47 grantees operating in 27 countries, reaching more than 10 million women of reproductive age and children under five. The CSHGP's unique partnership model combines global implementation with technical leadership, rigor, and collaborative learning and action. CSHGP's program model is responsive to the priorities and mandates of the Global Health Bureau and contributes significantly to USAID's leadership role in innovative community-oriented programming. Evaluative rigor, a focus on facilitating local ownership and an equity focus are central to these grants.

Evaluative rigor is built into these programs through the collection of 19 standard, population-level indicators at baseline and end of project, strong monitoring and evaluation plans, and in the case of Innovation Grants, OR designs—all of which are supported and reviewed by MCHIP technical advisors and other external experts. The population-level data generated through this program have demonstrated that CSHGP grantees have consistently increased coverage in key interventions over the national average from baseline to end of project, and have achieved an average estimated mortality reductions of 22% for children under five.

All CSHGP grantees work in partnership with local institutions, and many have laid out sustainability plans from the outset of their programs to plan for the continuation of health benefits once their funding has ended. The CSHGP has supported efforts, through its technical support mechanism within MCHIP, to facilitate a community of practice around the issue of sustainability planning and measurement.

CSHGP grantees often work in remote regions where the overall health status of the population is poorest in comparison to the national average, or work to increase knowledge or access to services for specific groups that have been marginalized because of gender, ethnic, geographic or other equity issues. USAID continues to support its portfolio in strengthening this area, with support from MCHIP in the development of guidance for program design, monitoring and evaluation (PDME) through an equity lens.

In MCHIP Year 3, 19 CSHGP projects will be active in 11 countries where MCHIP has (or will soon have) a country program: Bangladesh, Benin, Ethiopia, India, Indonesia, Liberia (2), Malawi (3), Nepal (4), Rwanda (2), South Sudan and Tanzania. Of these 19 CSHGP projects, Innovation Programs—which include an OR component—will be active in Nepal, Bangladesh, Benin, Indonesia, Sudan, Rwanda and Liberia.

Innovation Programs will also be underway in countries where MCHIP is not presently active, including Cambodia, Niger, Honduras, Pakistan, Burundi and Afghanistan.

MCHIP STRATEGY FOR PVO/NGO SUPPORT

MCHIP's vision is to maximize the inclusion of PVO and NGO contributions in scale-up of proven interventions at the country level. The strategic areas of focus and evaluative rigor of the CSHGP position it as an important resource for informing national programming, and MCHIP country programs offer a clear opportunity for ensuring that the learning emerging from CSHGP grants can be maximized to this effect. MCHIP's strategy for leveraging the experience of CSHGP grantees in Year 3 will include the following components:

- Ongoing technical support to CSHGP grantees to ensure a high level of rigor and quality across the portfolio of grants.
- Management support to CSHGP to ensure clear guidance to grantees for program design and implementation, and to maximize linkages between the technical interventions and strategies carried out by grantees, and those implemented through MCHIP Country Programs and core-supported initiatives.
- Catalytic efforts to strengthen connections and ongoing learning between CSHGP grantees and MCHIP country staff, especially where there is an overlap in technical or strategic focus.
- Diffusion and documentation of learning emerging from the CSHGP, especially as it relates to areas of technical focus of MCHIP, or critical program learning questions that MCHIP is seeking to address.

YEAR 3 ACTIVITIES/EXPECTED RESULTS

In Year 2, the MCHIP team worked with the CSHGP to position its program to both inform and benefit from MCHIP's global leadership and country activities. In Year 3, MCHIP will build on Year 2 results to expand its efforts in each of the main areas of its strategy. Specifically we will:

- Build on the research guidelines developed during Year 2 to further strengthen the overall portfolio of innovation grantees through simplifying and streamlining the detailed implementation plan (DIP) preparation and OR concept paper preparation processes; developing a communications plan for articulating the expected contributions of the innovation portfolio to USAID priorities, MCHIP country programs, Missions and other partners; and creating communities of practice related to innovation and OR, with support from the Core Group.
- Maintain support systems already in place to ensure quality programming and evaluative rigor across the CSHGP portfolio; and maintain the information systems established to allow the CSHGP to track key information on its grantees that is fed into internal reports to USAID and other program stakeholders.
- Expand the in-country linkages between MCHIP country programs and CSHGP grantees for the purposes of facilitating the identification of opportunities to leverage the learning from both programs to inform decisions about scaling up certain strategies or interventions. Specifically, MCHIP will:
 - Seek to involve key country staff in CSHGP DIP reviews, and mid-term and final evaluations.
 - Where relevant, assist in the diffusion of key findings from CSHGP mid-term or final evaluations that hold promise for informing country-level programming.

This work will be informed by the work completed during Year 2 to document the Kenya Mission/Bilateral/MCHIP/CSHGP coordination/collaboration.

- More widely diffuse to MCHIP country programs, CSHGP grantees and CORE members in general key resources that were developed through MCHIP in Year 2, including the MNCH HSS Framework, Equity Guidelines and CCM Essentials Guide.
- Expand efforts to document and highlight CSHGP learning as it contributes to key program learning areas of MCHIP, through continued posting of grantee results highlights; focused briefing papers on topics that link to cross-MCHIP learning questions; and establishment of a BBL/Elluminate series that can become a forum for regularly disseminating interesting lessons from CSHGP programs.

CORE Group

OVERVIEW

CORE Group is an independent organization that fosters collaborative action and learning to improve and expand community-focused public health practices. CORE Group currently represents 56 NGOs with extensive experience implementing community-oriented health and development programs, with presence in 180 countries. CORE Group created and manages the Community Health Network, an international network of public health organizations, scholars, advocates and donors that support the health of underserved mothers, children and communities around the world. In this capacity, CORE Group provides several unique advantages to MCHIP's vision to: a) contribute to USAID's leadership role in innovative integrated community MCH programming, and b) maximize the inclusion of NGO contributions in scale-up of proven and integrated MCH interventions at the country level. CORE Group opens up MCHIP access to an expanded base of community expertise and experiences as well as access to community health practitioners. CORE Group serves as a program learning mechanism to provide innovative ideas and practitioner experiences to MCHIP strategy and product deliberations, as well as a vehicle for rapid action-oriented diffusion of lessons learned, tools and new opportunities to increase positive health impact. CORE Group serves as a catalyst for establishing strategic partnerships and inspiring effective practice across a wide variety of organizations.

MCHIP STRATEGY FOR CORE GROUP

CORE Group participation in and contribution to MCHIP Year 3 activities are intended to expand MCHIP's focus on improving learning related to integration of health care delivery at the community level, and to increase the diffusion of that learning both within MCHIP country programs and across the wide array of member organizations and others that participate in the CORE Group Network. MCHIP will seek to leverage existing diffusion mechanisms already in place through CORE—including its spring and fall member meetings, Community Health listserv and Elluminate distance learning sessions—to further diffuse learning that emerges from its country programs and global efforts, as well as to gain input on key activities from CORE's diverse member base of practitioners. The Year 3 workplan activities that involve CORE have been designed through joint planning between MCHIP and CORE to ensure that they resonate with both the strategic areas of focus within MCHIP and the organizational vision and goals of the CORE Group. As a result of this joint planning process, CORE Group's role is envisioned to expand beyond the realm of the PVO/NGO support element of MCHIP, to also contribute to MCHIP strategic initiatives in MNCH, nutrition, malaria, tuberculosis and immunization.

YEAR 3 ACTIVITIES/EXPECTED RESULTS

CORE Group provided input into several MCHIP products and strategies in Year 2. CORE Group provided a community-level programming perspective on MCHIP's development of a field guide to incorporate equity into program design and measurement, and provided feedback for incorporation of "community" into MCHIP's HSS framework. CORE Group finalized the ***Community Case Management Essentials – Treating Common Childhood Illnesses in the Community – Guide for Program Managers***, co-branded it with MCHIP, disseminated it across multiple organizations, and methodically advanced the approach and affiliated standards and tools.

Fiscal year 2011 will be a natural extension of increased interaction with MCHIP building upon CORE Group's community perspective. This partnership with MCHIP will enable CORE Group to continue to facilitate inter-organizational "Communities of Practice" that contribute to MCHIP

teams focused on product innovation and diffusion across an integrated continuum of mother-newborn-child care. CORE Group will focus on program learning, innovations through OR, improvement of quality tools and building capacity of NGOs to implement integrated community-oriented health programs. CORE Group will work through its membership and diverse partners to support MCHIP to develop practical approaches and strategies for implementation of community-oriented health programs aligned with the five key principles of the “GHI.”

Key Results for Year 3 will include:

- Expanded diffusion of program learning between MCHIP country programs and CORE Community Health Network, through leveraging opportunities for joint participation (CORE representatives/MCHIP staff) in technical meetings, working sessions, etc. sponsored by each organization.
- Development of “Communities of Practice” related to innovation and OR thematic areas, for the purpose of promoting peer-to-peer learning across NGO practitioners.
- Through existing communities of practice, provide input from a community health systems perspective, and then assist to diffuse key MCHIP products and initiatives related to equity, community health worker performance, potential use of birth registries for improving immunization coverage, tuberculosis, and mHealth.
- Participation as a key partner in the Helping Babies Breathe Global Development Alliance (GDA).
- Diffusion of and knowledge building around the Nutrition Program Design Assistant Tool (NPDA).
- Participation as a key partner in MCHIP’s CCM efforts, primarily through further diffusion of the CCM essentials guide, which was co-branded with MCHIP in Year 2.
- Participation as a key partner in the Maternal and Child Anemia Taskforce with MCHIP and A2Z to diffuse guidance on best practices for scaling up anemia programs.

Maternal Health

OVERVIEW

Worldwide, maternal mortality remains unacceptably high, despite noted improvements over the past 15 years. The 2010 global review of maternal mortality estimates in the *Lancet*⁵ demonstrates that progress is being made in some countries, while in other countries, little reduction in maternal mortality has been achieved. While the global maternal mortality ratio (MMR) is estimated at 251 maternal deaths/100,000 live births, wide variations persist, with the MMR highest in the region of sub-Saharan Africa and the number of maternal deaths greatest in South Asia.

The major causes of maternal mortality are well-known, and have been the target of MCHIP’s interventions from its start. PPH and PE/E—which together account for more than 40% of maternal mortality—will remain principal areas of focus, while we will begin to explore underlying practices that contribute to puerperal infection. Through special programs in nutrition, MIP and PMTCT, MCHIP will continue to address anemia, malaria and HIV in a targeted manner. MCHIP’s activities in this area will be fully integrated with program efforts addressing the newborn, for example, management of neonatal asphyxia, ENC and kangaroo mother care for the LBW newborn.

⁵ Hogan MC, Foreman KJ, Naghavi M, Ahn SY, Wang M, Makela SM, Lopez AD, Lozano R and Murray CJL. Maternal Mortality for 181 Countries, 1980-2008: A systematic analysis of progress towards Millennium Development Goal 5. *Lancet* 2010 375(9726): 1609–1623.

MCHIP has a unique opportunity to assist countries in scaling up key interventions that can address these major causes of maternal mortality. MCHIP is now working in over 30 countries and working in maternal health in more than 20 of these countries. The MCHIP Maternal Health team will serve as a technical resource to country programs—field-funded MCHIP programs, bilateral USAID programs and programs being implemented by other development partners—to guide national programs in the implementation of key evidence-based interventions, such as active management of third stage of labor or use of magnesium sulfate. This will help drive the adoption of these types of interventions across a large number of countries and help those countries achieve impact at scale. Through its relationships with national ministries of health, NGOs, bilaterals, faith-based organizations, national and international midwifery and ob/gyn societies and other development partners, MCHIP will make technical, training and implementation resources available. Using platforms such as the Africa Regional Meeting on PPH and PE/E, MCHIP will catalyze actions toward scale-up. Where appropriate, MCHIP can leverage a small amount of core resources to help countries enhance programs to provide services at broader geographical scale.

MCHIP is at the forefront of addressing major causes of maternal mortality and, as in Year 2, will continue to demonstrate global leadership in maternal health, through collaboration with the World Health Organization (WHO), UNFPA, UNICEF, FIGO, ICM and others. In recent meetings with UNFPA, specific areas of collaboration were identified, especially in the areas of midwifery support and promotion of best practices in maternal health. Meetings with regional offices of WHO will be held to engage partners, especially in Africa, in an agenda that addresses major causes of morbidity and mortality. Specifically, MCHIP will use the survey of country-level PPH activities that was done as part of the PPH strategy development to engage directly with country programs, bilateral projects and partners to ensure that PPH reduction efforts in country are being maximized and that synergies are being sought. This will take place in countries such as Tanzania, Mozambique, Kenya, Mali, Rwanda, Madagascar, Zambia, Zimbabwe, Ethiopia, Mali, Nepal, India, Afghanistan, Bangladesh, Cambodia and other countries as feasible.

MCHIP will also work with all global partners on the development of improved maternal health indicators, such as receipt of oxytocin in the third stage of labor.

MCHIP STRATEGY FOR MATERNAL HEALTH

The MCHIP maternal health strategy is focused on expanding coverage of key interventions for maternal survival, especially for PPH and PE/E. This is achieved predominantly by enhancing the role of skilled attendants working at the facility level and the quality of care that they offer. We recognize, however, that there remains a substantial percentage of women who still deliver at home and, therefore, we will continue to identify, understand and implement selected community-based service delivery approaches.

The MCHIP strategy for maternal health will:

- Support scale-up of PPH prevention programs to improve coverage of the appropriate use of a uterotonic drug in the third stage of labor in (cumulative) 16 MCHIP-supported countries.
- Expand the use of evidence-based PPH management approaches in 11 MCHIP-supported countries within the context of skilled attendance at birth.
- Introduce and/or expand the use of magnesium sulfate and other clinical strategies in the management of pre-eclampsia/eclampsia in seven MCHIP-supported countries.

- Monitor the progress and expansion of PPH and PE/E programs in 20 MCHIP priority countries.
- Expand approaches for pre-service education of midwives through programs based on sound health workforce principles and using proven educational tools and approaches in five MCHIP-supported countries.
- Understand and improve the quality of maternal health care provided by measuring quality of care and promoting and using approaches to improve quality of care, and studying the role that incentives play in driving quality improvement.
- Promote the implementation of appropriate community-based maternal health services, for example, birth preparedness counseling and advanced distribution of misoprostol for self-administration by women at the time of birth.

Skilled Attendance at Birth and Improved Quality of Care

Efforts to decrease maternal morbidity and mortality over the past two decades have focused on clinical interventions, which are predominantly delivered in facilities, to address these causes. These interventions are grouped as the well-known packages of Basic and Comprehensive Emergency Obstetric and Newborn Care (BEmONC and CEmONC). This packaging of the signal functions of BEmONC or CEmONC is useful because it creates a benchmark for training, service delivery, quality measurement, system readiness, etc. The goal is and should be that all women choose to deliver in a facility that can provide at least high-quality BEmONC by a trained provider, typically a midwife, and have access to a facility that can provide CEmONC. This “health center intrapartum-care strategy” is well presented in the 2006 *Lancet* Maternal Health Series⁶.

MCHIP supports this health center intrapartum-care strategy and feels that supporting skilled birth attendance in a health center or hospital is fundamental to maternal survival. The core workplan supports efforts toward ensuring skilled attendance at birth, especially provided by midwives, the backbone of the maternal health service delivery system. The ***Quality of Care surveys*** being conducted in seven countries (Ethiopia, Kenya, Rwanda, Madagascar, Tanzania and Zimbabwe) will give detailed guidance about clinical practices and quality, with an emphasis on management of pre-eclampsia and hemorrhage. MCHIP may also use the QoC survey tools and approach in Guatemala, the only GHI country in LAC, to assist the Mission to plan its approaches to PPH reduction and PE/E management. MCHIP will use these results to discuss improved management and evidence-based practices globally and in the countries where the survey is done. Disseminating the results will generate momentum to address the gaps identified. We will encourage USAID missions and field-funded programs to address (and measure) quality of care as part of their maternal health activities, and provide technical support to country programs as needed. Modified versions of the QoC tools and approach may be applied on a limited basis in other countries such as Mozambique or Indonesia to measure specific elements of service provision.

As described earlier in this document, quality of care is a fundamental, cross-cutting theme of MCHIP and will be addressed in a number of ways, in addition to the QoC surveys mentioned above. MCHIP will continue to participate in the working group with other USAID-funded partners to review quality of care approaches. In addition, MCHIP will briefly ***summarize the methodology of quality improvement*** that is being used in various MCHIP country programs and describe the linkage to the QoC surveys. This will serve as an internal reference for MCHIP country programs that are considering quality improvements in their workplans. As well,

⁶ Campbell OMR, Graham WJ, et al. Strategies for Reducing Maternal Mortality: Getting on with what works. *Lancet* 2006 368(9543): 1284–99.

MCHIP will identify and document how programs using quality improvement approaches generate and use their data on a local (facility-based) level to monitor and encourage progress. This approach of **local review of quality indicators** is being used in Mozambique and Nigeria and eventually in other MCHIP countries, and will be supported, tested and documented with a small amount of core funds.

It is known that there is a distinct relationship between improved quality and performance and some form of motivation or incentive. There has been much attention of late on using incentives to expand coverage or increase demand. But it is less clear how incentives can be used to improve quality or **how to incentivize quality**. MCHIP has a unique opportunity in both Malawi and Tanzania to monitor and document a system that is being put in place by other development partners to incentivize quality through the achievement of enhanced standards of care. MCHIP will leverage the activities of partners and engage in the processes in both countries to support and document the results.

MCHIP supports midwifery education and the performance of midwives as a fundamental process for increasing skilled attendance at birth. In light of a recent external assessment of Access to Clinical and Community Maternal, Neonatal and Women's Health Services (ACCESS) Program investments in pre-service education (PSE) in Africa, and the experience of strengthening the midwifery workforce in Afghanistan, additional programmatic activity is anticipated in PSE of midwives. This also aligns with UNFPA's support to ICM for the strengthening of midwifery schools, accreditation processes and professional associations. In Year 3, MCHIP will **develop a PSE strategy, implementation guide and compilation** to assist programs to implement PSE programs, in a health workforce context. This strategic program approach will be largely supported with Africa Bureau funds. This competency-based educational framework will also be applied in two countries in LAC (Peru and Paraguay), using LAC Bureau funds, to review the approach to educating midwives in use of AMTSL. In addition, in order to attempt to **model the impact of investments in PSE**, MCHIP will collaborate with Jhpiego to demonstrate the impact on maternal and newborn survival. This will have broad applicability for countries that are making determinations about the anticipated return on investment of educating midwives.

The **WHO Technical Consultation on Postpartum and Postnatal Care** report was made available in September 2010. Until the evidence is graded and guidelines are developed, MCHIP will use interim guidelines to develop implementation tools, such as a pre-discharge maternal newborn services checklist.

Another cross-cutting theme for MCHIP is the delivery at community level of evidence-based interventions that are proven to have an impact on maternal, newborn or child health. These may include distribution of iron and folate, management of newborn sepsis, provision of DMPA or emergency contraception, birth preparedness and complication readiness, or prevention of PPH through education, promotion of skilled attendance and advanced provision of misoprostol. These interventions will be gathered into a **matrix or menu of CB service delivery interventions** and prepared in a manner that explains these interventions to field implementation teams and country missions, thus allowing countries to choose the desired interventions from the menu of overall recommended interventions and design that grouping of interventions that best works with its CB health care system. Many of these interventions are currently being used in countries and will continue to be used throughout the remainder of MCHIP. Others will be introduced to countries and be programmed for implementation in Year 3 or 4 of the program. Furthermore, through use of the LiST, we will **model the impact of selected groupings of these interventions** to see what impact they can have in reducing mortality.

As mentioned earlier, further to the request of USAID, MCHIP will prepare ***MNH/FP country profiles*** that describe the maternal, newborn and PFP situations in USAID priority MCH countries. These profiles can be used for advocacy for improved programmatic approaches and strategic planning. Another set of tools that will be developed for the same strategic implementation purpose will be materials that show ***reduction in neonatal asphyxia, infection and complications of prematurity from improved labor and delivery practices***. These materials will be used for education and program implementation.

Reduction of Morbidity and Mortality from Postpartum Hemorrhage and Pre-Eclampsia

In the past 10 years, some components of maternal mortality reduction efforts have been more disease-focused, addressing the specific major causes and diseases that have led to maternal death. The global community has recognized the package of interventions and practices that can reduce PPH, and these practices have been adopted in numerous countries. The work done under POPPHI made substantial contributions to lower mortality from PPH. ***Two task forces from POPPHI, specifically the Drugs and Devices task force and the Community Interventions task force will be continued***, so as not to lose the momentum developed. This will contribute to an overall promotion of PPH reduction initiatives in multiple countries that will be supported by the ***PPH strategy*** and tracked by maintenance of the ***PPH activity data base***. The focus of MCHIP core funds will be to take effective interventions to scale in several MCHIP and other countries, by playing a catalytic role. MCHIP core funding will also be used to support country programs to implement, expand and/or scale up the PPH reduction program in at least five countries, including Malawi, Madagascar, Nepal, Zimbabwe and others, including potentially one LAC country where POPPHI had previously measured PPH activities.

In response to the increasing global attention to ***initiatives for the prevention and management of pre-eclampsia and eclampsia***, MCHIP will continue to build on Year 2 accomplishments. In consultation with USAID, MCHIP will review investments made in PE/E prevention and diagnostics, and how some of the innovations to date can be used in program settings and possibly replicated in additional countries. In consultation with USAID, MCHIP may use a small amount of core funds as seed or matching funds for countries that are interested in identifying and implementing PE/E innovations. Opportunities to identify countries include the Africa regional meeting, review of the results of the quality of care assessments, or through other channels. In addition, MCHIP will continue the work of the specific ***PE/E working groups*** and structure their activities to ensure concrete outputs. This means that we will work more concretely and actively with the working groups to accelerate their production of outputs (such as the PE/E training materials) and the implementation of those products at the field level.

It is expected that there has been progress made in countries since the first survey measuring the use of AMTSL was conducted. The QoC surveys will be measuring the provision of AMTSL; therefore, MCHIP will carry out a ***quantitative comparison of use of AMTSL*** between these two time periods in Tanzania, Ethiopia and three other countries, and describe the environments that promoted or limited the change in rates. This will be presented through presentations and the publishing of a manuscript.

As in the POPPHI Program and MCHIP in Year 2, in Year 3 MCHIP will seek the engagement of FIGO and ICM in the promotion of and advocacy for reduction in morbidity and mortality from PPH and pre-eclampsia. MCHIP will continue these relationships and formalize them by developing ***memoranda of understanding*** each ***with FIGO and ICM***. These memoranda of understanding will have a specific list of activities that the groups will carry out that will further advance understanding of and use of the best practices, including PFP, being promoted by USAID, MCHIP and the global community.

In an effort to share more widely the steps for implementing PPH and pre-eclampsia reduction programs, a ***PPH Program Implementation Guide and Compilation of Resources*** and a ***Pre-Eclampsia Program Implementation Guide and Compilation of Resources*** will be developed and widely disseminated, via the MCHIP Web site, at appropriate conferences and through field technical visits. These toolkits will be developed using guidance from the K4Health toolkit development methodology and will be provided to MCHIP field staff and offices to allow them to advocate for, implement and monitor programs targeting PPH and pre-eclampsia. These will be made available for people at the Africa Regional Meeting on PPH and PE/E so that country teams have concrete guidance and resources that they can take home to develop/further their program implementation strategies and plans.

MCHIP will also conduct a brief review of all the PPH/PE activities ongoing within the country programs and support five of those major programs to go to a broader scale. MCHIP will direct some core resources into those programs to assist achieving impact at scale.

Many of these activities will come together in an ***Africa Regional Meeting on Technical and Programmatic Approaches for the Prevention and Treatment of PPH and Pre-Eclampsia***. This meeting, to be held in Addis Ababa in February 2011, will describe the accomplishments to date in PPH programming, share the technical approaches to PE/E prevention and management, and describe how PE/E programming can be built on the PPH program platform. This meeting will be supported with field funds from country programs, core funds from MCHIP and Africa Bureau funds and be co-funded by the Oxytocin Initiative, implemented by PATH with Gates Foundation Funding. Other partners will include WHO/Regional Office for Africa (AFRO), Africa's Health in 2010 and Strengthening Pharmaceutical Systems. Participants will come mostly from African countries and will share African experiences of PPH programs. This approach is similar to that taken for the Entebbe meeting on PPH in 2004. MCHIP will follow up with participating countries on the progress of their PE/E and PPH implementation activities.

Two additional core-funded activities will look at potential barriers to successful use of uterotonics. The first will be the development and testing of a ***policy tool to guide*** MOHs in ***selection of appropriate oxytocics*** based on issues of pharmaceutical availability, cool chain, skilled attendance rates and other factors. The second, implemented in cooperation with the Oxytocin Initiative, will look more specifically at actual ***oxytocin potency*** in Nepal and Indonesia (combined with data from India and Ghana). With these data in hand, MCHIP will work collaboratively with UNICEF to develop a ***policy and strategy for inclusion of oxytocin in the vaccine refrigerator*** found in many facilities. We will also work with WHO and other partners to investigate the feasibility of adopting the use of temperature-time indicators as standard in the packaging of oxytocin.

Maternal Anemia

Maternal anemia, even moderate cases, increases the risk of dying during delivery. The recent *Lancet* series on maternal and child undernutrition estimated that 20% of maternal deaths are due to maternal anemia and stunting in women. Moreover, maternal iron deficiency anemia adds thousands of deaths to the total maternal deaths from obstetric complications annually.

Despite the consequences of maternal anemia, there is little attention given at global and country levels to the problem. Maternal anemia control programs are the primary maternal nutrition program worldwide; however, these programs are not well-funded and have therefore failed to significantly reduce maternal anemia in developing countries.

MCHIP will work at the **country level to integrate anemia prevention and treatment actions** (including iron/folate supplementation, insecticide-treated mosquito nets (ITNs), intermittent preventive treatment for pregnant women [IPTp]) into its maternal health initiatives to identify the barriers (e.g., supply and demand problems) and to improve maternal anemia control programs and reduce maternal anemia. To improve programming in these areas, MCHIP will use innovative strategies to solve supply and demand barriers to successful programs such as pay-for-performance for increasing the number of women receiving iron-folic acid supplements from health workers or community health workers, and using cell phones to remind women to take their iron-folic acid supplements. MCHIP will not take the lead at the global level to improve the global response to maternal anemia but will participate as needed with the A2Z Project on these issues. Indeed MCHIP is well-placed to do so, involved as we are in focused ANC.

As more attention is being focused on nutrition and maternal morbidities (for example, calcium and pre-eclampsia) MCHIP will undertake a review of the **evidence for linkages between specific nutritional deficiencies and specific causes of maternal morbidity and mortality**. This document, once developed, will be used internally and externally to assist the development of nutritional interventions within comprehensive primary, secondary and tertiary disease prevention strategies.

YEAR 3 ACTIVITIES/EXPECTED RESULTS

During Year 3, MCHIP will continue to build on work initiated in Years 1 and 2 to introduce and scale-up the key interventions as follows:

- Through the Africa Regional Meeting and LAC activities, global awareness will be raised and PPH-PE/E programming will be introduced or scaled up in priority countries.
- Improved maternal health programming will be planned and implemented in Rwanda, Madagascar and Zimbabwe based on the results of the Quality of Care surveys in these respective countries.
- Advocacy for increased investments in competency-based midwifery pre-service education based on results of the Modeling impact of investments in Pre-service education assessment.
- Standardized guidelines to ensure cold chain for oxytocin will be established through work with global partners.
- The global agenda for PPH, PE/E, and SBA will be advanced through collaboration with FIGO and ICM.
- Increased awareness of maternal anemia as a major contributor to maternal mortality through advocacy meetings and development of a strategic plan to address it in select countries.

Table 3. MCHIP Expected Results for Introduction and Scale-Up: Maternal Health

	EXPECTED RESULT	PROGRAM YEAR 1	PROGRAM YEAR 2	PROGRAM YEAR 3	LOP YEAR 5 (# OF COUNTRIES)
PPH	Improved advocacy and global awareness			PPH Scorecard; partnerships with global agencies; key task forces; Africa regional meeting; oxytocin selection and storage	

	EXPECTED RESULT	PROGRAM YEAR 1	PROGRAM YEAR 2	PROGRAM YEAR 3	LOP YEAR 5 (# OF COUNTRIES)
(PPH)	PPH prevention programs expanded	Mali, DRC	Kenya, Mozambique, Madagascar, Liberia, India, Nigeria and Malawi	Zimbabwe, Nepal, Rwanda, Paraguay, Indonesia Ethiopia and Bangladesh	20 countries—field and core
	PPH treatment introduced		Mali, Kenya, DRC, Malawi, Mozambique, Madagascar, Liberia, India and Nigeria	Zimbabwe and Nepal	15 countries—field and core
PE/E	Global agenda for PE/E advanced	PE/E Technical Working Group (TWG) and Task Forces established	Terms of reference for both groups established at meeting in November, 2009	Clinical guidelines with WHO; Africa regional meeting; TWGs	
	Quality of Care Surveys conducted	Design and preparation	Conducted in Kenya, Ethiopia and Tanzania	Conducted in Rwanda, Madagascar, Zimbabwe	6 countries—field and core
	Program model for prevention and management of PE/E developed and introduced		Nepal	2–4 African countries based on QoC results and Regional Meeting interest	7 countries—field and core
	PE/E program implementation monitored			7 countries where PEE programming is ongoing	10 countries
SBA	Global clinical guidelines updated		Postnatal care guidelines; PPH treatment guidelines	Pre-eclampsia guidelines	
	Quality of care improved			Processes documented; local data use in Nigeria; P4P-Quality linkage in Tanzania and Malawi	
	PSE global and country-level agendas advanced			PSE implementation guide developed and used in Madagascar, Zimbabwe, Liberia and India; Pre-service impact model	
	Midwifery faculty development accomplished			Faculty pathway developed with UNFPA and WHO; applied in Zimbabwe, India, Tanzania and Zambia	

	EXPECTED RESULT	PROGRAM YEAR 1	PROGRAM YEAR 2	PROGRAM YEAR 3	LOP YEAR 5 (# OF COUNTRIES)
	Improved delivery of high-impact interventions by strengthening SBA skills	Mozambique	Malawi, Kenya, Madagascar, India, Liberia, Mali, Lesotho and DRC	Zimbabwe	10 countries—field and core
Maternal anemia	Country-level barriers and facilitators for successful maternal anemia control programs identified through a national consultation		Bangladesh and Indonesia		5
	National strategic plan for addressing maternal anemia developed		Bangladesh and Indonesia		5
	Country-level maternal anemia control activities implemented		Bangladesh or Indonesia		5

Newborn Health

OVERVIEW

Of the 7.7 million children who die every year before reaching their fifth birthday, about 3.1 million are newborns who do not survive their first four weeks of life. The majority of these newborns live in developing countries and most die at home. Up to two-thirds of these deaths can be prevented if mothers and newborns receive known, effective interventions during pregnancy, childbirth and in the first hours and days after birth. A strategy that promotes universal access to ANC, skilled birth attendance and early postnatal care will contribute to sustained reduction in maternal and neonatal mortality.

Three causes—infections, birth asphyxia and preterm/LBW—account for 86% of neonatal deaths. While much is known about what to do to address these causes of mortality, less is known about how to deliver lifesaving interventions in low-resource settings, especially in the poorest communities, where most of these deaths occur. MCHIP will apply a systematic effort to introduce and improve coverage of evidence-based interventions including ENC (including hygienic cord care, maintenance of warmth, and immediate and exclusive breastfeeding), extra care for LBW babies (including KMC), neonatal resuscitation and sepsis management.

MCHIP's work will focus on the most vulnerable part of the neonatal period—the first week of life—as well as on CB care and linking communities to facilities. In addition to these post-delivery interventions, antenatal and intrapartum interventions mentioned in the maternal section such as skilled birth attendance and improved care of PE/E will contribute to the reduction of neonatal mortality.

MCHIP's goal is to support the reduction in the global burden of neonatal mortality and by so doing contribute to the reduction in MDG 4. MCHIP will be a key contributor to USAID's goal to reduce under-five mortality by 25% by 2013 in 30 priority countries, and to its pathway for the introduction and expansion of newborn interventions.

MCHIP STRATEGY FOR NEWBORN HEALTH

The MCHIP strategy for newborn health will:

- Support U.S. Government (USG) and GHI strategies to reduce the under-five mortality rate by 35% and reduce newborn mortality by 30% by 2015.
- Improve coverage of evidence-based approaches to improve newborn health by focusing on 20 priority MCH countries; in Year 3, MCHIP will be supporting the implementation of newborn interventions in 19 countries—10 in Africa, three in Asia and six in LAC (cumulative from Year 1);
- Support integration of ENC packages into MCH systems;
- Assure that evidence-based ENC programs are documented and promoted at scale;
- Provide technical leadership in newborn health globally; and
- Strengthen and support strategic alliances, through collaboration with UN agencies, private sector, and professional medical and nursing associations that support implementation of newborn health programs at scale.

Program Learning

MCHIP will also address key questions related to the effective implementation of these interventions at scale. For example, there are limited data on the use of KMC for CB management of the neonate, and because mothers using KMC are released early from the hospital, MCHIP will include testing and evaluating the feasibility of CB KMC. MCHIP will also examine approaches and timing for postnatal care, and learning more about the combinations of newborn health intervention packages, including management of infection and birth asphyxia in the community. The current CB injectable antibiotic treatment strategies are associated with major challenges (e.g., community acceptance, feasibility of implementation). Testing and development of these strategies for high mortality settings are issues that MCHIP and its partners can contribute to program learning.

Global Leadership

Building on the program learning questions described above, MCHIP will support global learning through technical consultations on critical technical areas including: use of maternal steroids during premature/preterm labor to improve survival of premature babies; care for LBW babies in the community; postnatal care; management of birth asphyxia; and handwashing for newborn survival. MCHIP will maintain a leadership function with strategic partners and alliances to advance global learning and advocacy aimed at increasing and leveraging resources from governments, donors and NGOs for newborn health programming. These alliances include UNICEF, WHO (Child and Adolescent Health and Making Pregnancy Safer), Saving Newborn Lives/SC, the Department for International Development, International Pediatric Association, PMNCH, Countdown to 2015, International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B), the Child Health and Nutrition Research Initiative, the BMGF, the Global Alliance for Prevention of Prematurity and Stillbirths (GAPPS) and the American Academy of Pediatrics (AAP).

ENC and KMC

In Year 2, MCHIP introduced facility-based KMC services in Democratic Republic of Congo and expanded KMC services in Nigeria, Ethiopia (under the ACCESS Program), and Malawi. In Year 3, MCHIP will continue to **expand KMC services** in Malawi, Nigeria, Ethiopia, Bangladesh, Mali, Indonesia and Mozambique. It will also complete the establishment of the two facility-based KMC services initiated in DRC. The two KMC centers will serve as learning centers for expansion to other health facilities by partners including MOH and UNICEF.

UNICEF co-funded the study tour for MOH and MCHIP staff to visits KMC sites in Mali in Year 2. During Year 2, the Community Kangaroo Mother Care (CKMC) TWG, after review of the MCHIP/Bangladesh data on the promotion of universal skin-to-skin which showed that only a small percentage of mothers practice KMC for more than two days, recommended that CKMC intervention should be programmed to **target specifically the LBW or small babies**. The Bangladesh and Malawi programs have been adjusted based on this recommendation. It is important to note that all KMC activities would include counseling for mothers, fathers and other family members on essential newborn care and postpartum family planning.

In Year 3, MCHIP will continue its collaboration with SNL and JHU to contribute to program learning on CKMC. The three partners will seek external funds, from Wellcome Trust, to conduct an effectiveness study on CKMC in Bangladesh. In addition to seeking external funds for an effectiveness study and recognizing the need to ensure thermal care and adequate feeding for LBW/premature babies, MCHIP will review its CKMC activities in Malawi using field funds to document lessons learned that would assist other MCHIP countries to provide supportive thermal and feeding care for LBW/premature babies. Using field funds, MCHIP would expand its KMC activities in Ethiopia to include a community component. Utilization of the facility-based KMC services in Ethiopia is very low. This is not surprising, given that over 90% of births in Ethiopia occur at home and most newborns including LBW babies are not taken out of the house in the first 30–40 days of life. A study in India⁷ showed that in situation with provision of good thermal care and breastfeeding at home, LBW case fatality could be reduced by 58% and preterm case fatality reduced by 70%. Seventy-five percent (75%) of the observed reduction was attributable to supportive care. Thermal control was achieved through the use of specially made sleeping bags. Although not proven, the use of skin-to-skin, shown to be effective in the hospital setting to provide adequate thermal care, could be an effective alternate. With a strong program monitoring and evaluation component, these series of community KMC (support for skin-to-skin and adequate breastfeeding) activities will contribute to the global knowledge on supportive care for LBW/premature babies in the community.

To establish a **KMC community of practice** and ensure continuity of KMC support beyond the project years, MCHIP will collaborate with The International KMC Foundation (IKMCF) based in Bogota, Colombia, and other partners to source, compile and make available through the IKMCF and MCHIP Web sites KMC-related training materials, guidance, implementation guides, job aids, videos and other supportive materials. Also, available on the site would be a list of KMC trainers that countries could contact to assist them to introduce or expand KMC services.

Additional efforts focused on the development of videos and other supportive materials will take place in Azerbaijan. MCHIP, in response to a USAID/HIDN directive, will support the development of educational materials to complement existing Clinical Practice Guideline (CPGs). The CPGs were developed by the MOH, with support from USAID-funded bilateral programs, to introduce evidence-based practices to providers working in MNCH. USAID has requested that MCHIP develop clinical training videos and client pamphlets. Initial discussions suggest materials in ENC are needed. During Program Year 3, further to consultation with partners in country, MCHIP will prioritize the CPGs requiring supplemental materials, identify the appropriate format of these materials and support their production.

MCHIP's strategy for the prevention of preterm births and their complications is to ensure proven interventions known to reduce the incidence of preterm births are included in all its focused ANC programs. The interventions will be context specific and include: syphilis screening and treatment; reproductive and urinary tract infection screening and treatment; intermittent presumptive

⁷ Bang et al., 2005.

treatment of malaria; iron/folate; and steroids for pregnant women with threatened preterm deliveries where appropriate. All the listed interventions with the exception of maternal steroids are included in MCHIP's focused ANC package. In Year 3, further to discussions with GAPPS, National Institute of Child Health and Human Development (NICHD), SNL and other partners, MCHIP will sponsor a consultative meeting on maternal steroids during preterm labor in developing countries. MCHIP's program direction on this intervention, in collaboration with its partners, will be determined after the consultation. Year3 activities may include data collection on maternal steroid utilization in selected countries, and the program design and evaluation in one country.

In Year 2, MCHIP extended its ENC program to India, and Mali (to begin in Year 3), and disseminated the joint statement by WHO/UNICEF and supported by USAID and Save the Children through three regional meetings/conferences—the White Ribbon Alliance Annual conference held in Tanzania, the Asia best practices conference held in Thailand and the East Central and Southern Africa College of Nursing conference held in Zambia. The dissemination was done in collaboration with WHO and other regional organizations in sub-Saharan Africa and Asia. In Year 3, MCHIP will continue to disseminate the joint statement at appropriate regional forum and facilitate its adoption and implementation at country level. MCHIP will work with WHO and UNICEF to disseminate and facilitate country adaptation of their training manual associated with the joint statement “Caring for the Newborn at Home: A Training Course for Community Health Workers.” This training manual will be the primary training manual for MCHIP postnatal home visits. This is an integrated package of home care practices that includes counseling on postpartum family planning.

MCHIP in collaboration with other partners will assist in the dissemination of the findings from recent studies on the impact of chlorhexidine application to the umbilical cord to prevent neonatal sepsis. MCHIP staff will participate in two dissemination workshops in Asia—Bangladesh and Nepal—and provide technical support to integrate this intervention into ongoing ENC activities in the two countries and elsewhere. Assuming WHO gives its approval to expand the use of chlorhexidine application on umbilical cords to Africa, MCHIP will explore the feasibility of integrating this intervention with ongoing ENC activities in Nigeria and other African countries.

Newborn Sepsis

MCHIP and its global partners including SNL and Johns Hopkins University Institute for International Programs established a TWG on neonatal sepsis management in year 2. This TWG would assist in defining a strategy for the introduction and expansion of CB infection management of neonatal sepsis (CBIMNS). The TWG assigned an intern to assist in the mapping of neonatal sepsis management at the community level in sub-Saharan Africa and Southeast Asia.. This activity will continue in Year 3. Using Africa Bureau and field funds, MCHIP initiated CB management of neonatal sepsis work in Nigeria. MCHIP is working with the Nigeria Society of Neonatal Medicine (NISONM) to introduce this intervention in three Local Government Authority areas in the three MCHIP-supported States, one LGA per State. MCHIP will continue to support this work under Year 3. There is commitment from Federal MOH, WHO and UNICEF to use the tools developed by NISONM from this activity to expand community-based neonatal case management to other LGAs in Nigeria. Unfortunately, there has been no commitment from the other USAID bilateral programs as they were not able to attend the stakeholders' meeting held to discuss this activity. MCHIP will continue to dialogue with them, including inviting them to a second stakeholders' meeting scheduled for the first quarter of the upcoming fiscal year.

MCHIP will introduce community management of newborn infections in Indonesia. This activity is primarily supported by field funds, but to better document lessons learned, core funds might

be used to complement the M&E component of the program. Using LAC funds, MCHIP will develop strategies to implement prevention and treatment of newborn sepsis in the Dominican Republic and Paraguay (See LAC section). To facilitate program learning, awareness creation and mobilization of resources to scale up this intervention, process documentation will be completed for all the newborn sepsis management programs.

Neonatal Resuscitation

In Year 2, under USAID leadership, MCHIP assisted in finalizing the Global Development Alliance on HBB. MCHIP also partially supported AAP with funds to train over 100 Master Trainers in HBB, and orient over 50 program managers and policymakers on HBB. MCHIP supported the field-testing of the HBB materials in Kenya and Bangladesh, and will assist the two countries to develop national strategies for scaling up neonatal resuscitation in the context of ENC. Working with ECSA-CON during their annual conference, MCHIP oriented over 200 nurses, midwives, and principals and registrars of nursing and midwifery schools from more than 13 countries in East, South and Central Africa on HBB as part of its strategy to improve pre-service newborn curriculum. MCHIP together with the Regional Centre for Quality of Health Care (RCQHC) based in Makerere University, Uganda, and Africa 2010 developed a workplan to provide TA to selected pre-service schools to strengthen the ENC and neonatal resuscitation components of their curricula. In Year 3, MCHIP will continue to partner with AAP, NICHD, Health Care Improvement Project/University Research Co. and Health Tech to introduce and expand HBB activities in Africa and Asia. MCHIP will support the AAP to develop a training video to accompany the current set of HBB training materials, develop a quality assurance system to ensure that the effectiveness of the HBB training is maintained in the implementation roll-out, and also to provide TA in MCHIP HBB countries. In partnership with AAP, MCHIP will support three regional workshops to train HBB Master Trainers in Africa, Asia and LAC. The Africa workshop will be held in Uganda in collaboration with the RCQHC. Discussion will be held with the MCHIP maternal team, RCQHC and Africa 2010 to explore the feasibility of combining the PPH/PEE and HBB Africa regional workshop. This would require adding one or two additional days to the PPH/PEE workshop, and having non-midwifery attendees, such as pediatricians, join the workshop later in the week to participate in the HBB component of the workshop. All of the HBB regional workshops will be conducted in the context of broad newborn health and would include state-of-the-art (SOTA) and skills-building sessions on ENC, KMC and handwashing.

The preceding paragraph described MCHIP's activities for improving management of birth asphyxia after it has occurred. In addition to neonatal resuscitation, MCHIP is committed to enhancing the prevention of birth asphyxia through upgrading the knowledge and skills of service providers to appropriately detect and manage antenatal conditions, such as pre-eclampsia, that have an impact on birth asphyxia. Appropriate monitoring of labor through the correct use of partographs will also be strengthened (see maternal section for more information).

Handwashing with Soap for Newborn Health

In Year 2, MCHIP collaborated with USAID and Unilever to finalize and launch the Global Development Alliance on Handwashing for Newborn Survival. Though the process was delayed, it provides a solid foundation for collaboration with the private sector and a framework to expand handwashing for newborn survival activities in additional countries as opportunities arise. Additionally, agreements have been made with the London School of Hygiene and Tropical Medicine and with the CDC and ICDDR,B to carry out formative research in India and Bangladesh respectively. Using field funds, MCHIP initiated work at the district level in Indonesia as well as established a relationship with government, multi-lateral institutions,

NGOs and the private sector at the national level, which will be leveraged to scale the district level activities in Year 3.

In Year 3, MCHIP will complete the formative research in India and Bangladesh and hold a technical consultation meeting with stakeholders to share the findings and come to consensus on appropriate messages, programmatic approaches and indicators to improve handwashing for newborn survival, as well as identifying remaining knowledge gaps. In collaboration with Unilever, MCHIP will develop and distribute communication materials to be integrated into MCHIP ENC and other maternal and newborn health activities in India, Bangladesh, Indonesia and potentially Nigeria. MCHIP will explore broader distribution of materials and methods through the Core Group, the new USAID global environmental health program as well as other appropriate regional events. Handwashing for newborn survival will also be an integral part of the series of regional HBB workshops planned for Year 3.

YEAR 3 ACTIVITIES/EXPECTED RESULTS

MCHIP's newborn activities primarily contribute to the USAID Newborn Health Results Pathway and, in addition, advance the achievement in the Skilled Birth Attendant Results Pathway through the strategy of home visits by community health workers.

During Year 3, MCHIP will continue to build on work initiated in Years 1 and 2 to introduce and scale-up the key interventions, ENC, KMC, neonatal resuscitation, handwashing and management of neonatal infection, proven to prevent or treat the three main causes of neonatal deaths as follows:

- Move implementation of KMC forward for LBW newborns in three countries (Mali, Bangladesh and Malawi); and establishing a KMC community of practice.
- Scale up ENC in Mali, India and Kenya.
- Explore the feasibility of integrating the application of chlorhexidine on umbilical cord into the ENC intervention in Nigeria—assuming WHO gives its approval for global use.
- Continue supporting the introduction of CB infection management of neonatal sepsis in Nigeria
- Improve the survival of preterm births by increasing the use of maternal steroids during preterm labor by better understanding of barriers that limit its utilization in developing countries, and developing a strategy for increasing its utilization during premature labor.
- Support the improvement and scale-up of newborn resuscitation in Kenya, Bangladesh, Dominican Republic, Nigeria, Ethiopia and selected pre-service nursing/midwifery schools in Ghana and other countries in East, South and Central Africa, and a network of regional trainers in LAC.
- Conduct the Quality of Maternal and Newborn Care Assessment in countries to be determined.
- Support the scale-up of handwashing for newborn survival in India, Bangladesh and Indonesia, and explore initiation of work in Nigeria.

Table 4. MCHIP Expected Results for Introduction and Scale-Up: Newborn Health⁸

	EXPECTED RESULTS	PROGRAM YEAR 1	PROGRAM YEAR 2	PROGRAM YEAR 3	LIFE OF PROGRAM FISCAL YEAR 2013
ENC (and postnatal care for mother)	Postnatal/ENC introduced (<=three districts)		India, Malawi, Mali, Nigeria and Dominican Republic	Mali, Indonesia, Dominican Republic, Paraguay and Colombia	15
	PNC/ENC expanded (>three districts)		Bangladesh and Democratic Republic of Congo	Bangladesh, India, Nigeria, Malawi, Ethiopia, Zimbabwe and Mozambique	10
Disseminate/ launch UN Joint statement	Joint UN Statement on CB newborn care launched and implemented in six countries		Bangladesh, India, Kenya, Mali and Nigeria Over 20 countries (White Ribbon Annual conference and Asia best practices regional meeting)		15
KMC (facility and community)	KMC introduced and expanded		Malawi, Bangladesh, Nigeria, DRC, Mali, Dominican Republic and Nicaragua	Malawi, Bangladesh, Nigeria, DRC, Mali, Indonesia, Dominican Republic, Nicaragua, Guatemala, Honduras, El Salvador and Peru	15
	CKMC programs	Bangladesh	Bangladesh and Malawi	Bangladesh, Malawi, Ethiopia, Mozambique and Indonesia	8
CB infection prevention and management	Newborn infection management introduced		Bangladesh, Nigeria and Dominican Republic	Bangladesh, Nigeria and Dominican Republic and possibly Paraguay	8
	Newborn handwashing promoted through public and private sector alliance		India, Indonesia and Bangladesh	India, Indonesia, Bangladesh and Nigeria	8
Management of asphyxia	Introduce management of asphyxia in facility and home (stimulation only) settings		Kenya and Bangladesh	Bangladesh, India, Kenya, Ethiopia, Nigeria, Zimbabwe, India, Ghana, Dominican Republic and Peru	8

⁸ This table includes countries supported by both core and field funds.

Child Health

OVERVIEW

Child mortality remains high in most developing countries despite being only five years away from the target date for reaching the MDG goals. Nearly two-thirds of child deaths could be prevented through provision of simple, inexpensive, cost-effective preventive and case-management interventions including those addressing malnutrition, which is an underlying factor in at least 30% of childhood deaths. However, reaching children in the poorest communities of the poorest countries remains a challenge. More equitable efforts are needed because children in the poorest households receive less health care and have higher mortality rates than children from the richest households.

Actors outside of the facility-based health system, such as CHWs, can facilitate access to illness treatment and other services. Some countries do not support delivery of services by CHWs, or restrict the services they can deliver, such as antibiotics for pneumonia. Most countries using CHWs for provision of sick child care struggle to provide the support necessary to achieve high-quality delivery at scale of CB illness treatment. An uninterrupted supply of essential health products and regular supportive supervision are critical health systems supports required for effective community case management (CCM).

Despite strong evidence of impact and official endorsement by WHO, progress in the adoption and scale-up of integrated community case management (iCCM) for the sick child is slow paced, and the situation is worse in Africa relative to Asia.⁹ Community treatment of pneumonia has stalled as many countries are reluctant to adopt this policy. Sustained advocacy over the past years is winning over an increasing number of countries. More countries, particularly in Africa, have adopted iCCM: Ethiopia, Mali, Uganda and Zambia have recently endorsed policies permissive of introduction of iCCM. This is coming at a time when there is growing support for an integrated iCCM package that includes treatment for malaria, pneumonia, diarrhea and malnutrition. The trend is shifting also to include management of non-complicated acute malnutrition in the package (Mali, Senegal). A few countries in Africa are moving to scale (e.g., DRC, Rwanda and Senegal).

Pneumonia remains the number one killer of children. While burden of pneumonia can be somewhat reduced through adoption of HiB and pneumococcal vaccines into routine immunization services, the most potent intervention to reduce pneumonia is appropriate case management. In some settings, high coverage with suitable antibiotics can be accomplished entirely through fixed facility services. However, in many of the country settings where MCHIP is involved, a large proportion of cases of ARI do not come to the attention of the formal health sector. Taking antibiotic treatment out to the community level offers a very promising approach to increasing coverage and reducing mortality. In non-malaria-endemic settings, there are successful examples of pneumonia and diarrhea case management done by CHWs (notably in Nepal). In malaria-endemic areas, it makes more sense programmatically to integrate community case management of ARI, diarrhea and malaria. Furthermore, leveraging resources of PMI and GFTMA provides an opportunity to go after all three major child killers.

Since the change of antimalarials from SP/chloroquine to ACTs, CB treatment of malaria has faced two challenges: concern over increased risk of resistance and high cost of ACTs. Even where CB distribution of artemisinin combination therapy (ACT) is allowed, priority in access to drugs is often given to health facilities. Planning in most settings does not yet take iCCM into account. The entry of rapid diagnostic tests (RDTs) is changing the face of malaria treatment.

⁹ Marsh DR, Gilroy KE, Van de Weerd R, Wansi E, Qazi S. Community case management of pneumonia: at a tipping point? *Bull World Health Organ.* 2008;86:381–9.

Their use adds complexity to algorithms and support systems (e.g., ensuring continuous supplies of test kits). Although PMI does not promote the use of RDTs at the community level, in some countries the national policy supports the use of RDTs at this level. In these countries, MCHIP will assist the MOH to expand iCCM using RDTs. In several countries, there is evidence that money and lives are wasted when community workers continue to use expensive ACTs despite negative RDTs. This is largely because countries have no antibiotics or no policy permitting CHWs to treat children who are presenting with fever and negative RDT results for presumed pneumonia.

The President's Malaria Initiative (PMI), together with the Obama administration's GHI guidance to integrate MCH programs, do more of what works and promote proven approaches, which provides unique opportunities for the USG to contribute substantially to the rapid expansion of iCCM globally. Both USG financial resources and TA are poised to assist countries to make further progress beyond malaria-specific mortality reduction to reducing mortality of all three of the major causes of childhood deaths worldwide: diarrhea, pneumonia and malaria.

Diarrhea is the second leading cause of child death in children under five years globally. About one in every five child deaths—around 1.5 million—is attributed to diarrheal diseases. The overall incidence rate of diarrhea has changed little in the last few decades. As suggested in the USAID/ Basic Support for Institutionalizing Child Survival (BASICS) III final report, lack of attention to diarrheal disease is in part a consequence of this community and HF-based emphasis being replaced in most countries by Integrated Management of Childhood Illnesses (IMCI), a more exclusively HF-based strategy which has had disappointing results. There has also been a decreased attention to diarrheal disease control as resources and focus have been diverted to large-scale, disease-specific programming focused on HIV, malaria and other conditions. Nevertheless, as attention shifts back toward integrating interventions delivered at the community level, the application of CB approaches may present an opportunity to attract resources to contribute to the control of diarrheal disease. This approach is complementary to the overall child health approach that MCHIP applies and—subject to availability of funds—will be an important element of the MCHIP strategy to lowering child mortality attributed diarrhea in priority countries.

MCHIP STRATEGY FOR CHILD HEALTH

MCHIP is committed to the MDG 4 goal of reducing child mortality by two-thirds. MCHIP will advance USAID's effort to expand access to quality-delivered, proven interventions to children in hard-to-reach areas.

Building on strategies outlined in the MCHIP Year 2 workplan and the lessons learned from predecessor projects, MCHIP will focus on two main priorities for addressing child mortality; introduction and expansion of CCM of pneumonia and roll-out of diarrheal disease management.

Integrated community case management (iCCM). This approach encourages integration of case management for pneumonia, malaria, diarrhea and identification/referral of cases of malnutrition. MCHIP will focus on the following tasks related to iCCM:

1. **Ensuring appropriate integration between iCCM and other community-level interventions.** MCHIP will work with country programs to better integrate iCCM with other CB interventions. Better integration has the potential to increase efficiencies in delivery and create resource mobilization for iCCM. Where necessary, MCHIP will join with partners to create permissive policy (e.g. in DRC, MCHIP is spearheading the integration of FP with ICCM, including conditions for the delivery of long acting methods; in Mali, MCHIP

is supporting the development of an integrated package of CB services that includes FP and newborn health). In all cases, MCHIP will assist in the development of approaches and adaptation of tools.

2. **Contributing to the improvement, adaptation and dissemination of simplified iCCM tools and common indicators.** Most countries collect substantial amounts of data that are either not used or are under-used beyond the introduction phase. Indicators used for iCCM programs often differ from those used at health facilities or those applied in other countries. MCHIP will continue to work with USAID and other partners to define a list of common iCCM indicators and support selected countries to use these indicators. Use of these more standardized data measures should improve iCCM documentation and advocacy for additional political support and resources.
3. **Developing approaches to improve quality and integration of iCCM within the national health system.** Currently, iCCM services are reaching only a small population. Achieving mortality impact at national scale requires involvement by a large number of volunteers and health workers, most of them with modest educational backgrounds requiring additional training and support. At the HF level, we are challenged by understaffing of health professionals and often poor motivation. NGO participation brings additional human resources but bears the risk of reducing ownership by the MOH, which is critical for sustainability. Furthermore, some countries use paid CHWs, whereas the majority rely on volunteers. MCHIP will work with the MOH and partners to develop approaches that build on complementarities of partners and effectively maintain the quality of services provided by CHWs.
4. **Ensuring supply chain for iCCM.** MCHIP will coordinate with other partners (e.g., the JSI project, SC4CCM) to ensure adequate attention is given to all aspects of the supply chain in countries where we are engaged in iCCM.

Comprehensive Diarrheal Disease Control. MCHIP expects to contribute to broader child efforts to increase appropriate use of fluids (including ORS) for household-level management of diarrhea using strategies tailored to the country context. We will also seek opportunities to integrate important key aspects of diarrheal disease control including routine use of zinc (rather than the inappropriate treatments commonly used) and key WASH practices (notably handwashing, clean water and sanitation, and to include other elements where appropriate).

As has been well documented in recent years, despite remaining among the top two killers of children, in very few countries is serious attention being given to the control of diarrheal disease. More effective action to drive down the burden of mortality and poor nutritional outcomes attributable to diarrhea will require: effective advocacy to engage host governments, donors and technical assistance partners, and sound context-specific strategies aiming for impact at scale.

MCHIP's approach is not prescriptive; we do not intend to go into countries with a pre-formed package to offer. Instead, we propose to engage key stakeholders and partners, first to galvanize commitment and second to characterize the diarrheal issue in their setting with regard to scope, determinants and available promising lines of attack. In Year 3, MCHIP intends to facilitate such a process in at least two countries beyond Kenya (e.g., DRC, Mali).

In 2009, UNICEF and WHO laid out a seven-point plan for comprehensive diarrheal disease control (see Figure 3). Despite the significant contribution to under-five mortality and the new, more effective protocol for ORT and zinc treatment that has been specified, individual countries are still giving insufficient focus to improving diarrheal case management. MCHIP sees the

seven-point plan as a useful tool in revitalizing diarrheal disease case management in high-burden countries. Both the introduction of rotavirus vaccine into the RI schedules of a number of new countries in the next year, and a new call for measles eradication, are high visibility initiatives that MCHIP is in a position to capitalize on to raise the profile of diarrheal disease prevention and treatment more broadly. In addition, MCHIP will leverage opportunities to revitalize diarrheal disease case management in those countries poised to introduce the new treatment protocol for diarrhea with low-osmolarity oral rehydration solution and zinc supplementation. The opportunity also exists to link with new programs focusing on nutrition, including the provision of counseling on feeding practices during diarrhea episodes. Finally, MCHIP will take advantage of the in-country presence of JSI, PATH, PSI and SC working on projects with potential diarrhea links.

Building on lessons learned from USAID/BASICS, Point of Use Water Disinfection and Zinc Treatment (POUZN), and similar projects, MCHIP will conduct situational assessments in focus countries to develop a strategy with in-country stakeholders and host governments to revitalize diarrheal disease control. The POUZN project identified key factors that need to be addressed in order to increase diarrhea treatment uptake, such as:

- Sustained availability and access to treatment supplies;
- Leveraging both the public and private sectors to expand access to key diarrhea treatment products;
- Staff training questions;
- Caregiver and provider behaviors associated with provision of multiple unnecessary diarrhea treatments; and
- Using social capital and radio communications to increase the uptake of key treatment behaviors.

For example, in Benin, POUZN offered diarrhea treatment kits (2 sachets of ORS and one blister of pediatric zinc) through both the commercial sector and public sector reinforced by CB distribution. According to a 2009 survey, this system was able to ensure that one-third of the children who had diarrhea in the last two weeks were treated with zinc, up from 1% in 2007.

Figure 3. Seven-Point Plan for Comprehensive Diarrhea Control

<p>Prevention Package</p> <ul style="list-style-type: none"> ▪ Rotavirus and measles vaccinations ▪ Promotion of early and exclusive breastfeeding and vitamin A supplementation ▪ Promotion of handwashing with soap ▪ Improve water quantity and quality, including treatment and safe storage of household water ▪ Promotion of community-wide sanitation <p>Treatment Package</p> <ul style="list-style-type: none"> ▪ Fluid replacement to prevent dehydration (ORT) ▪ Zinc supplements

MCHIP will provide TA directly to countries in order to assist them to update diarrheal disease control programs. Working with MOHs, we will provide the technical support needed to integrate new treatment protocols as part of IMCI, but will also invest in the introduction and expansion of community case management programs that include diarrhea control activities, as well as

improving household-level prevention and management of diarrhea. Building on lessons learned from both USAID/BASICS, HIP, POUZN and similar projects, MCHIP will provide TA to ensure that national policies and strategies incorporate a context-appropriate mix of approaches and interventions (e.g., rotavirus vaccine, low osmolarity ORS, zinc supplements) including needed training and supportive supervision tools and systems to orient health workers to updated policies and new interventions. In addition, MCHIP will work with the national health management information systems to ensure that the capacity exists to monitor and track the scale-up and sustained delivery of diarrheal disease control programs.

1. **Expand the role of CHWs to include diarrheal disease control activities and contribute to reductions in under-five mortality attributed to diarrheal disease.** MCHIP will continue to expand the role of CHWs in the context of an integrated CCM package that includes a strong diarrheal disease case management component. This has been an entry point to expand diarrheal disease control activities in the country through community-level cadres providing services to reach the unreached and also to revitalize existing national diarrheal disease control programs.
2. **Advancing activities to revitalize diarrheal disease case management at the country level.** MCHIP began working with in-country diarrheal disease stakeholders in Kenya in Year 2, and will continue in to work in Kenya as well as Mali and DRC in Year 3. In addition, we will coordinate with USAID Missions to help in identifying additional countries for targeted MCHIP support.

The MCHIP five-year life of program (LOP) strategy for child health will:

- Follow the Paris Principles and work to leverage global and country partners, with special emphasis on collaboration with PMI, UNICEF and the Catalytic Initiative, to support rapid scale-up of priority child health interventions.
- Raise awareness and resources for pneumonia and diarrheal disease within an integrated vision and create conditions that will facilitate collaboration and coordination in the field, especially at the country level.
- Rapidly accelerate the introduction and expansion of integrated child health programming and learning at the global and country levels for iCCM, ORT revitalization including addition of zinc, optimal infant and young child feeding/nutrition before, during and after illness, and water/sanitation/hygiene interventions (notably handwashing), and specific approaches for urban child health.
- Link program implementation with operational research to identify evidence-based solutions to challenges in the field (quality as well as increased coverage of iCCM, task sharing, etc.).

MCHIP will strategically use core funding to closely collaborate with key global partners such as PMI, UNICEF (e.g., Catalytic Initiative) to advance the USAID results pathways for pneumonia, ORT and zinc, primarily through integrated iCCM, increasing access to treatment for pneumonia, diarrhea and malaria to those outside the reach of current health services, and to improve adherence to optimal use of ORT and other fluids for home-based management of diarrhea.

PROGRAM LEARNING

MCHIP will contribute to consolidating and disseminating iCCM program learning, in the form of the “toolkit.” This is intended to be a rich repository of materials, which have been developed and refined in real program use, generally within national iCCM programs. The expected

process is to include collecting and making available these materials in electronic form (on a Web site), working with counterparts in selected target countries where there may be openness to adopting iCCM, helping to organize and manage a regional meeting of such counterparts, during which these tools would be presented, and following up in-country with advocacy and program planning support.

In Year 2, MCHIP began a documentation effort in Senegal and the DRC. In addition to reflecting back key lessons learned for program managers in country, in Year 3 MCHIP will synthesize these findings for several audiences, including global level leadership in iCCM and malaria. A particular focus will be on key factors required for successful scale-up. As more countries express interest and begin introducing iCCM, guidance based on the experience of countries that are further ahead in iCCM can be invaluable in helping program managers make sound strategic choices.

As with other technical areas addressed by MCHIP, much of our child health effort depends on functional CHWs. MCHIP will be looking systematically across country experiences, documenting the conditions necessary for effective community-level work. This will include looking at factors influencing CHW motivation and at how to ensure that where CHWs are responsible for multiple interventions, sometimes related to a variety of programs, performance is not compromised. These issues will be addressed through a combination of desk review, key informant interviews and primary data collection.

Continuing work begun in Year 2, MCHIP will further disseminate country-level child health LiST tool analyses, with guidance on interpretation. MCHIP will further develop child health country profiles for all USAID priority MCH countries, as a tool for planning and prioritizing.

YEAR 3 ACTIVITIES/EXPECTED RESULTS

Program Learning Opportunities

Documenting lessons learned by countries that have taken iCCM to scale is an important aspect of MCHIP's long-term child health strategy. In Year 3, MCHIP will conduct a third country case study in a series toward this purpose in one Anglophone African country (TBD). In addition, MCHIP will conduct an assessment of iCCM in Rwanda. Participation in country assessment exercises by key stakeholders, such as UNICEF and WHO, in addition to MCHIP and USAID staff, will enrich multi-agency buy-in to study findings and recommendations. These iCCM country studies will inform the design of programs and evaluations during the anticipated expansion of iCCM in priority MCH and PMI countries.

MCHIP will work at global, regional and country levels as described below to contribute to the mortality reduction in 20 priority countries over the LOP.

Year 3 Expected Results

- Building on work by the DHS, SUZY,POUZN, UNICEF and WHO, MCHIP will develop a document that summarizes key diarrhea treatment lessons learned and illustrates the level of global coverage of ORS and zinc availability.
- Convene key stakeholders, in the focus countries (Kenya plus one to two additional countries), to assess current diarrhea control activities, gaps (according to the seven-point framework) and develop a strategy for scaled up ORT revitalization and other key elements of diarrheal disease control.
- Participate in Zinc Taskforce calls and explore incentives around ORS/ zinc provision and use by providers and caregivers and share lessons.

- Summarize available evidence on effective diarrhea treatment communication channels and messages in a concise document (based on findings from POUZN and SUZY).
- Support WASH/Health advocacy efforts associated with Global Handwashing day, Global Toilet day, and World Water day.
- Identify key moments to highlight the need for ORS/zinc revitalization and work with sector partners to raise awareness.
- Finalize and disseminate iCCM indicators, matrix and toolkit, along with developed guidelines for the use of the global and key iCCM indicators.
- Countries where MCHIP has iCCM involvement will have made appropriate revisions to their standard iCCM indicators and will be making more effective use of these data for program management and decision-making.
- Regional workshop(s), conducted in partnership with UNICEF, WHO, USAID and other iCCM stakeholders, disseminate the toolkits and indicators, contributing to creating interest in introduction of iCCM in additional countries.
- iCCM Toolkit, indicators and matrix further refined and improved over time based on field experience.
- Country iCCM implementation improved through the use of indicators and applying matrix components to the country program.
- Country-level iCCM program learning better documented in implementing countries through routine tracking and measurement using the iCCM indicators.
- Finalized DRC documentation and additional iCCM documentation carried out and finalized in a third country.
- Supported the implementation of iCCM in DRC, Mali and Rwanda in the context of a CB, integrated package.
- Support introduction of iCCM in at least two countries (e.g., Mali, Mozambique, Ghana, Kenya).
- In selected countries (e.g., DRC, Mali, Rwanda) iCCM better linked/ integrated with other interventions delivered at community level: FP, DOT, cotrimoxazole prophylactic treatment, community management of uncomplicated acute malnutrition and systematic use of iCCM sites for outreach activities, especially EPI.
- Successfully advocated and supported introduction of CB treatment of pneumonia in the context of iCCM in select countries.
- Supported country-level problem characterization, planning and coordination of efforts to more effectively drive down the burden of child diarrhea mortality in Kenya and one or two additional countries.

Table 5 summarizes MCHIP targets for introduction and expansion of iCCM, ORT revitalization and zinc introduction.

Table 5. MCHIP Expected Results for Introduction and Scale-Up: Child Health

EXPECTED RESULTS		PROGRAM YEAR 1-2	PROGRAM YEAR 3	LIFE OF PROGRAM—FISCAL YEAR 2013
Programmatic analyses and findings provide further evidence for effective introduction and scale-up of integrated CCM and ORT revitalization programs		Country case studies conducted in two PMI countries	Country case studies conducted in two countries Results of CCM studies disseminated in 4 countries	5
Joint advocacy and technical support for integrated CCM carried out with Catalytic Initiative/ACSD and Global Action Plan for Prevention and Control of Pneumonia (GAPP)	To be coordinated jointly with USAID, UNICEF and implementing partners		Regional conference on CCM held to disseminate CCM tools and indicators	
Number of countries with integrated CCM or pneumonia control programs	Introduction	Mali	Indonesia, Mali, plus at least two others	6
	Expansion	DRC, Rwanda	DRC, Rwanda	8
Joint advocacy and technical support for ORT revitalization carried out with Catalytic Initiative/ACSD, ClIFF ORT/Zn and ZTF ¹⁰	To be coordinated jointly with USAID, UNICEF and implementing partners	DRC, Kenya	DRC, Kenya, Zimbabwe, plus one	3 or more
Number of countries with revitalization of ORT and introduction of zinc activities	Introduction	Kenya and Mali	Kenya, Mali, plus one or two selected countries	13
	Expansion	DRC	DRC plus one or two selected countries	6

Country-Level Activities

Using the seven point plan from WHO and UNICEF as a framework, MCHIP will explore the possibility of developing diarrhea disease control programs in two countries, including Kenya, Mali and another country to be identified. These programs will seek to address questions raised from previous diarrhea work and document the comprehensive approach highlighted above. Building on the country profiles, MCHIP will continue to analyze the epidemiological burden of the GHI countries and compare this with mission needs to assess potential countries for implementation such as Mali, DRC and Benin. The goal is to demonstrate and document the feasibility of addressing diarrheal disease through a comprehensive approach and share the experience with other countries.

MCHIP is taking the opportunity in Kenya to develop a package of diarrhea interventions at facility levels and expand the role of CB structures founded on the seven-point plan as laid out by UNICEF and WHO.

1. Revitalization/reopening of ORT corners in health facilities. This goes along with the improvement of HW capacity to manage DD as well as working with stakeholders to make zinc available and affordable.

¹⁰ ClIFF countries: Kenya, Nigeria, India, Ethiopia

* implemented under ongoing BASICS TOs

2. Using ORT corners and possibly drug dispensing structures as site for communicating key WASH messages and practices to caregivers and parents: this will include education on, display and demonstration of use of tippy tap, handwashing, home water containers and fecal disposal at home.
3. Using CHW and other CB actors to provide information on WASH, care seeking for DD and home-based care for children with DD, compliance with immunization and where possible administering treatment including zinc.
4. Working with CB public health officers to work with village-based structures to promote proper disposal of feces, protection of water source and proper storage of water, as well as POU treatment, handwashing. These messages will be tested through on-going behavioral surveys.
5. Currently, there appears to be a real gap in Kenya associated with ORS/zinc supply. MCHIP will explore the challenges associated with product availability and supply and looks at expanding community access through social marketing or other mechanisms.
6. Support the inclusion of other country approaches in the health system for systematization, expansion and sustainability. For example, in Kenya, MCHIP will assist MOH and partners to integrate the CLTS and SLTS in the community strategy.

In addition to this package approach, it is clear that the MCHIP team will need to address the challenges around procurement of diarrhea treatment materials. Zinc is currently not available in country and access to ORS is declining. The MCHIP Team will explore with missions how best to address this concern.

Immunization

OVERVIEW

Vaccination programs prevent approximately 4 million deaths each year, and about 20% of the remaining 7.7 million child deaths could be prevented through vaccines that are currently used or soon to be introduced in developing countries. USAID provides considerable financial support to the GAVI Alliance (GAVI) and polio eradication efforts. Disease control initiatives against polio, measles and tetanus similarly attract sizable resources from the donor community. However, the availability of these resources has exposed the relative lack of technical support being provided by partners to strengthen the capacity of MOHs to develop and implement their RI programs. USAID, through its contracts, has partially filled this niche over the years to complement the efforts of other global partners.

MCHIP STRATEGY FOR IMMUNIZATION

In alignment with the principles of the GHI, MCHIP will continue USAID's strategy of combining technical support to MOHs and partners at national and sub-national levels with technical leadership at global and regional levels. Working with global and regional partners (including WHO, UNICEF, U.S. CDC, GAVI, the BMGF and others) and directly with USAID Missions and partners at the country level, MCHIP will advance the immunization pathway goals of: 1) increasing sustainable immunization coverage with all appropriate vaccines to reach the unreached and reducing child mortality from vaccine-preventable diseases; and 2) supporting the effective and sustainable introduction of affordable, safe, high-quality new and/or underutilized vaccines and innovative technologies. In most of its activities, MCHIP continues the strong contributions IMMUNIZATIONbasics (IMMbasics) and earlier USAID global immunization projects have already made at global, regional and country levels.

By their nature, immunization programs are designed to achieve public health impact at scale, but clearly some programs are stronger and more effective than others. MCHIP aims to provide complementary TA to USAID/GHI priority countries with low or faltering coverage and requires additional core MCH resources to attract additional Mission field support to do so.

The Reaching Every District (RED) approach—originally designed by WHO, UNICEF and USAID—will be a key feature of MCHIP country support. RED is a package of immunization “best practices” that can be introduced to reach the unreached and thereby increase and sustain high levels of immunization coverage. RED focuses at the district and HF level to:

1. Improve the planning and management of available immunization resources by, among other things, targeting districts and health facilities with large numbers of unimmunized children for special attention;
2. Select and use an appropriate mix of service delivery approaches to ensure that all children have at least four appropriately spaced immunization contacts before 12 months;
3. Strengthen the linkages between health facilities and the communities they serve, encouraging community involvement in the tracking of pregnant women, infants and vaccination defaulters, and other activities;
4. Ensure regular support supervision and on-the-job training for those who deliver and manage immunization services; and
5. Use data for the active monitoring and management of RI services over time.

Application of this systematic approach has been associated with improved coverage in many countries. An important part of RED entails encouraging countries to once again target for special attention those districts and health facilities with large numbers of unimmunized and partially immunized children and then to use appropriate combinations of service delivery strategies—fixed, outreach and periodic intensification—to reach them by 12 months of age with the full infant immunization series.

MCHIP builds on the work started by IMMbasics and others to revitalize RED in the Africa region and also use RED and RED-like approaches at the country level to strengthen immunization services and increase coverage in areas of low performance. MCHIP will also begin work, again with WHO/AFRO, to adapt and test the use of the RED approach to manage an expanded package of MNCH/FP interventions, either singly or in combination as integrated approaches.

To ensure that USAID MCH priority countries are ready to incorporate new vaccines and that those with low or faltering immunization coverage are strengthened, in addition to support for RED, MCHIP will also provide TA to the USAID MCH and GHI priority countries for: multi-agency EPI reviews and coverage surveys; comprehensive multi-year plans (cMYPs) and annual work planning; cold chain and vaccine management assessments and capacity building; data quality audits and data quality self-assessments; development of vaccine introduction plans and technical support for smooth introduction of the new vaccines; and preparation of GAVI applications and supporting documents (including cMYPs) for all types of funding, including funding for new vaccines.

In Year 2, MCHIP was unexpectedly requested to field a team of seasoned experts at short notice to provide technical support through WHO/HQ and through WHO/AFRO for emergency preparedness and response to countries in Africa. USAID is deliberating currently to determine whether they will play a continuing role on H1N1 and whether MCHIP will contribute.

Global and Regional Partnerships

MCHIP provides **global** technical leadership to numerous bodies and serves on several advisory panels, including: WHO's Immunization Program Advisory Committee; WHO on its ad hoc Advisory Committee on Gender and Immunization; WHO/Performance Assessment Tool for Quality Improvement in Hospitals Project Optimize Program Advisory Group; WHO/ Strategic Advisory Group of Experts (SAGE) on its ad-hoc group studying the impact of new and underutilized vaccine introduction on immunization systems and health systems; WHO/SAGE on its study of the epidemiology of the unimmunized child; WHO/UNICEF's Vaccine Presentation and Packaging Advisory Group; UNICEF's technical group of experts developing a "Communication Framework for Pneumonia and Diarrhoea Control and New Vaccine Introduction"; UNICEF's Cold Chain and Logistics Task Team; CDC's external Routine Immunization Research Review; World Bank as part of its multi-agency assessment of polio in Nigeria; GAVI on its design and launch of the architecture and a constituency to support civil society organization engagement in immunization; USAID on the field experience in pandemic H1N1 influenza preparedness and response; WHO on its consultation to assess the feasibility of measles eradication; and others. At the **regional** level, the Program will continue providing support to WHO regional offices, with particular attention given to the Africa Regional Office (AFRO), to AFRO's subregional Inter-Country Support Team (IST) offices and at the annual meeting of the Task Force on Immunization (TFI) in Africa.

Furthermore, MCHIP will seek opportunities to contribute its expertise and field experience to the continuing global dialogue on: better linking of immunization with other health interventions; engaging civil society; strengthening the relatively weak link between health services and communities to increase birth and subsequent vaccine doses; identifying reasons for non-immunization; preparing guidance to national managers on revision of their immunization schedules; using RI outreach as a platform for other health interventions; and capitalizing on RI contacts—whether in static facilities or through outreach—to add birth spacing messages.

USAID is a key supporter of the Polio Eradication Initiative (PEI), notably in communication and surveillance. In collaboration with MOHs, WHO, UNICEF, the Bill and Melinda Gates Foundation, CORE, CDC, USAID bilaterals and other partners, MCHIP provides focused TA to help guide the PEI strategy, communication and RI linkages at global and regional levels as well as in priority countries, including DRC, India and Nigeria. MCHIP and its subcontractor, the Communications Initiative (CI), are actively involved in global and regional polio and immunization meetings, as well as reviewing and contributing to training and information, education and communication (IEC) materials, data collection and survey tools, and other communication-related documents. In addition, MCHIP advises a multi-agency expert group (led by UNICEF), on refining and implementing a standard set of polio communication indicators that are to be used globally and in polio-endemic and at-risk countries to contribute to improving polio coverage and PEI goals. This past year, a series of peer-reviewed journal articles capturing lessons learned in polio communication was organized by CI, with contributing authors from CI, MCHIP, USAID and other organizations/affiliations. These articles will be further disseminated and used to guide communication approaches and learning for PEI and countries. CI will also assist in organizing approximately four or five Polio Communication Reviews, which bring panels of experts and field teams together to focus on the specific issues faced within polio-affected countries. CI staff and consultants will also continue to participate as technical experts in country Polio Technical Advisory Group (TAG) panels, notably in Afghanistan and Pakistan. For program learning and global exchange, CI will continue to maintain a web page on polio which disseminates lessons learned from research and various meetings and consultations to targeted audiences of policy makers and polio communication implementers.

A key issue for the success of polio eradication—particularly in countries like India with large populations—is to ensure that new birth cohorts are protected against Wild Poliovirus. This includes the initial Oral Polio Vaccine (OPV0) contact at birth as well as completion of the RI OPV schedule by six months of age. Using a “tracking every newborn” approach in India, MCHIP will work in one block in each focus district (i.e., three in UP and one in Jharkhand) to build capacity for generating due lists to track pregnant women and newborns and to ensure that infants delivered at facilities are given both OPV0 and BCG before discharge. This will link with Janani Suraksha Yojana to strengthen contacts with pregnant women and facilities to increase OPV0 vaccination and to improve use of vaccination cards and primary health care follow-up mechanisms for ensuring that these infants complete their full OPV series. More broadly, MCHIP will also work to improve the use and link of the polio microplanning with planning RI services, including triangulation of data for improved implementation and monitoring of polio and RI performance.

Opportunities for Program Learning

Through MCHIP, USAID will have an ally in marshaling and managing knowledge and disseminating experience that has been accumulated over many years of consistent USAID support for RI and polio eradication. In addition to the documentation efforts mentioned above (e.g., experience in adding other interventions to RI, epidemiology of the unimmunized child, relation of gender and sex to immunization, field experience in pandemic H1N1 influenza preparedness and response, etc.), MCHIP also links to an exciting BMGF learning grant (ARISE, Africa Routine Immunization System Essentials) that is systematically identifying, documenting and making information available about strategies in the Africa region that work to strengthen RI system performance and sustain high levels of coverage. This grant is managed by JSI, MCHIP’s lead organization for child health and immunization.

YEAR 3 ACTIVITIES/EXPECTED RESULTS

MCHIP will use global core funds to continue Year 1 and Year 2 achievements to make progress in Year 3:

- Participate with USAID and partners in global/regional advocacy and planning to mobilize resources and coordinate support for implementation at the country level.
- Supplement field support in selected countries in the development and implementation of strategies to reach unimmunized and partially immunized children with lifesaving vaccines in MCH priority countries with fragile or ineffective immunization systems.
- Support the introduction of new vaccines by working with countries on national introduction plans and GAVI applications; strengthening RI systems; building the capacity of health workers and managers; and monitoring and evaluating the introduction process.
- Use RI and polio eradication strategies to strengthen each other and guide integration efforts (i.e., link polio and RI data and decision-making more effectively; compile and disseminate lessons learned; identify and help to address issues with integration).
- Continue working with WHO/AFRO to add selected MNCH/FP interventions to the existing RI platform and simultaneously expanding the RED approach to support multiple interventions. (This will include field-testing in one country the use of an adapted RED approach to improve coverage/continuity of some aspects of MNCH/FP.)
- Finalize a monograph on the experience using routine outreach—a mainstay of immunization programs around the world—as a platform on which to add other interventions.

- Collaborate with learning grant activities supported by the BMGF to identify and document innovations and other successful approaches to RI strengthening in Africa.

Core-supported immunization activities are also included in other pathways and strategies, including those focused on FP, and in the country strategies for DRC, Kenya, India, Zimbabwe and Rwanda. With support from USAID's Reproductive Health and Family Planning Division, MCHIP will further document and explore how routine vaccination contacts can be used systematically to counsel mothers about healthy timing and spacing of pregnancy and provide FP services.

Table 6. MCHIP Expected Results for Introduction and Scale-up: Immunization

EXPECTED RESULTS		PROGRAM YEAR 1 (INC IMMBASICS) AND PROGRAM YEAR 2	PROGRAM YEAR 3	LIFE OF PROGRAM—FY13
Analysis of immunization in high-burden countries	Expansion and improvement	Analysis conducted	Country summaries updated and used with USAID Missions Literature review on unvaccinated child	All MCH priority countries
RI coverage increased by one year of age in areas receiving MCHIP TA	Expansion and improvement	DRC, India, Madagascar, Nigeria and S. Sudan and Rwanda	DRC, India, Rwanda, Zimbabwe and Kenya	Six or seven countries
Resources leveraged toward implementation of coordinated RI improvement plans	Expansion and improvement	Benin, DRC, India, Madagascar, Timor-Leste, and S. Sudan, Senegal and Uganda	DRC, Kenya, India, Rwanda, Zimbabwe, Uganda and Senegal	Six or seven countries
RI planning and management capacity at district level improved	Expansion and improvement	One regional RED adaptation workshop conducted with WHO/AFRO India, Nigeria, S. Sudan, Madagascar and Timor-Leste	One or two regional RED adaptation workshops conducted DRC, India, Kenya, Zimbabwe and Timor-Leste	TBD
RED+ Selected MNCH/FP interventions added to RI and RED	Action research/introduction	Literature review on integrated outreach One country selected with WHO/AFRO for RED+ design and testing	One or two countries (e.g., Liberia, India)	3 countries
MCHIP technical input given related to new vaccine introduction	Introduction and expansion	WHO guidance to national policymakers on immunization schedules drafted Technical input provided to multiple global policies	Global policies, strategies and post-introduction evaluation guidelines finalized with MCHIP input	Seven or more key global and/or regional policies
New vaccines and innovative technologies introduced	Introduction and expansion	Rwanda (pneumococcal vaccine) Drafted protocol for assessing Healthcare Waste Management (HCWM) pre and post new vaccine introduction	Two countries Rwanda (rotavirus vaccine)	Four to six countries

EXPECTED RESULTS		PROGRAM YEAR 1 (INC IMMBASICS) AND PROGRAM YEAR 2	PROGRAM YEAR 3	LIFE OF PROGRAM—FY13
Routine immunization and polio eradication strategies used to mutually strengthen each other	Introduction and expansion	Four polio endemic countries	Five or more countries	Five to seven endemic and re-importation countries

Family Planning within the Context of MCHIP

OVERVIEW

While the benefits of FP are multi-dimensional, including individual, economic, social and environmental benefits, the focus of MCHIP/FP is on associated health benefits and activities are framed here in that context.

Relation to Pathways: MCHIP includes FP/MNCH integration as a key strategy for reducing maternal, infant and child morbidity and mortality. This is accomplished through the contribution to various pathways either by preventing unintended pregnancies or by promoting healthy pregnancy spacing, defined as at least 24 months birth-to-pregnancy interval for live births or a minimum of six months after an abortion or miscarriage. The table below summarizes interactions with MCHIP pathways.

Table 7. FP Interaction with MNCH Pathways

PATHWAY	FAMILY PLANNING	CONSEQUENCES
Maternal <ul style="list-style-type: none"> ▪ Pre-eclampsia ▪ Eclampsia ▪ Prevention of PPH ▪ Skilled birth attendance 	Prevention of unintended pregnancy Prevention of pregnancies for high parity and older mothers Prevention of short interval births (<33 months)	Prevention of obstetric complications Prevention of unsafe abortion
Newborn/Infant/Child <ul style="list-style-type: none"> ▪ ARI Immunization <ul style="list-style-type: none"> ▪ Oral Rehydration Treatment 	Prevention of short interval births Prevention of unintended pregnancies Promotion of exclusive breastfeeding Promotion of maternal health and nutrition	Prevention of adverse outcomes- LBW, stillbirth, pre-term, small for gestational age Prevention of maternal death Protection of infant/child health and development

MCHIP STRATEGY FOR FAMILY PLANNING

As outlined in previous workplans, the five-year LOP strategy for FP will:

- Systematically integrate FP in maternal and newborn care, with an emphasis on linking immediate and exclusive breastfeeding with the lactational amenorrhea method and other key messages, and providing immediate postpartum family methods such as tubal ligation and IUD. The program will assess ways to increase the number of women who transition appropriately from LAM to another modern method, continuing the efforts that ACCESS-FP has initiated for a seamless transition from ACCESS-FP to MCHIP.
- Ensure that FP counseling and provision of commodities are strengthened as an integral component of postabortion care (PAC), and that PAC becomes a component of all emergency obstetric and newborn care (EmONC). Long-term and/or permanent methods such as IUDs, implants and tubal ligation should be available for women wanting to space or limit pregnancies.
- Systematically integrate FP services into contacts for both well and sick infants and children, including immunization, nutrition and other services to support initiation and continuation of FP to achieve healthy spacing intervals.

Final submission: Approved 21 October 2010

- Develop and apply CB models for FP integrated within the MNCH continuum of care.

Relationship to the GHI

The FP/MNCH component responds to the core principles in the following ways:

1. FP/MNCH integration addresses **women's needs to prevent unintended pregnancy** and is centered on responding to those needs. It interfaces with providers, communities and family members in responding to needs.
2. Due to the integrated nature of the FP component within MNCH, it requires **strategic coordination** with the other components, specifically, tailoring FP messages and services to the postpartum period and the nature of the service or other contact.
3. The FP/MNCH component **promotes innovation and systematic learning about effective integration**. This is visible in efforts to link immunization and infant and young child nutrition with FP, as well as supporting analysis of Demographic and Healthy Survey (DHS) information to highlight missed opportunities at the country level. The Healthy Fertility Study (HFS) in Bangladesh is an important example of on-going research, aimed at learning about effective integration to promote pregnancy spacing and its impact on newborn outcomes.

YEAR 3 ACTIVITIES/EXPECTED RESULTS

This section is organized into three key areas, global leadership, FP integration with maternal and newborn health, and FP integration with infant and child health. Activities for each of these three areas are discussed briefly along with expected results for the year summarized at the end of the section. In this program year, emphasis is being placed on field programming and maximizing opportunities to learn about integration.

Global Leadership

Promotion of Best Practice

For best practices related to FP/MNCH integration, there are a variety of global activities that MCHIP will support; many of these build upon the foundation established through ACCESS-FP. These include:

- Two technical presentations and representation at selected international conferences including the Global Health Council and American Public Health Association. During the year, abstracts will be submitted for at least five presentations by MCHIP and/or partner staff.
- MCHIP staff will also participate in various TWGs including PAC, healthy timing and spacing of pregnancies, and the PFPF group in IBP.
- An annual literature review of PFPF will also be undertaken and focus on programmatic updating of PFPF-related studies. This review will be posted electronically and shared with the broader MNCH/FP community.
- MCHIP will develop a technical brief on best practices and lessons learned with regard to FP/MNCH integration.
- The PFPF Web site, housed at K4Health, will be updated and maintained. A link to this Web site will be made from the MCHIP Web site.
- Continuation of work with Reproductive Health and Research at WHO to develop PFPF guidance.

PPFP Community of Practice

MCHIP will continue to support the PPFP community of practice established under ACCESS-FP. Key activities in this area include the maintenance and updating of the PPFP community of practice site housed under the WHO/IBP site. The PPFP community of practice currently has over 700 members representing 71 countries. During the year, there will be at least three on-line technical discussions in which experts present SOTA information and experience with PPFP programming and the annual PPFP meeting.

FP/MNCH Integrated Country Profiles

During this year, profiles will be developed for five key MCHIP countries. These will be developed from DHS information and will build on the profiles developed under ACCESS-FP. However, in addition to information about FP needs and use, they will be expanded to address missed opportunities for service contacts for all key services. These profiles have proven to be important advocacy tools and it is anticipated that under MCHIP these profiles will contribute to more strategic service integration.

Translation of PAC Curriculum

During this year, revisions to the PAC Curriculum will be translated in consultation with the Priority Area PAC Champion into both French and Spanish.

Application of LiST tool to FP

In addition, the LiST tool will be adapted to provide a quantitative estimate of mortality averted through contraceptive use during the first two to three years postpartum. This information will be used to promote the integration of FP/MNCH with policymakers.

Integration with Maternal and Newborn Health

These activities are largely the continuation of activities initiated under ACCESS-FP. These include: leadership in PPIUCD, PPIUCD OR in Rwanda, the HFS and the integrated MNH/FP package in Mali.

Leadership in PPIUCD

Over the past year, there has been an enormous interest in the PPIUCD and consequently demand for technical support. It should be noted that the PPIUCD work includes postplacental IUCD, immediate PPIUCD, intra-operative IUCD and postabortion IUCD. In addition to quality clinical services, the programmatic aspects include demand generation as well.

- Leadership of PPIUCD working group: A working group has been established and will continue during the coming year. An initial meeting will be held with subsequent virtual meetings. This working group will be linked with the Long-Acting and Permanent Method (LAPM) community of practice. Virtual discussions will include demand generation for PPIUCD, technical and material requirements for PPIUCD service provision and postabortion IUCD.
- Development of TA resources for PPIUCD: At the moment, there are a limited number of clinicians who can provide support for PPIUCD initiatives. During this year, a clinical training will be held (in either India or Paraguay) to standardize skills for five regional master trainers and familiarize them with the PPIUCD learning resource package, including the postabortion IUCD. These master trainers will serve as a resource for MCHIP and the global community. This activity will be coordinated with RESPOND, other CA and professional (FIGO; ICM) agencies.

- Documentation and dissemination of the PPIUCD experience in Paraguay: Data from the national hospital in Paraguay of over 10,000 PPIUCD and postabortion IUCD clients are being reviewed to provide insight into an insertion technique that has a reportedly low expulsion rate of 4%, comparable to the interval IUD rate. While the data are still being analyzed, the results will be reviewed and have the potential to affect PPIUCD insertion technique around the world. In the upcoming year, documentation will be completed and results will be widely shared at the global level.

PPIUCD Operations Research in Rwanda

In collaboration with Family Health International's PROGRESS project, ACCESS-FP has been providing guidance in design, implementation and evaluation of an OR study introducing PPIUCD services in four district hospitals and eight health centers including Muhima Maternity since November 2009. This OR examines the feasibility and acceptability of PPIUCD services in selected facilities in Rwanda by drawing upon ACCESS-FP's experience, particularly in India and Kenya. It is anticipated that this OR will not only strengthen existing IUCD services and reduce unmet need of FP among postpartum women in the project sites but eventually be scaled up in other parts of the country. MCHIP will continue to support the study, be responsible specifically for:

- Providing ongoing technical expertise to the demonstration project;
- Leading PPIUCD trainings and regular supportive supervision;
- Testing and modifying ACCESS-FP's PPIUCD learning resource package (developed for India) and PPFPP global learning resource package in the context of Rwanda.

Healthy Fertility Study in Bangladesh (both core and field support)

MCHIP will support the HFS, taking over this role from ACCESS-FP. MCHIP will ensure the necessary technical support for the intervention design and follow-up, Johns Hopkins Bloomberg School of Public Health (JHBSPH) will ensure the research aspects of the study, and local partners, the Bangladeshi MOH, Shimantik and Center for Data Processing and Analysis, will ensure the implementation. During the coming year, the results from the three and six month follow-ups will continue to be disseminated. Information relative to women's practices the first year postpartum will be collected and compared for the intervention and control areas. The findings from the first year will be important in demonstrating the effect of the intervention. The findings will be disseminated within Bangladesh and globally as indicated. It is anticipated that at least one article will be prepared and submitted to a peer-reviewed journal. In addition, a JHBSPH doctoral student will be completing her dissertation examining the quality of care in the intervention and control sites. Her findings will also be disseminated within Bangladesh as indicated, with at least one article prepared for a peer-reviewed journal.

Strengthening FP in Postabortion Care and Postpartum in Ghana

Building on PSE work in Ghana and Malawi, MCHIP will complete work with PSE institutions in the two countries by the end of Year 2. In addition, MCHIP will work with local partners in Ghana to design and carry out an evaluation of the practices of graduates in order to estimate the effect of this activity. It is anticipated that a sample of graduates, stratified by rural/urban and facility level, will be selected for follow-up. The practices of this group of graduates will be compared with graduates who did not receive the integrated curricula. The evaluation of this group of graduates will have implications for PSE globally.

Integrated MNH/FP Package in Mali (both core and field support)

MCHIP's work in Mali offers a unique opportunity for an integrated MNH package. This package focuses on three key components, active management of the third stage of labor

(AMTSL), ENC, and PFP. While effectively engaging all levels of the health system, the integrated package focuses special attention on workers at the periphery; the auxiliary midwife (matron) linked with community health workers. For PFP, these linkages provide important opportunities to link with skilled birth attendants, ensuring quality service delivery of FP services. In addition, linkages with the community health workers provide the opportunity to reach women and families not in contact with services and extend PFP services beyond the clinic walls.

Integration with Infant and Child Health

Leadership for Maternal, Infant and Young Child Nutrition (MIYCN)/FP Working Group and Model Development

Building on earlier initiatives, MCHIP will continue to provide leadership for the MIYCN/FP working group. The LAM working group will be merged into this group. The working group will hold quarterly meetings and provide a forum for members to share experiences and learning based on both academic findings and field work.

Because of the synergies between FP and infant and young child nutrition, MCHIP will identify a field site where the programmatic interconnections between nutrition and FP can be developed and explored. Using existing nutrition platforms (such as CB growth monitoring and promotion of breastfeeding support groups), opportunities will be identified to integrate PFP messages linked to services. Where CB distribution of contraception is being implemented, opportunities will be identified to integrate infant and young child nutrition counseling. In both cases, an emphasis will be placed on extending coverage and increasing service use. Another opportunity could be through agriculture promoters, which could be an important way to reach men and heads of households. During Year 3, MCHIP will identify at least one field site where combined MIYCN and FP activities can be piloted and evaluated.

Developing Immunization/FP Models

- Reaching Every District: Liberia

The RED+ approach is a strategy to increase and sustain high levels of RI. Developed in 2002 by WHO and partners, it uses five components, at the district level, to plan, manage and monitor services. These are: planning and management of resources, reaching target populations, linking services with communities, supportive supervision and monitoring for action. (See Immunization section for additional detail.) These components will be used for the development of the integrated approach of FP and immunization in at least one setting. Emphasis will be placed on outreach and the intervention will include FP services. Liberia is identified as possible model site.

- Systematic screening and strengthening service delivery Systematic screening is a simple procedure allowing health care providers to address multiple needs of a client during a single visit, and it has been demonstrated to be effective (e.g., Systematic Screening to Integrate Reproductive Health Services in India; N.P. Das, Urvi Shah, Varsha Chitania Population Research Centre, University of Vadodra Pratibha Patel The Vadodra Municipal Corporation M.E. Khan, Anurag Mishra, and James R. Foreit Frontiers in Reproductive Health Program; August 2005). In 2010, ACCESS-FP carried out an adaptation of systematic screening for postpartum women in Northern Nigeria and found the procedure to be effective at identifying women, but disappointingly, it did not increase service use. Modifications need to be made in service delivery approaches to ensure that women have access to their FP methods of choice. MCHIP will take the lessons learned from Nigeria and undertake an adaptation that ensures effective, immediate service delivery including long acting methods. Two possible sites for this model are yet to be determined.

Summary of Expected Results

Global Leadership

- Two technical presentations at international fora to share best practices in FP/MNCH integration.
- Presence on key TWGs sharing best practices in FP/MNCH integration.
- Up-to-date summary of new literature in PPF and FP/MNCH integration.
- Technical brief on best practices and lessons learned in FP/MNCH integration.
- Updated Web site summarizing evidence and tools related to FP/MNCH integration.
- Three on-line discussions addressing FP/MNCH integration led by technical experts.
- Annual Community of Practice meeting focused on sharing experiences and effective approaches for FP/MNCH integration.
- Five “missed opportunities” country profiles for key MCHIP countries disseminated to USAID leadership and other partners.
- Revisions to the PAC curriculum translation in French and Spanish completed.
- Quantitative estimate of health impact of contraceptive use on mortality prevention for two to three years postpartum and application in advocacy presentations for five countries.
- RHR/WHO programmatic guidance for PPF issued.

FP Integration with Maternal and Newborn Health

- Active PPIUCD community of practice is exchanging tools, experience and promoting method as part of a menu of services.
- Quality PPIUCD services are implemented in four countries through MCHIP TA.
- Findings from Paraguay experience are finalized and disseminated widely.
- OR findings are collected, analyzed and disseminated, examining the impact of introducing PPIUCD in selected facilities in Rwanda with PROGRESS.
- HFS—Bangladesh:
 - Results for 12 months are collected, analyzed and disseminated;
 - Results for 18 months are collected and analyzed; and
 - Results for integrated service quality are collected analyzed and disseminated.
- PSE for postpartum and postabortion FP is evaluated through a comparative analysis of graduate performance in Ghana. Findings are widely disseminated.
- Integrated package design and baseline are completed and being implemented in two districts in selected regions of Mali with local partners.

FP Integration with Child Health

- An active working group is sharing program tools and working toward objectives.
- Effective model of FP/MIYCN integration is developed and implemented in one country setting with significant program learning.
- Effective model of FP/immunization integration is developed in one country setting with significant learning.
- Effective application of systematic screening is linked with FP services in two country settings.

Malaria

OVERVIEW

Today, approximately 40% of the world's population—mostly those living in the world's poorest countries—are at risk of malaria. Malaria is found throughout the tropical and sub-tropical regions of the world, and causes more than 250 million acute illnesses and at least 881,000 deaths annually (WHO, 2008). Eighty-six percent of deaths due to malaria occur in Africa, south of the Sahara, mostly among young children. Malaria kills an African child every 30 seconds. Many children who survive an episode of severe malaria may suffer from learning impairments or brain damage. Pregnant women and their unborn children are also particularly vulnerable to malaria, which is a major cause of maternal anemia, LBW, maternal death and infant mortality. Malaria, together with HIV/AIDS and TB, is one of the major public health challenges undermining development in the poorest countries in the world.

One of MCHIP's goals is to reduce the global burden of malaria morbidity and mortality. This will contribute to improved MNCH outcomes, including a reduction in maternal and child morbidity and mortality, which will directly support the MDGs 4, 5 and 6. MCHIP will support the PMI goal to reduce malaria deaths by half in 15 target countries, as well as USAID malaria countries, by reaching 85% of the most vulnerable groups—children under-five years of age and pregnant women—with proven and effective malaria prevention and treatment measures. These measures include: ITNs, indoor residual spraying (IRS), RDTs, new lifesaving anti-malarial drugs for children, and treatment to prevent and control malaria in pregnant women, as well as intermittent preventive treatment for infants (IPTi) (pending WHO approval).

MCHIP STRATEGY FOR MALARIA

MCHIP will apply successful approaches and innovative strategies that are flexible and pragmatic to strategically integrate malaria prevention and control on the platform of MCH comprehensively at the global, regional and country levels. Since MCHIP addresses malaria prevention and control in MCH, the Program's implementation strategy is naturally aligned with the strategic principles of PMI, including the GHI. For example, MCHIP recognizes that **women are central** to addressing malaria prevention (especially among pregnant women) and control—as leaders in their communities. Also, MCHIP will **strategically integrate** malaria on an MCH platform through the promotion of ITNs and delivery of IPTp in the context of focused ANC and case management for children. Further, MCHIP aims to coordinate implementation and foster partnerships with HIV/AIDS programs (e.g., PMTCT and MIP) to integrate programs.

At the **global level**, MCHIP will aim to continue to provide technical leadership, in collaboration with the Roll Back Malaria Partnership, including PMI, GAPP, WHO and UNICEF, which will contribute to the synthesis and dissemination of best practices and lessons learned—leading to program learning—to regional and country-level stakeholders. At the **regional level**, MCHIP will support efforts to strengthen the link between malaria and MCH partners, building stronger partnerships (e.g., reproductive health, child health, HIV, TB and laboratory/malaria control), which will contribute to effective integration, coordination and harmonized implementation. At the **country level** (primarily through field support funds), MCHIP will provide technical and programmatic guidance to introduce, accelerate and scale up implementation of malaria interventions—targeting proper case management, improving diagnostics and community interventions, MIP and promoting the use of ITNs on the platform of MCH services and programs. These efforts will contribute to implementation of the countries' national malaria plans and support the achievement of PMI targets. At the community level, MCHIP will provide TA to grantees of the Malaria Communities Program in planning, implementing, monitoring and evaluating malaria projects with multiple interventions,

including IPTp, ITNs, prompt recognition and treatment of illness with ACT, and cooperation with IRS efforts. This will lead to improving communities' access to preventive services and treatment, and strengthen links to facilities.

MCHIP will aim to build national and local (community, NGO, private sector and facility) capacities and strengthen health systems to accelerate scale-up of malaria prevention and treatment programs—especially for women and young children through maternal and child platforms. In Years 1 and 2, MCHIP supported a number of efforts that set the stage for malaria implementation and scale-up at the global, regional, country and community levels. Table 8 summarizes MCHIP's core-supported efforts in Years 1–3 as well as our expected results in Year 3 and over the life of the program.

YEAR 3 ACTIVITIES/EXPECTED RESULTS

Table 8. Summary of Core Activities and Expected Results

ACTIVITIES			YEAR 3 EXPECTED RESULTS	LIFE OF PROGRAM FISCAL YEAR 2013
PROGRAM YEAR 1	PROGRAM YEAR 2	PROGRAM YEAR 3		
Malaria In Pregnancy—Global Technical Leadership				
Technical and programmatic participation in RBM MIP working group	Technical and programmatic participation in RBM MIP working group Co-chair RBM MIP working group Dissemination of MIP tools and resources to PMI country teams	Technical and programmatic participation in RBM MIP working group Co-chair RBM MIP working group	Technical guidance (e.g., best practices and lessons learned) disseminated at global, regional and country levels Contribution to the prioritization of MIP research agenda Stronger linkages between RH and malaria control through regional networks and in MCHIP country programs	Contribution to: Improved IPTp uptake Increased ITN use Early ANC attendance MDGs 4, 5 and 6
Malaria in Pregnancy—Documentation and Dissemination of Best Practices and Lessons Learned				
Documentation in Zambia started	Documentation—Zambia and Senegal Desk Review—Malawi Dissemination at global and regional malaria and MCH conferences	Documentation—Malawi Dissemination through MCP workshop as well as global and regional malaria and MCH conferences	Standardized framework for the analysis of best practices and lessons learned in MIP implementation finalized Reinvigoration of MIP programming at global, regional and country levels	Contribution to: Improved IPTp uptake Increased ITN use Early ANC attendance MDGs 4, 5 and 6
Malaria in Pregnancy: Core Support at the Country Level				
MIP bottlenecks assessed and addressed in Nigeria	MIP bottlenecks assessed and addressed in Nigeria Technical and programmatic support to start up in Burkina Faso malaria program, supporting MIP, diagnostics and case management	-	-	Contribution to: Improved IPTp uptake Increased ITN use Early ANC attendance MDGs 4, 5 and 6

ACTIVITIES			YEAR 3 EXPECTED RESULTS	LIFE OF PROGRAM FISCAL YEAR 2013
PROGRAM YEAR 1	PROGRAM YEAR 2	PROGRAM YEAR 3		
iCCM—Global Technical Leadership				
CCM Task Force, CCM.ORG	CCM Task Force, CCM OR Group, work on toolkit, indicators and matrix	Participation in GAPP, iCCM and global Malaria fora Participation in dissemination workshops for toolkit and best practices	Contribution to a) the iCCM toolkit and Web site b) the iCCM implementation matrix and indicators Regional conference on CCM held to disseminate CCM tools and indicators	Contribute to MDG 4, improved stakeholder engagement among CCM Task Force, CCM.ORG and RBM East/West Networks
iCCM: Documentation and Dissemination of Best Practices and Lessons Learned				
Senegal initial planning	Senegal documentation completed and disseminated in country DRC data collection completed	DRC documentation finalized and disseminated in country Third country identified and documented Global dissemination in conjunction with toolkit	Implementation improved in countries documented iCCM countries improve tools and documentation Country case studies conducted in two countries Results of CCM studies disseminated in 4 countries	Contribute to MDG 4, expanded evidence base for CCM implementation and scale-up, and increased country-level capacity for CCM in five countries
iCCM: Core Support at Country Level				
Mali, DRC (non PMI)	Support to Mali for the development and introduction of iCCM including newborn and FP Support to CCM implementation in DRC, Rwanda	Continuous technical support to DRC, Rwanda and Mali Rapid national assessment of the Rwanda CCM program Facilitate movement toward CCM in additional candidate countries	CCM efforts advanced in current and two to three new countries Rwanda assessment results used to inform program expansion/improvement and global evidence base for CCM	DRC, Rwanda, Mali and at least two other countries TBD

ACTIVITIES			YEAR 3 EXPECTED RESULTS	LIFE OF PROGRAM FISCAL YEAR 2013
PROGRAM YEAR 1	PROGRAM YEAR 2	PROGRAM YEAR 3		
Malaria Communities Program—Support to PMI/MCP Team				
<p>Report guidance updated</p> <p>Five annual reports and 13 work plans reviewed</p> <p>TA plans created</p> <p>Assistance provided with PMI annual report</p> <p>Supported organization of national workshop in Benin</p>	<p>Report guidance updated; final report guidance created</p> <p>Annual reports and work plans reviewed</p> <p>Six TA plans created</p>	<p>Update report guidance</p> <p>Review 18 annual reports and work plans; review two final reports and provide feedback to PMI and grantees</p> <p>Create TA plans with grantee and PMI, as needed</p> <p>Coordinate peer reviews of annual reports and work plans</p> <p>Prepare information for PMI annual report</p> <p>Organize BBLs following site visits</p> <p>Organize and facilitate portfolio review meeting</p>	<p>Report guidance updated</p> <p>Eighteen annual reports and work plans reviewed; two final reports reviewed</p> <p>TA plans created (as needed)</p> <p>Peer reviews coordinated</p> <p>Information contributed to PMI annual report</p> <p>Project information, including lessons learned disseminated</p>	<p>Strengthened NGO capacity to implement CB malaria prevention and treatment programs</p> <p>Lessons learned about CB malaria programming documented and disseminated</p>
Malaria Communities Program—Support to MCP Grantees				
<p>Ad-hoc support provided to grantees</p> <p>Site visits conducted</p> <p>Regional workshop organized</p> <p>PDME curricula adapted</p> <p>Sustainability Elluminate created and delivered</p> <p>information package for new grantees prepared and disseminated</p> <p>RFA disseminated</p>	<p>Regional training event facilitated</p> <p>Site visits conducted</p> <p>Ad-hoc TA provided</p> <p>Elluminate sessions designed and delivered</p> <p>Information packaged prepared and disseminated</p> <p>Technical information disseminated</p>	<p>Organize and facilitate regional event</p> <p>Conduct site visits, as requested</p> <p>Assist grantees with documenting and disseminating lessons learned through report feedback and site visits</p> <p>Design and deliver Elluminate sessions</p> <p>Disseminate technical information, lessons learned and best practices</p> <p>Provide ad-hoc TA as requested</p>	<p>Regional event conducted</p> <p>Site visits conducted</p> <p>Assistance with documentation provided</p> <p>Elluminate sessions delivered</p> <p>Technical information disseminated</p> <p>Ad-hoc assistance provided</p>	<p>Strengthened NGO capacity to implement CB malaria prevention and treatment programs</p> <p>Lessons learned about CB malaria programming documented and disseminated</p>

Malaria in Pregnancy

MIP is a major public health problem in tropical and subtropical regions throughout the world. In most endemic areas of the world, pregnant women are the main adult risk group for malaria. Malaria during pregnancy has been most widely evaluated in Africa south of the Sahara where 90% of the global malaria burden occurs. The burden of malaria infection during pregnancy is caused chiefly by *Plasmodium falciparum*, the most common malaria species in Africa. Every year at least 30 million pregnancies occur among women in malarious areas of Africa, most of who reside in areas of relatively stable malaria transmission. In areas of stable malaria transmission, MCHIP supports WHO's three-pronged approach, which includes:

- Prevention:
 - Uptake of IPTp
 - Use of ITNs
- Treatment:
 - Prompt diagnosis and treatment for malaria

MIP programs are at a crossroad. While many countries have made important strides in achieving their goals, most African countries are still far from achieving RBM's goal (80%) and PMI's goal (85%) for IPTp uptake and ITN use. In fact, there is concern that MIP programs have lost momentum and if MIP programming is not prioritized, countries that have made progress may slide back and countries that are initiating new programs may not be able to advance rapidly toward scale-up.

As countries expand their MIP programs and work toward scale-up, there are critical lessons learned, as well as best practices, that should be considered, adopted and applied based on the contextual needs of each country. MCHIP, in close collaboration with PMI, will build on MIP best practices, and existing tools and lessons learned to support countries in their efforts to rapidly expand MIP prevention and control.

Year 3 Expected Results

- **Technical leadership and participation in the global and regional meetings and fora.** MCHIP will continue to provide technical leadership for the RBM MIP Working Group. This will include support for the MCHIP Director's role as co-chair, defining the agenda for the global MIP group, as well as MCHIP's technical participation in the RBM MIP Working Group.
- **Disseminate MIP documentation (Zambia and Senegal) of best practices and lessons learned through regional networks.** Dissemination regionally to countries throughout Africa is an opportunity to not only share best practices and lessons learned among countries, but also to drive momentum and leadership to accelerate MIP programming. MCHIP will provide technical support, representation and materials for the MCP regional workshop targeting grantees. This workshop, supported through the MCP is an opportunity to dissemination MIP and iCCM best practices and lessons learned as well as build the capacity of grantees to accelerate malaria prevention and control at the community level.
- **Documentation of MIP best practices and lessons learned** in Malawi (desk review completed Year 2). Building on the documentation from MCHIP Years 1 and 2, MCHIP will document MIP programming experiences in Malawi. The documentation in Year 3 will provide further insight into successful practices and lessons learned in MIP programming.

Controlling Childhood Illness through iCCM

WHO estimated that in 2008 malaria caused nearly 250 million acute illnesses, leading to approximately 863,000 malaria deaths. The vast majority of those deaths are among children under five years of age, and most occur in sub-Saharan Africa. Approximately one in six child deaths in Africa is due to malaria. Malaria can be prevented with proven interventions that include the selected and safe use of insecticides that kill the malaria transmitting mosquito (mainly through use of ITNs). Prompt diagnosis and appropriate treatment of malaria can shorten the duration of the illness and reduce the frequency of complications and the risk of death.

MCHIP will employ a number of innovative strategies at the community level to reduce the prevalence of malaria, the prevalence of severe anemia associated with malaria in children under five, and mortality due to malaria in children under five. The new administration's GHI places an emphasis on integration, bringing important implications for iCCM of the sick child. In Year 3, as PMI, along with UNICEF and others, pushes to accelerate introduction and expansion of iCCM in all PMI countries, MCHIP will work very closely with PMI and its partners to address bottlenecks to implementation. These efforts will include the adoption of innovative approaches as PMI countries are sequenced for iCCM introduction/expansion. PMI, together with the new administration's GHI guidance to integrate MCH programs, provides unique opportunities for USG to contribute substantially to the rapid expansion of iCCM globally. Both USG financial resources and TA are poised to assist countries to surpass their previous horizons to have an impact on mortality, expanding impact from malaria-specific mortality reduction to reducing the three remaining top causes of childhood deaths worldwide: diarrhea, pneumonia and malaria.

The entry of RDT is changing the face of malaria treatment. The introduction of ACTs, and in some cases RDTs, adds complexity to algorithms and support systems (e.g., continuous supplies of drugs and test kits). Although PMI does not promote the use of RDT at the community level, in some countries, such as Mali, the national policy supports the use of RDT at this level. In these countries, PMI, through malaria operational plans (MOPs) will assist the MOH to expand iCCM using RDTs. During documentation of country experiences implementing iCCM, MCHIP will assess whether RDTs are being correctly used and if appropriate treatment is provided. The entry of RDTs increasingly heightens the urgency for iCCM so that CHWs are equipped to assess and treat fever for pneumonia in children when RDT proves negative for malaria. Policy revision as well as a continuous supply of respiratory timers and antibiotics is urgently needed. In several countries, there is evidence that money and lives are wasted when community workers continue to use expensive ACTs despite negative RDTs. This is largely because countries have no antibiotics or policy to support treating these children for pneumonia, who are presenting with fever and negative RDT results for malaria.

MCHIP will continue the review of CCM and documentation of CCM lessons learned by applying the evaluation framework utilized in DRC and Senegal in Year 2. Adding to the lessons learned, a third evaluation will be carried out in an Anglophone African country to be identified in Year 3 (e.g., Malawi). The lessons learned from the reviews carried out in Senegal and DRC in Year 2, along with the lessons learned in the additional review to be carried out in Year 3, will be shared at global CCM, such as GAPP and CCM.ORG. Based on a better understanding of innovative approaches to CCM programming (training, supervision, health worker motivation, drug logistics and monitoring), MCHIP will design innovative CCM programs to introduce in newly identified countries.

Year 3 programming will build on the achievements from Year 2, with an aim to ensure that malaria programming is supporting rapid implementation and scale-up of pivotal child health interventions.

Year 3 Expected Results

- **Participation in at least one global meeting or regional meeting of the CCM Task Force and/or RBM meeting:** MCHIP is committed to continuing its global leadership role in iCCM. Participation in key international meetings provides a forum for MCHIP to assure that shared USAID perspectives on best practices, bottlenecks and, sometimes, controversial issues (e.g., use of RDT at the community level) surrounding iCCM are discussed at the global table.
- **Review of global iCCM experience and documentation of iCCM in two BASICS supported African (Francophone) countries and one Anglophone country with integrated CCM including malaria:** In Year 1, a global review of iCCM experience was undertaken with MCH funding and is near completion. Documentation of two countries in Africa began in Year 2 and a third will be completed in Year 3. These two activities are complementary and will make an important contribution to better understanding of this still nascent approach.
- **Regional meeting held to disseminate global review of iCCM tools, indicators and documentation of iCCM programs in three countries:** Lessons learned from the global review and three country documentation, including bottlenecks identified as well as promising practices, will be shared in international for a, including a regional meeting that is to be coordinated with UNICEF. In addition, MCHIP will continue to participate in meetings of the GAPP, CCM Task Force, RBM meetings and CCM.ORG.
- **Key tools, learning and resources applied when planning iCCM introduction in PMI and MCH countries:** MCHIP will work very closely with PMI and UNICEF/Catalytic Initiative as they plan the rapid scale-up of iCCM. MCHIP will assist in iCCM planning and introduction as requested by PMI countries in their MOPs. MCHIP will share the lessons learned from documentation in three iCCM countries on bottlenecks and best practices to enable new countries to build on this experience. Innovations for programming in training, supervision, monitoring, CHW incentives and logistics will be suggested as they design their new iCCM programs.
- **Continuous TA provided to support country activities on child health efforts:** MCHIP will provide continuous TA to support country activities in DRC, Mali, Rwanda and other countries as identified in Year 3. Support in DRC will include assistance as the country plans to introduce IPTi. In Mali, MCHIP will work with the MOH as it develops a new cadre of trained Community Health Workers (CHWs) to provide CB treatment services for childhood illness. In Rwanda, MCHIP will coordinate with different actors within the MOH to assist in the evaluation of the national CCM program.

Malaria Communities Program

The MCP supports the efforts of communities in PMI focus countries to combat malaria through small grants to U.S., international and local NGOs. MCP grantees collaborate with local partners and other donor organizations in country and operate within respective PMI country strategies to implement malaria prevention and treatment activities and build local ownership of malaria control for the long-term. Similar to support provided to USAID's CSHGP, MCHIP supports the administration of PMI's MCP at USAID, as well as the 20 grantees in the program by providing technical and programmatic guidance including resources and ongoing advice to strengthen project design, implementation, monitoring and evaluation.

Strategy

MCHIP's five-year vision for MCP is that all grantees implement sound CB malaria projects that contribute to the respective COPs, and that lessons learned regarding community-oriented

malaria prevention and treatment are shared widely, informing overall country malaria strategies. The USAID PMI team and in-country partners are important allies to supporting this overall vision.

Within MCHIP, the MCP support function is the responsibility of the PVO/NGO support team, but coordinates closely with other MCHIP malaria team members to ensure congruence with MIP and malaria CCM efforts. MCHIP thereby draws upon a wealth of technical knowledge and capacity to provide support in two main areas: Support to MCP Administration (PMI/USAID) and Support to MCP Grantees.

Support to MCP Administration includes updating work plan and reporting guidance, reviewing annual reports and work plans, creating TA plans with individual grantees when needed, and providing information about MCP projects to USAID and PMI staff. Support to MCP grantees includes responding to ad-hoc requests for assistance, providing on-site TA, documenting and sharing promising practices and lessons learned, and disseminating technical resources. MCHIP also organizes training events and meetings, at PMI's request, to provide additional opportunities to build grantee capacity and to strengthen projects.

Year 3 Expected Results

- Eighteen annual reports, 18 work plans, and two final evaluation reports reviewed, and feedback provided.
- Peer review of annual reports and work plans facilitated.
- TA plans created, as needed.
- Ad-hoc TA via e-mail and phone provided at grantee request.
- In-country TA provided (schedule to be determined with PMI/MCP and grantees after review of work plans and annual reports) and BBL updates coordinated for PMI and MCHIP staff following each site visit.
- Grantee contributions to PMI Annual Report facilitated.
- Reporting and work planning guidance updated.
- Promising practices documented and shared.
- Technical information disseminated to grantees.
- Regional meeting organized and facilitated, providing technical updates in MIP and CCM to 18 grantees and sharing lessons learned from CB programming in these technical areas.
- Portfolio review meeting organized for PMI/MCP staff.

HIV

HIV/PMTCT-MNCH INTEGRATION

Overview

Many countries in sub-Saharan Africa have successfully increased PMTCT coverage by integrating PMTCT into antenatal care, adopting the opt-out approach to provider-initiated HIV testing and counseling, and offering single dose nevirapine to HIV-infected women and newborns. These measures prevent the transmission of HIV to untold numbers of infants each year and have contributed to a significant reduction in HIV-associated child mortality in high-prevalence countries.

Despite these successes, there are still serious gaps in the continuum of MNCH for pregnant and postpartum women living with and infants exposed to HIV. For example, although 70% of pregnant women in Africa have at least one ANC visit and the majority of these women are now tested for HIV during their pregnancies, at least 40% of those who test positive do not get the drugs they need to stop transmission to their infants. Single dose Nevirapine, while more simple to implement than more complex regimens, exposes HIV+ women to the risk of developing Nevirapine resistance, compromising future treatment options. For this reason WHO now recommends either highly active antiretroviral therapy (HAART) or combination prophylaxis for PMTCT. Pregnant Women who meet clinical criteria for HIV treatment require this service to save their own lives, of course.

At every step of the PMTCT cascade some women or infants are lost to follow up. For example, while 45% of HIV-infected pregnant women receive ARV drugs to prevent transmission, only 32% of infants receive the ARV prophylaxis they need at birth. Finally, despite the UNAIDS global target that calls for providing antiretroviral treatment (ART), cotrimoxazole prophylaxis or both to at least 80% of the children in need by 2010, of the two million children who were living with HIV in 2007, the vast majority did not receive either of these drugs.

In 2006, 2009 and 2010, changes were announced in the WHO PMTCT and HIV treatment guidelines in use in most countries. In 2006, based on emerging evidence, WHO recommended that countries adopt the more efficacious, triple-therapy ARV regimens for the treatment of HIV in pregnant women. In 2009, WHO revised its recommendations again, this time modifying the criteria for treatment and calling for ART for more HIV-infected pregnant women than ever before.¹¹ Recommendations for pediatric HIV treatment and infant feeding also changed in 2009 and 2010 to include:

- Daily cotrimoxazole prophylaxis for newborns exposed to HIV, beginning at four to six weeks of age
- HIV viral testing (DNA-PCR) for HIV-exposed infants
- ARV and continued cotrimoxazole treatment for those infants who test positive
- New infant and young child feeding (IYCF) guidelines that encourage exclusive breastfeeding regardless of the HIV status of the mother or child

Most high-prevalence countries in sub-Saharan Africa are adopting these new recommendations in some fashion, but many are also having difficulty operationalizing them for financial, operational and programmatic reasons. As a result, too many pregnant women still do not have access to HIV testing and counseling, and in some settings single-dose nevirapine is still the only PMTCT regimen available to most HIV-infected pregnant women. Financing, supply and other operational issues make it difficult for countries to adopt the more efficacious (and also more costly) triple therapies, and even the much less costly cotrimoxazole is not routinely given to HIV-exposed infants.

Many countries are now exploring ways to operationalize the new WHO recommendations and to more fully integrate PMTCT, HIV treatment and MNCH/FP services to increase coverage at the same time.

MCHIP Strategy for HIV/PMTCT-MNCH Integration

¹¹ In 2009, WHO increased the recommended threshold for ARV treatment of pregnant women to a CD4 cell count of ≤ 350 cells/mm³ or WHO clinical stage 3 or 4 classification, regardless of CD4 count. This higher threshold and acceptance of clinical classification regardless of the CD4 count, means that many more pregnant women than ever before are now eligible for ART to protect their own health, as well as that of their babies.

MCHIP will use core HIV funding in Year 3 (Office of HIV/AIDS [OHA] and MCH/HIV) for work in Kenya with the possibility of adding one additional high-prevalence country in sub-Saharan Africa—to integrate, improve the quality and expand the coverage of a full package of PMTCT and HIV treatment options for women and infants. We will work with relevant PEPFAR funded PMTCT partners, including EGPAF, ICAP and others, to ensure this integration. Plans for a pilot activity in one district in Kenya are well advanced and the activity described below should begin early in Year 3. MCHIP will then survey its own programs before selecting a second country or countries for a similar activity in Year 4. The Kenya pilot project and each of these activities is described briefly below.

Year 3 Activities/Expected Results

Kenya HIV/MNCH Integration and Mother-Baby Pack (MBP) Pilot Activity

Kenya has adopted the 2010 WHO Revised PMTCT and IYCF guidelines. With core funds, MCHIP will support the Kenya Ministry of Public Health and Sanitation (MOPHS) and the Bondo District Health Management Team (DHMT) to roll out these new guidelines and then document the results and lessons learned for future dissemination and use in other sites. Kenya now provides PMTCT services in more than 3,000 sites and ARV treatment or prophylaxis to an estimated 70% of pregnant women living with HIV. But too many women who test positive are being lost to follow-up and/or subjected to multiple, unnecessary clinic visits because HIV-infected pregnant women who require ART for their own health must be referred from ANC to separate HIV clinics, called comprehensive care centres (CCCs). As a result many women who meet clinical criteria for life-saving ART end up receiving only ARV prophylaxis. Logistical challenges, including distance to PMTCT sites and lack of partner involvement, also make it difficult for many mothers and children to access lifesaving HIV prevention, care and treatment.

Working with the Bondo DHMT, MCHIP will address the remaining gaps in PMTCT coverage and quality, and work to improve the access that pregnant women and infants have to ARVs and cotrimoxazole. The specific objectives in Bondo are to:

- **Facilitate the implementation of the new 2010 Kenya PMTCT and IYCF guidelines.** The new Kenya PMTCT and IYCF guidelines equip health care workers and stakeholders with the guidance needed to support HIV-infected mothers to offer optimal safe feeding and health care for HIV-exposed and infected children. The new PMTCT and IYCF guidelines are complementary and will be implemented together in demonstration mode in the pilot site.
- **Integrate HAART and PMTCT prophylaxis using UNICEF’s MBP.** UNICEF has developed the MBP to include a full supply of ARVs and cotrimoxazole for the HIV-positive woman and her infant, for PMTCT. If successful, the MBP will promote greater integration of HAART and PMTCT at the MNCH clinic, increase women’s access to the more efficacious ARV treatment regimens and streamline the procurement of and the supply chain for these lifesaving PMTCT medicines. UNICEF has agreed to collaborate with MCHIP and will provide the MBPs for inclusion in the roll-out of new PMTCT guidelines in selected districts in Kenya, including Bondo.
- **Improve the quality and coverage of PMTCT services.** MCHIP will use WHO’s RED¹² approach and the SBM-R approach to address quality and coverage. SBM-R has been shown

¹² Developed in 2002 with implementation by WHO, UNICEF, and other immunization partners, the “Reach Every District” (RED) approach is applied to improve coverage and effectiveness. The basic components of RED include: (1) effective planning and management of resources: ensuring effective management of human, financial, and material resources at every governing level; (2) reaching all target populations: by reaching out to previously underserved, unreached communities, in giving support and access to services; (3) supportive supervision; (4) monitoring for action by promoting the use of data for planning and decision making at all governing levels; and (5) linking communities with health services through regular encounters between community leaders and health workers.

to improve the quality of PMTCT in other parts of Kenya and was presented at the International AIDS Society conference in Vienna in July 2010. This successful approach will be implemented in this pilot district. RED was originally developed and introduced in Kenya to improve the coverage of RI and vitamin A, but it has also been adapted and used informally (Malawi) and formally (Zambia) to improve the quality and coverage of PMTCT services in pilot areas. In Bondo, MCHIP will adapt and use the RED approach to mobilize and link CHWs and clinical service providers to improve adherence, follow-up and referral for women living with HIV/AIDS and their infants. Other RED components may also be adapted and used to plan for and manage the more integrated PMTCT/MNCH approach.

- **Improve follow-up rates for HIV-infected mothers and their infants up to 18 months postpartum.** Increased integration of MNCH and PMTCT and HAART services will result in greater coverage and continuity of care for women and their children. MCHIP will also adapt and use elements of the RED approach to improve follow-up rates for HIV-infected mothers (and their babies) through 18 months post-delivery.
- **Increase access to family planning, including LAM, among PMTCT clients.** All PMTCT clients, whether positive or negative, deserve access to quality postpartum family planning counseling and services. MCHIP will work to ensure that integration of MNCH and PMTCT includes postpartum family planning, including LAM.
- **Document results and lessons learned.** Consistent with MCHIP's objectives, this pilot activity in Bondo will not only inform future roll-out of the new WHO recommendations in Kenya, it will also contribute to global program learning around the topic of integrated MNCH/PMTCT and pediatric HIV care. Findings will be shared with the PEPFAR PMTCT Technical Working Group and submitted for presentation at relevant conferences.

Inventory of MCHIP PMTCT/MNCH Integration Activities and Selection of Second Country or Countries for Program Learning

MCHIP and its partner organizations are working on PMTCT and some element of PMTCT-MNCH integration in a number of other countries including Nigeria, Mozambique, South Africa, Tanzania, Malawi, Zimbabwe, Rwanda and Uganda. MCHIP has also begun discussions with EGPAF about a possible collaboration in one of the countries where both of our organizations are currently working. Using a small amount of core funding in Year 3, MCHIP will survey its own and its partners' programs, particularly those that are supporting PMTCT-MNCH integration and the roll-out of WHO's revised PMTCT and infant feeding recommendations. The survey will include an inventory of the work that is going on in these programs. We will also engage the different country teams in interviews and focus groups to document lessons learned to date and determine the need and potential for mounting a small implementation research activity in Year 4.

Based on the findings of the survey, MCHIP will work with USAID to identify a second country or countries for a pilot activity that is similar to the one proposed above for Kenya. Given the very modest amount of funding that is likely to be available for any work that might result from the proposed survey, MCHIP proposes to select a country where integration efforts are ongoing and a small core investment in developing and testing an approach to improving the coverage, quality and/or the continuity of PMTCT care could be expected to leverage additional resources. Ideally, the country selected will be one in which EGPAF or MCHIP is already implementing an integrated PMTCT/MNCH model, so that MCHIP's modest investment might be used to make minor improvements and then rigorously document the results.

Year 3 Expected Results

- Uptake of PMTCT increased.

- Integration of HAART and PMTCT at MCH clinics achieved (i.e., women and children can initiate HAART at MCH clinic as well as HIV clinic).
- Uptake of HAART for treatment-eligible women in MCH clinics increased and sustained.
- Loss to follow-up of HIV-infected mothers and HIV-exposed infants reduced.
- Uptake of pediatric ART and prophylactic cotrimoxazole increased.
- Quality of PMTCT and ART programs improved as measured by SBM-R scores.
- RED approach adapted and field-tested for PMTCT.
- CHWs and midwives mobilized to support PMTCT program.

MALE CIRCUMCISION—SWAZILAND AND REGIONAL

Overview

Successful interventions must employ multifaceted, high-impact, innovative strategies to achieve quantifiable improvements in neonatal, infant and maternal mortality rates. One such approach—scaling up the delivery of high-quality, safe medical male circumcision (MC) services as part of a comprehensive package of HIV prevention counseling and sexual and reproductive health care for men and their partners—has the potential to dramatically alter the progression of the HIV epidemic in countries with the greatest HIV/AIDS burden. In these countries HIV contributes to a large proportion of maternal and child deaths and is undermining progress towards the MDGs.

Mathematical modeling shows that a rapid (5 year) scale up of MC to 80% of eligible males in East and Southern Africa would avert more than 4 million new adult infections (many among women) and save more than US \$20 billion in treatment costs by 2025.

MCHIP Strategy for Male Circumcision—Swaziland and Regional

As mentioned above, rapid scale-up of MC stands to avert as many as one HIV infection for every four MCs performed,¹³ as well as to reduce the transmission of sexually transmitted infections such as herpes simplex virus and human papilloma virus, an established precursor to cervical cancer.^{14,15} Female partners of circumcised men also experience lower rates of bacterial vaginosis, a condition that is associated with preterm labor. By interrupting the transmission of HIV and other reproductive tract infections, MCHIP-supported safe, voluntary MC presents a far-reaching, long-term solution to complex, HIV/AIDS and sexual health related issues stymieing improvements in maternal, neonatal and child mortality rates in the highest prevalence countries.

MCHIP will contribute to the reduction of incidence of HIV/AIDS in Southern and Eastern Africa by investing in strategies and tools that will ultimately result in large and rapid increases in coverage of males circumcision, while promoting safe sexual behavior by circumcised men and their partners. MCHIP MC programs integrate HIV testing and counseling, STI screening, HIV risk reduction counseling and FP/RH education and referrals into routine MC group education as well as counseling for clients and couples. Included among the initiatives supported by this award will be efforts to promote Models for Optimizing the Volume and Efficiency of MC Services, or MC-MOVE. MC-MOVE employs a set of service

¹³ Futures Institute (2007). Costing Male Circumcision in Swaziland and Implications for the Cost-Effectiveness of Circumcision as an HIV Intervention. USAID Health Policy Initiative.

¹⁴ Tobian AA et al (2009). Male circumcision for the prevention of HSV-2 and HPV infections and syphilis. NEJM.

¹⁵ Gray RH et al (2008). Effects of male circumcision on female partners' genital tract symptoms and vaginal infections in a randomized trial in Rakai, Uganda. Am J OB Gyn.

principles that extend the preventative benefits of MC to a greater number of clients while maintaining quality and limiting human resource and physical infrastructure burdens on already strained health care systems.

Standard MC service delivery models allow for one clinician to perform roughly eight to 10 MCs daily. However, in Southern and Eastern Africa surgical capacity is critically low, the numbers of MCs required are large and the demands on surgeons and doctors for other surgical services such as emergency obstetric care are significant. For this reason, utilizing trained non-physician clinicians to perform multiple aspects of MC surgery is a key component of MC-MOVE. Task-shifting and task-sharing to nurses and other non-physician cadres allow for the most strategic use of the highest trained health personnel. By working alongside highly experienced providers in an environment that promotes supportive supervision and mentoring, non-physicians have been proven to safely conduct major obstetric surgical procedures.^{16,17} One of the benefits of MOVE's efficiency is that it will enable countries to massively scale up MC while minimizing disruptions to emergency obstetric care and other key surgical services.

In Year 2, MCHIP investments, in collaboration with the MC Partnership, in Swaziland have expanded service delivery of MC and set the groundwork for Swaziland's upcoming Accelerated Saturation Initiative (ASI) by recruiting and deploying teams of one doctor, seven nurses, two counselors and support staff to identified MC service delivery sites. The ASI is a Government of the Kingdom of Swaziland initiative which aims to circumcise 80% of eligible adult and adolescent males in less than one year. Using the remaining MC core funds, MCHIP will continue recruiting doctors and nurses for the ASI and will transition management of this process to a new USAID award expected in September or October 2010.

Initial pilot sites employing MC-MOVE concepts, such as Orange Farm in South Africa, the Litsembe Leftu Male Clinic in Mbabane, Swaziland and five MCHIP-supported sites in Iringa, Tanzania, demonstrate promising results; for example, the five Tanzanian sites were able to perform more than 10,352 MCs during six weeks in June/July. While 99% percent of clients were tested for HIV, only 1% experienced an adverse event.

To support the adoption of MOVE principles in other MC service delivery sites in the region, MCHIP, working through a subaward to colleagues in Orange Farm, South Africa, will develop a video to be filmed at sites that have successfully adopted MC-MOVE principles in Kenya, South Africa, Swaziland and Zimbabwe. This video will be used for both advocacy and training.

Regional MC policies focus mainly on adults and adolescents, since this is the age group at greatest immediate risk for HIV acquisition through heterosexual sex. However, these programs recognize the critical role of neonatal/infant circumcision as an HIV prevention intervention that offers long-term sustainability. In contrast to adult and adolescent MC, neonatal/ infant MC results in fewer adverse events, reduced cost per procedure,¹⁸ faster healing, and eliminates the risk—present in adult and adolescent MC—of increased HIV acquisition or transmission if sex is resumed or initiated before wound healing is complete. Following a Neonatal MC Consultation in Geneva in October 2009, efforts are underway to develop a neonatal/infant MC training package. MCHIP support for training material development will enable ministries of health to roll out safe, evidence-based newborn circumcision linked with broader maternal, newborn, HIV and reproductive health services including comprehensive parent/guardian counseling.

¹⁶ Pereira C et al (1996). A Comparative Study of Caesarean Deliveries by Assistant Medical Officers and Obstetricians in Mozambique. BJOG.

¹⁷ Kruk, ME et al (2007). Economic Evaluation of Surgically Trained Assistant Medical Officers in Performing Major Obstetric Surgery in Mozambique. BJOG.

¹⁸ Auvert B, et al (2008). Estimating the resources needed and savings anticipated from roll-out of adult male circumcision in sub-Saharan Africa. PLoS One.

The MCHIP MC team has already presented its work at the International AIDS Society conference in Vienna in July 2010. The first presentation was a poster documenting differences in surgical time during training among the three adult MC techniques. The second was an oral presentation from the Tanzania team covering how to achieve high uptake of HIV testing and counseling among MC clients. We will continue to look for opportunities for the MCHIP MC team to share our lessons learned; we are currently documenting the use of Observed Structured Clinical Exams (OSCE) to assess the clinical skills of volunteer human resources for MC.

Flexibility remains within the overall scope of work and budget under MCHIP MC, Southern and Eastern Africa to meet any needs that are identified in this innovative and dynamic HIV prevention strategy over the course of the year.

Year 3 Activities/Expected Results

Year 3 Activities

- In August 2010, MCHIP issued a subaward to Progressus, the organization managing the MOVE site at Orange Farm South Africa, to design and produce an illustrative, educational video that effectively demonstrates MC-MOVE concepts. MCHIP, in consultation with USAID, will continue managing the subaward and provide inputs to structure and editing of the video.
- Finalize the neonatal/infant MC training package, in collaboration with WHO and other partners. Training in neonatal/infant MC will enable ministries of health to implement safe, evidence-based neonatal/infant circumcision services that are linked with broader maternal, newborn, reproductive health and HIV services including comprehensive parent/guardian counseling. MCHIP will conduct a field test of the training package in a clinical setting and incorporate findings into the training materials.

Year 3 Expected Results

- Process for recruiting, orienting and assessing clinical skills of volunteer MC doctors and nurses established and documented.
- Forty-minute film documenting how safe adult MC can be efficiently performed in the Southern Africa region.
- Neonatal/infant MC training materials field tested and finalized.

OHA—EVALUATION OF CENTERSHIP MODEL

In MCHIP Year 2, OHA provided funding to MCHIP to support activities related to the dissemination of findings of the Five-year Evaluation of the Global Fund to Fight AIDS, Tuberculosis and Malaria. Efficient use of these funds resulted in a cost savings, which OHA requested MCHIP to invest in supporting the evaluation of a “centership” model, described further below

USAID is exploring creating resource “hubs” that can be accessed by communities, the public and private sectors. The “hub” or centership will serve as a locally staffed back-end office that will supply communities with a place to exchange data and other information across sectors; allow access to IT and communication resources; and provide technical expertise to train and aid community members in gathering and analyzing available information to formulate a community-owned response to identified problems. In addition, it is anticipated that the centership will provide the same services to public and private sectors for a fee.

The centership approach is part of a larger USAID Country Ownership strategy to facilitate community ownership of the health information system. USAID is piloting the centership approach in Namibia, and has identified a diverse array of international and host-country partners to work with. The implementation of the centership pilot is being led by a team from USAID's Leadership, Management and Sustainability Program. MCHIP, through consortium partner ICF Macro, was requested to conduct an evaluation of this intervention to gain a better understanding of whether the intervention translates into improvements in outputs and outcomes as a function of various inputs.

In Year 2, MCHIP participated in initial planning meetings for this evaluation with USAID Washington staff, MSH and focus communities in Namibia. In Year 3, MCHIP will design a monitoring and evaluation system for the pilot communities that can be used to track the results and lessons learned from this multi-year pilot activity.

Integration of Water, Sanitation and Hygiene (WASH) with MNCH for Improved Newborn and Child Health

OVERVIEW

Diarrhea remains a leading cause of child death and morbidity worldwide. Every year more than 1.5 million children under the age of five continue to die as a result of acute diarrhea. The burden of diarrhea falls disproportionately on young children and is preventable through a variety of well-defined interventions, including increased access to water supply and sanitation and promotion of key hygiene practices such as treatment and safe storage of water at the point of use, handwashing with soap and safe disposal of feces. Effective response to cases of diarrhea including ORT and zinc also play a significant role in reducing mortality associated with child diarrhea. Despite recognized interventions, access to water and sanitation remains a problem, with an estimated 1.1 billion people living without an improved water source and over half of the developing world—2.5 billion people—without access to improved sanitation. Correct and consistent practice of hygiene behaviors is also problematic due to a complex combination of barriers including lack of knowledge, attitudes and beliefs that constrain practice and lack of the enabling environment necessary for compliance.

About 3.7 million newborns die every year in developing countries, and almost one-third of these deaths are due to infections. Evidence from studies in India, Pakistan, Bangladesh and Nepal has shown that infection prevention and management interventions can significantly reduce death rates among newborns. A recent study in Nepal found that birth attendant and maternal handwashing with soap and water were associated with a 41% lower mortality rate for newborns exposed to handwashing. These results indicate that measures to improve and promote birth attendant and maternal handwashing could improve neonatal survival rates.

MCHIP STRATEGY FOR WASH

MCHIP recognizes the key role that WASH interventions can play in contributing to broader MNCH activities. MCHIP will continue to emphasize strategic WASH interventions that are integrated with its ongoing MNCH work. In particular, MCHIP will expand and scale up activities to improve handwashing for newborn survival through the GDA for Handwashing for Newborn Survival. These activities are described in greater detail in the newborn health section.

YEAR 3 ACTIVITIES/EXPECTED RESULTS

MCHIP will also explore opportunities to incorporate WASH elements into CCM programs and the CCM toolkit. Furthermore, MCHIP will leverage both WASH and child health channels to

scale up comprehensive control of diarrheal disease strategies including ORT, zinc and WASH elements. This scale-up will include facilitating development of these comprehensive approaches in Kenya and one or two additional countries as described in the Child Health section. This effort also includes supporting a double-blinded, randomized, placebo-controlled field trial in Orissa, India, to assess the efficacy of a point-of-use water product, Aquatabs™, to prevent diarrheal disease.

The India research activity will be conducted by the London School of Hygiene and Tropical Medicine, with MCHIP partner, PSI, providing technical support to increase awareness, acceptance and availability of Aquatabs™ in one of the largest slum areas of Bhubaneswar city.

More specifically, MCHIP will be responsible for the promotion and uptake of Aquatabs™ by the target population (an estimated 1,600 households and 2,400 children under five years of age). MCHIP will design, develop, pilot, deliver, monitor and modify, as necessary, a comprehensive communications campaign throughout the target population to ensure that uptake (measured by the portion of households that have detectable-free chlorine in their drinking water) is consistently 80% or greater. Communications messages will be delivered through different media such as wall paintings, mid-media activity and interpersonal communication. Outcomes of the project will be assessed through monitoring diarrhea morbidity, weight for age Z-scores, water quality testing, compliance to use of Aquatabs™ and survey of cost savings and absenteeism.

Urban Health

OVERVIEW

The largely agrarian, rural populations in most GHI countries are currently experiencing the world's most rapid rates of urban growth (roughly 4–5%, double the rates in East Asia or Latin America). Over the next two decades, each of these countries is likely to see for the first time the majority of its children living in cities—a turning point that the world population reached in 2007. Meanwhile, the design of most government MNCH programs remains strongly biased toward addressing the specific MNCH challenges of rural populations. Ethiopia presents an important opportunity to better understand and address urban challenges given the Government of Ethiopia's (GOE) leadership in establishing an Urban Health Extension Program (UHEP) throughout the country.

MCHIP STRATEGY FOR URBAN HEALTH

USAID/Ethiopia supports the UHEP through a PEPFAR-funded bilateral (USAID/UHEP). Consistent with the GHI principle of strategic coordination and integration, the USAID/UHEP supports integration of HIV and MNCH interventions in project areas to ensure comprehensive support and improve the quality of services provided to those most at-risk of contracting or dying from HIV/AIDS. They are also committed to systematically documenting experiences and sharing program learning of comprehensive MNCH and HIV services. During Program Year 2, MCHIP supported a team of national and international professionals to work with USAID/UHEP to identify opportunities for further integration of HIV/MNCH programming.

YEAR 3 ACTIVITIES/EXPECTED RESULTS

- Based on the recommendations of this assessment, Year 3 will focus on supporting Ethiopian leadership and managers to better understand the unique challenges posed by working with urban populations. Linking these leaders and managers with those working on similar issues will be invaluable in understanding how elements of the established rural health extension program in Ethiopia need to be tailored to meet the unique needs of

heterogeneous urban populations.

MCHIP will support an Ethiopian delegation to an international urban health meeting (such as the annual International Society of Urban Health) as well as visits to established urban health programs in other countries. USAID has taken a lead role in articulating urban health challenges and piloting appropriate responses through groundbreaking work in India and Ghana and under Child Survival Grants programs in several other countries, including Bangladesh, Haiti and Indonesia. Linking Ethiopian professionals with others is consistent with USAID's Maternal-Child Urban Health (MC-UH) Pathway priority of establishing an international community of practice.

- Given the need to better understand the unique needs of urban populations to inform programming, Year 3 also represents an opportunity to link to the MCHIP/Ethiopia field-funded program. USAID/Ethiopia has asked MCHIP to help better understand the barriers to facility-based skilled attendance in Ethiopia. MCHIP will explore opportunities to expand this scope to include peri-urban or urban areas. Pending availability of funds, MCHIP will explore studying the barriers to accessing maternal health services in Kenya.

Africa Bureau Funds

Africa Bureau funds are used strategically to support Africa Bureau priorities as well as to strengthen and advance specific technical components under MCHIP. MCHIP receives Africa Bureau funds to support efforts in MNCH, and malaria and immunization.

MATERNAL HEALTH

Midwifery Pre-Service Education Implementation Guide and Toolkit

MCHIP supports midwifery education and the performance of midwives as a fundamental process for increasing skilled attendance at birth. In light of a recent external review of ACCESS investments in midwifery education in Africa, and the strengthening of the midwifery workforce in Afghanistan, additional programmatic activity is anticipated in PSE of midwives. This focus on midwives also aligns with UNFPA's support to ICM for the strengthening of midwifery schools, accreditation processes and professional associations. MCHIP's PSE work will be carried out in consultation with WHO/AFRO.

In Year 3, MCHIP will **develop a PSE strategy, implementation guide and toolkit** to assist programs in implementing PSE programs in a health workforce context, in consultation with WHO/AFRO. These materials will also be shared with and guided by appropriate leading institutions in Africa, such as ECSACON and RCQHC. Within the implementation guide, additional emphasis will be put on the development of a pathway for professional development of midwifery faculty in clinical skills, teaching skills and pedagogic competencies. This pathway will be developed in conjunction with UNFPA and the ICM initiative, and will be put into action with an initial clinical training in newborn care skills related to the Helping Babies Breathe initiative (see below). When this training is conducted, the selected faculty will also participate in a short module on pedagogic skills, such as curriculum design, clinical coaching or effective lecturing, according to their needs.

Africa Regional Meeting on PPH and PE/E

MCHIP's efforts in Africa to demonstrate global leadership in advancing the agenda related to PPH and pre-eclampsia will continue in Year 3. MCHIP will organize an *Africa Regional Meeting on Technical and Programmatic Approaches for the Prevention and Treatment of PPH and Pre-Eclampsia*. This meeting, to be held in Addis Ababa in January 2011, will describe the

accomplishments to date in PPH programming, share technical approaches to PE/E prevention and management, and describe how PE/E programming can be built on the PPH program platform. This meeting will be supported with field funds from country programs, core funds from MCHIP and Africa Bureau funds, and will be co-funded by the Oxytocin Initiative, implemented by PATH with Gates Foundation funding. Other partners may include WHO/AFRO, Africa's Health in 2010 and Strengthening Pharmaceutical Systems. Participants will come mostly from African countries and will share their experiences related to PPH programs. This approach is similar to that taken for the Entebbe meeting on PPH in 2004.

NEWBORN HEALTH

In Year 2, MCHIP combined Africa/SD and USAID/Nigeria field funds to initiate activities to improve **management of neonatal infections at the community** including the peripheral health facilities and Primary Health Care Centers in northern Nigeria. A national stakeholders meeting was held to share the global evidence for CB case management of neonatal infections and to discuss how newborn deaths due to neonatal infections could be reduced by making treatment more accessible. MCHIP, in partnership with the Nigerian Society for Neonatal Medicine and in collaboration with the Federal MOH, WHO and UNICEF, initiated the process to conduct a situational analysis on neonatal infection management in selected general hospitals, primary health care clinics (PHCCs) and in the communities of three districts in northern Nigeria. In Year 3, MCHIP will continue to use a combination of Africa/SD and field funds to complete this assessment, and the findings will inform the improvement of infection management at the peripheral facility and the community levels. This activity will be part of a larger effort by the Nigerian Federal MOH to introduce and expand community-based management of neonatal sepsis with support pledged from WHO and UNICEF. Both WHO and UNICEF will be using tools developed by NISONM with financial and technical support from MCHIP. Unfortunately, no commitment was obtained from the existing USAID bilateral programs as they were not able to attend the stakeholders' meeting held to discuss this activity. A second stakeholders' meeting is scheduled for the first quarter of the upcoming fiscal year and the bilaterals would again be invited to participate in the discussion.

Africa/SD funds would also be used to support the improvement of **neonatal resuscitation in pre-service midwifery training**. As mentioned earlier, under neonatal resuscitation in Year 2, MCHIP supported a number of newborn care sessions, presentations and skills demonstrations at the ECSACON conference held in Lusaka, Zambia. MCHIP, in collaboration with ECSACON, Africa 2010 and RCQHC, held a joint meeting with the registrars and principals of various nursing and midwifery colleges during the conference to identify existing gaps in their newborn care curricula. In Year 3, working with these partners, MCHIP will support the strengthening of the newborn care component, in particular in neonatal resuscitation, of the pre-service curricula of selected countries in East, South and Central Africa. Potential activities will include initial curricula assessment, review and revision, developing of teaching aids, strengthening of clinical sites and training of tutors and preceptors.

Africa/SD funds will also be used to strengthen the **newborn component of pre-service curricula in midwifery schools in Ghana**. Under the ACCESS Program, the midwifery curricula for newborn care were reviewed and revised. Anecdotal information from various sources indicates most of the tutors and preceptors trained have been assigned to other training institutions and the replacement staff does not have the appropriate neonatal resuscitation skills. Using Africa/SD funds, MCHIP will conduct an assessment of the current knowledge and skills of tutors and preceptors related to newborn care, including neonatal resuscitation. This assessment will be integrated with a planned assessment for HIV-related knowledge using field funds. Identified gaps in newborn care, including neonatal resuscitation, will then be filled by revising the curricula to include current evidence-based newborn care interventions and

appropriate learning materials and job aids will be developed. Other potential activities will include the training of tutors and preceptors to use the learning materials and job aids, and site strengthening of selected clinical sites used by the midwifery schools.

CHILD HEALTH

Integrated Community Case Management (iCCM), including Malaria, and Control of Diarrheal Disease (CDD) through the revitalization of ORT and Zinc Introduction

In Year 3, MCHIP will continue **developing the package of interventions provided within or with iCCM** as well as continue to contribute to the improvement and adoption of a complete set of easy-to-manage iCCM tools and indicators that encourage the linkage of iCCM data to the national HMIS. MCHIP will work with selected countries to develop approaches to expand quality iCCM and better integrate the program with the national health system in a sustainable manner (inclusive of health financing, drug management and logistics, and human resources).

As has been well documented in recent years, despite remaining among the top two killers of children, in very few countries is serious attention being given to the control of diarrheal disease. More effective action to drive down the burden of mortality and poor nutritional outcomes attributable to diarrhea will require: effective advocacy to engage host governments, donors and technical assistance partners, and sound context-specific strategies aiming for impact at scale.

MCHIP will use core and bureau funding to support **expanding the role of CHWs to include comprehensive diarrheal disease control activities** and to contribute to the reduction of under-five mortality attributed to diarrheal disease. Resources will also be used to advance **activities to revitalize diarrheal disease case management at the country level**. MCHIP's approach is not prescriptive; we do not intend to go into countries with a pre-formed package to offer. Instead, we propose to engage key stakeholders and partners, first to galvanize commitment and second, to characterize the diarrhea issue in their setting with regard to scope, determinants and available promising lines of attack. In Year 3, MCHIP intends to facilitate such a process in at least two countries beyond Kenya (e.g., DRC, Mali).

Using a combination of core MCH and AFR/SD support, MCHIP child health advisors will contribute to **regional TAGs, task teams and working groups** with WHO/AFRO and other partners toward strengthening iCCM and CDD in Africa and priority countries. We will also provide technical support with USAID for coordination, technical updates and joint activities with UNICEF, WHO and others. This support will include participation in regional workshops and/or country monitoring visits, as possible, dependent on partner co-sponsorship and joint funding. Lessons learned and achievements from MCHIP child health countries will also be shared at regional fora and strategic short-term technical support provided to countries through linkages with bilaterals and other partners (e.g., DRC, Mali and Rwanda).

IMMUNIZATION

In Year 3, MCHIP will continue to coordinate with WHO/AFRO and its ISTs (as well as UNICEF, CDC, MOHs and other partners) on **revitalizing and expanding/adapting RED and RED+ across the region**, with particular support in two to three countries to improve coverage in low-performing areas. This support will include participation in RED-related workshops and/or country monitoring visits, as possible, dependent on partner co-sponsorship and joint funding. MCHIP will also assist with Africa regional efforts to reach unimmunized and partially immunized populations with routine services and new vaccines.

Using a combination of core MCH and AFR/SD support, MCHIP immunization advisors will contribute to **regional TAGs, task teams and working groups** toward strengthening RI and links with vaccine-preventable disease initiatives and surveillance in Africa and priority countries. We will also provide technical support with USAID for coordination, technical updates and joint activities with WHO/AFRO and others, including Africa 2010. MCHIP staff will also participate in

important regional immunization partnership meetings, including the ARCI (former TFD), WHO's Regional Working Groups and EPI Managers' Meetings, GAVI TWGs, etc.

In MCH's priority countries, particularly those with fragile or underperforming immunization systems, MCHIP will use AFR/SD support for **staff participation in EPI reviews** (e.g., DRC, Senegal and Uganda), **assessments and planning missions**. Findings and recommendations from these reviews and joint assessment visits will be used to help improve country multi-year immunization planning and workplans/strategies to target unimmunized and partially immunized children. Lessons learned and achievements from MCHIP immunization countries will also be shared at regional fora, and strategic short-term technical support provided to countries through linkages with bilaterals and other partners (e.g., DRC, Nigeria and Liberia).

Latin America and Caribbean

MATERNAL HEALTH

In LAC, every year, more than 22,000 women die from complications due to pregnancy and childbirth, with an estimated ratio of 194 maternal deaths per 100,000 live births. If appropriate care and interventions had been available throughout pregnancy, childbirth and the postnatal period, many of these deaths could have been prevented. Of particular importance is the postpartum period for maternal and newborn health services. Within the LAC countries, there is striking evidence of health inequality, with the highest prevalence in MCH. Most maternal deaths involve indigenous women, which is a result of strained economic conditions, higher fertility rates, and decreased health care quality and availability.

Guatemala displays one of the highest prevalences of health inequalities, particularly within maternal health. In 2000, the MMR was 154 deaths per 100,000 live births. By looking at the cause of death breakdown, over half of all maternal death was due to hemorrhage, with 66.5% of all maternal deaths occurring in women without a formal education.

In Honduras, data from 2007 revealed that the maternal mortality ratio in Honduras is 108 per 100,000 live births, and data from the *Dirección General de Vigilancia de la Salud* indicate that PPH is the leading cause of maternal death.¹⁹ One of the main challenges that the country faces to accomplish its goal to decrease maternal mortality is the high number of home births occurring due to lack of access to health services, geographical challenges for transportation and the cultural diversity of the population. Approximately 200,000 births occur annually in Honduras. Of these births, 33% occur at home on a national level, and 42.3% are attended by parteras²⁰ in rural areas. Of all births, 30,000 (15%) are likely to present with an obstetric complication. Of women who experience obstetric complications, one-third may occur during births that are assisted by a less skilled provider, particularly in the departments of Colon, Coban, El Paraiso, Intibuxca, La Paz, Lempira, Olancho and Santa Bárbara.²¹

In 2006, just over one in two births in Nicaragua took place in a HF (53%) and one third took place in a comprehensive or basic emergency obstetric care facility. A Pan American Health Organization (PAHO) report²² from 2005 showed that PPH remained the leading cause of maternal mortality in Nicaragua, accounting for 48%, followed by puerperal sepsis (15%) and eclampsia (14%). However, the POPPHI study conducted in 2006 showed that only .3% of observed deliveries received AMTSL according to this definition. Nicaragua, like many developing

¹⁹ WHO. Mortality Country Fact Sheet 2006. Available at:

http://www.who.int/whosis/mort/profiles/mort_amro_hnd_honduras.pdf. Accessed April 10, 2009.

²⁰ Parteras are less skilled providers, equivalent to the international term "traditional birth attendants," who attend births in the home.

²¹ RAMNI _MOH Document 2008 -2015.

²² <http://www.paho.org/HIA/archivosvol2/paisesing/Nicaragua%20English.pdf>

countries, has a high rate of episiotomy and cesarean operations, which are associated with morbidity and mortality. In 2006, 14% of births were delivered via caesarean section, which is near the upper level of 15% recommended by WHO. An assessment of Nicaraguan facilities in 2006 also showed that among cesarean deliveries, half (49%) were repeat caesareans, and in Managua the repeat cesarean rate reached 76%.²³

Paraguay has experienced an increase in MMRs as reporting tools have become more essential to proper health care, leading to the assumption that underreporting has been a large problem in the past. The MMR in Paraguay in 2003 was 174 deaths per 100,000 live births. Peru is another country that suffers from large differences in health quality, with disadvantaged regions faring poorly. In 2001, Peru experienced staggering MMRs in its poorer regions, with 300 deaths per 100,000 live births.

At the core of maternal and child survival within this region are persistent inequalities in access to health resources and services. Those individuals who are socioeconomically disadvantaged have higher health risks because of limited availability of physicians, limited deliveries attended by skilled professionals and LBW prevalence. The mortality statistics among these population groups are unacceptably high, with the high maternal and infant mortality rates due primarily to high rates of adolescent pregnancies, decreased levels of maternal education, limited access to services, poor sanitation and drinking water, and child malnutrition. Additionally, overuse and abuse of technology and abusive care are key issues to consider in programming for this region.

Year 3 Expected Results

- Oxytocin in Uniject pilot in Guatemala:
 - Please note: The planned dissemination of results of the pilot introduction of oxytocin-Uniject is on hold until the MOH and USAID/Guatemala have made a decision to consider oxytocin-Uniject.
 - Results of evaluation of the pilot introduction disseminated.
 - Plan for national scale-up developed.
 - Monitoring and evaluation systems strengthened to include oxytocin-Uniject.
- CAMBIO intervention in Nicaragua:
 - CAMBIO intervention (Changing AMTSL Behavior in Obstetrics), which included introduction of oxytocin in the Uniject device and reduction of episiotomies, replicated in Nicaragua and action plan developed for national scale-up.
- Introduction of oxytocin in the Uniject device in selected facilities and communities in Honduras:
 - Oxytocin in Uniject pilot in Honduras completed.
 - Results of evaluation of the introduction disseminated.
 - Plan for national scale-up developed.
- Formative research on use of cesarean operations in Nicaragua:
 - Protocol developed and translated.
 - Formative research conducted and analyzed on use of cesarean operation.
 - Results of formative research disseminated.

²³ UNFPA/Nicaragua. 2006. Evaluacion de Necesidades de los Servicios de Cuidados Obstetricos de Emergencia en Nicaragua. Managua, Nicaragua.

- National action plan developed to reduce use of cesarean operation for non-medical or non-obstetric reasons.
- Strengthening midwifery education in Paraguay and Peru:
 - Evaluation conducted to ensure integration of AMTSL and use of competency-based methodologies in midwifery pre-service and in-service curricula. 2nd level
 - Curricula revised as needed.
 - Tutors' knowledge and skills updated.

NEWBORN HEALTH

In LAC, 180,000 newborns die (newborn mortality rate [NMR] 15/1,000 live births), and 22,000 women succumb to complications (MMR 150/100,000 live births) related to pregnancy and childbirth every year. Nevertheless, there is great variability throughout the region, where some countries have an NMR as high as 31/1,000 live births (Haiti), and some as low as 5/1,000 live births (Cuba and Chile). There is also an inverse correlation between NMR and SBA in the region, with the exception of a few countries such as the Dominican Republic, where SBA is 98% but the NMR continues to be high at 22/1,000 live births.

Some countries with a high number of rural and indigenous populations and low SBA due to lack of access and/or cultural barriers have the highest mortalities (i.e., Haiti, Bolivia and Guatemala). One of the region's biggest inequities relates to income quintiles, where the NMR of the poorest quintile is double that of the richest one. The three main causes of newborn deaths are consistent with the global situation, but there are increasing numbers of premature births and an increase in deaths from related complications. Furthermore, the postpartum period for both newborn and maternal health services represents a key gap.

Since 2004, USAID and its partners have supported the LAC Neonatal Alliance—which originally included USAID's LAC Bureau, PAHO, the CORE Group, the ACCESS Program, Save the Children's Saving Newborn Lives, the Health Care Improvement Project, the United Nations Children's Fund (UNICEF) and the BASICS Project, and which has expanded membership to include the Regional Professional Associations (Pediatric, Obstetrics and Gynecology, ICM, Nursing) and other new members. The Alliance has worked to foster consensus among countries in the region on essential actions for newborn health through the establishment of a regional strategy and the development of a regional action plan to promote newborn health. This plan was approved by PAHO's Directing Council in September of 2008.

The Alliance members continue to work in the strengthening of country plans of action to reduce neonatal mortality in the region, and in the implementation of initiatives to address some of the causes of newborn mortality in LAC. For example, an initiative implemented by BASICS from 2006 to 2009 operationalizes with partners an important element of the LAC regional strategy: the prevention and treatment of neonatal sepsis. The project incorporated distance learning methodologies with in-country support and elements of collaborative models for quality improvement. El Salvador and the Dominican Republic focused on the prevention and treatment of neonatal sepsis at the hospital level and Honduras implemented at the community level. This initiative contributed to the reduction of admissions to nurseries due to suspected nosocomial infections by up to 30% in some hospitals and to an increase in newborn babies evaluated by the third day of life by 50% in some communities in Honduras.

During Program Year 3, MCHIP will also assist in-country partners in addressing the other main causes of newborn mortality: birth asphyxia and complications of prematurity. MCHIP will provide TA for the dissemination and expansion of the new HBB curriculum (Dominican

Republic, Peru, and possibly Honduras and Guatemala) and of the KMC method (Dominican Republic, Honduras, Nicaragua, Guatemala, El Salvador and Peru) in the region. The Project will also continue to participate in regional meetings of the professional associations as a platform to update and advocate for newborn health, evidence-based priority interventions on behalf of the LAC Neonatal Alliance. In collaboration with AAP and PAHO, MCHIP will conduct a regional workshop on HBB in the context of a broad newborn health, which will include SOTA and skills-building sessions on ENC, KMC and handwashing.

This proposed MCHIP work will continue to support the Alliance's activities and the implementation of the regional action plan at country levels, thereby supporting the USAID LAC Bureau's objectives to reduce newborn morbidity and mortality in the region.

Year 3 Expected Results

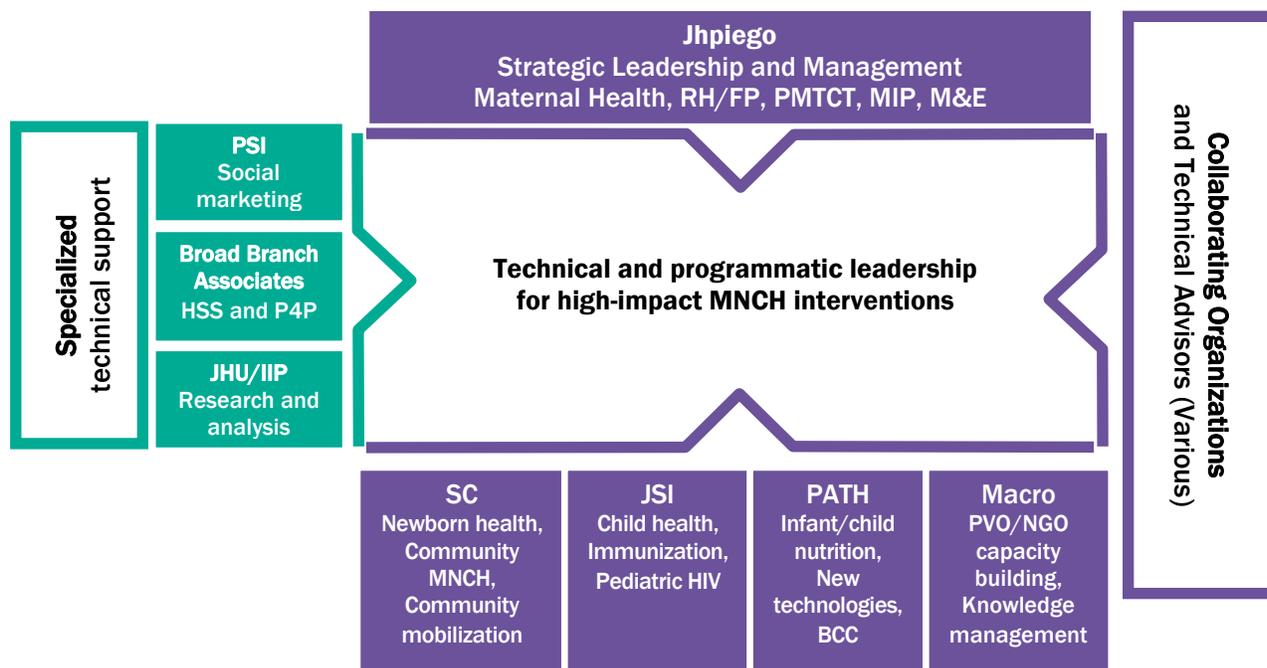
- Survey on postnatal care legislation and policies carried out in at least three countries and results and recommendations disseminated.
- Assistance to countries initiated for implementation and/or strengthening of postnatal care practices based on the results and recommendations of the survey.
- Technical oversight and assistance provided for dissemination of best practices and information exchanges on newborn health in LAC.
- Technical support contributed for the implementation/strengthening of national action plans for newborn health in one or two countries.
- In-country improvement of prevention and treatment of newborn sepsis initiated at facility and/or community levels in two to three countries.
- Technical support to in-country partners for implementation and scale-up of the HBB curriculum under a regional coordinating mechanism (Dominican Republic, Peru, and possibly Honduras and Guatemala).
- Technical support to in-country partners for implementation and scale-up of the KMC method under a regional coordinating mechanism (Dominican Republic, Honduras, Nicaragua, Guatemala, El Salvador and Peru).
- Conduct regional HBB workshop in the context of a broad newborn care including ENC, KMC and handwashing.

MCHIP Management

MCHIP is structured at the central and the field level to optimally utilize the strengths across the partnership while retaining a leadership role of each partner in different technical areas.

Figure 4 below displays partner roles and responsibilities within MCHIP. While each partner is assigned a technical leadership role, MCHIP will engage technical experts as needed from all MCHIP partners to enrich the technical resource pool.

Figure 4. MCHIP Partner Roles



For day-to-day management decisions and functioning of MCHIP, the MCHIP Executive Management Team (EMT) liaises with USAID and the broader partnership. The MCHIP EMT is responsible for ensuring the strategic direction and long-term vision of the program. The EMT is also accountable for the timely submission and approval of the workplan. This team consists of Koki Agarwal, Anita Gibson, Steve Hodgins, Pat Taylor, Leo Ryan, Nancy Caiola and Terry Padgett.

There is also a Partnership Management Team (PMT), composed of key program and financial/administrative representatives from each partner. The PMT will meet as needed to discuss management of issues of relevance to all partners, including but not limited to financial issues, award compliance and reporting. MCHIP is also organized along technical teams that are led by team leaders and include staff from across the partnership based on skills and expertise.

The MCHIP team also benefits from the guidance and support of the Corporate Representative Team (CRT), comprising one senior corporate representative from each MCHIP partner, as shown in Table 9.

The CRT ensures a smooth and well-functioning partnership, resolves conflicts, ensures appropriate staffing and funding, maintains cost share and provides strategic guidance to the Program. The CRT meets twice a year.

Table 9. Corporate Representative Team

CORPORATE REPRESENTATIVE TEAM	
Jhpiego	Alain Damiba, Ron Geary
Save the Children	David Oot
JSI	Carolyn Hart
ICF Macro	Leo Ryan
IIP/JHU	Jennifer Bryce
PATH	Catharine Taylor
Broad Branch	Rena Eichler
PSI	Megan Wilson

Figure 5 depicts the MCHIP organizational structure. The reporting structure is flexible. In most instances, Koki Agarwal and Anita Gibson will communicate with the USAID AOTRs regarding management, strategic planning and resource allocation. When specific country or global leadership issues are discussed respectively, Pat Taylor and Steve Hodgins will be the main points of contact. The PVO/NGO support team—through Team Leader Leo Ryan—will communicate directly with Nazo Kureshy at USAID and will copy USAID AOTRs and the MCHIP management staff for broader workplan and management issues. The

MCHIP management team will engage various representatives from country or technical teams as necessary. MCHIP’s technical backstopping team is depicted in Table 10. As country activities expanded in Year 2, MCHIP developed a backstop plan that includes a complete HQ support team for technical, operational and financial support for field activities and country management. This plan is updated regularly and will be shared with USAID.

The technical teams will support evidence generation (synthesis and coordination), application of evidence and dissemination, TA in priority areas, and facilitation of south-to-south transfer. MCHIP has proposed technical team leads for each of the areas. The Team Leaders work with the Global Leadership Team Leader to ensure technical integrity across the different interventions.

Figure 5. MCHIP Organizational Structure

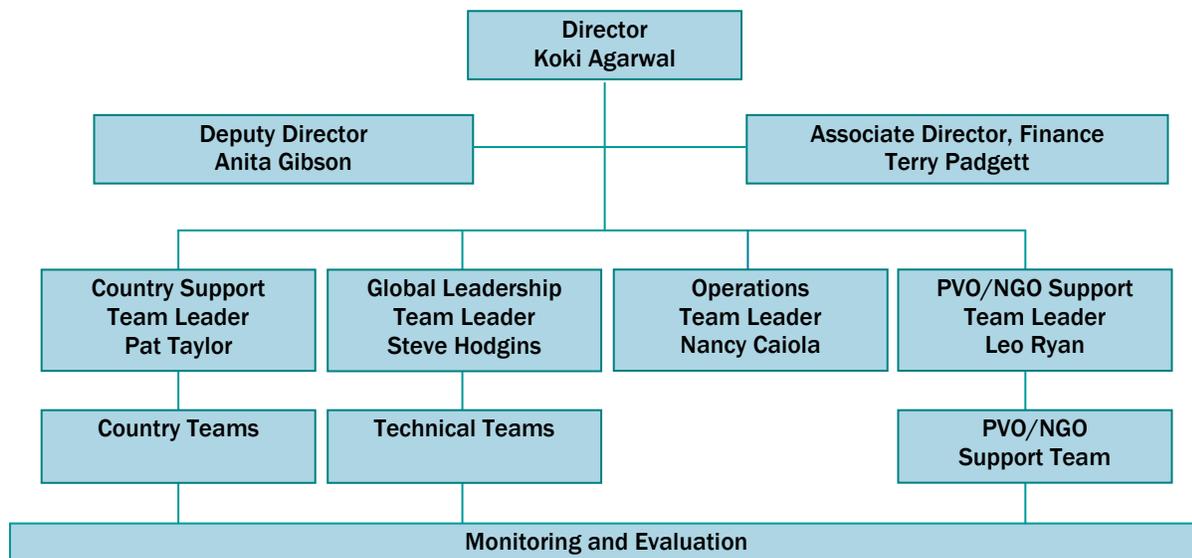


Table 10. MCHIP Headquarters Technical Backstop

TECHNICAL TEAMS	TEAM LEADERS/TECHNICAL CONTACTS
PVO/NGO Support	Leo Ryan
Maternal Health	Jeffrey Smith
Newborn Health	Joseph de Graft-Johnson
Child Health	To be determined
Immunization	Robert Steinglass
Family Planning	Catharine McKaig
Health Systems Strengthening	Rena Eichler
Community Interventions/Social Mobilization	Joseph de Graft-Johnson
Nutrition	Rae Galloway
M&E	Barbara Rawlins
HIV/AIDS	Kelly Curran
Malaria	Elaine Roman/Jennifer Yourkavitch (MCP)
Water and Sanitation	Dan Abbott
Urban Health	Anita Gibson
Research	Steve Hodgins/Linda Bartlett

Annex 1: Financial Overview

OVERVIEW

Please see Terry Padgett for details.

Table 13. Level of Effort for MCHIP Management and Key Technical Staff*

MANAGEMENT TEAM	
Director, Koki Agarwal	80%
Deputy Director, Anita Gibson	95%
Country Support Team Leader, Pat Taylor	65%
Global Support Team Leader, Steve Hodgins	80%
PVO/NGO Support Team Leader, Leo Ryan	97%
Global Operations Team Leader, Nancy Caiola	60%
Finance Director, Terry Padgett	60%
TECHNICAL LEAD	
Maternal Health, Jeffrey Smith	60%
Family Planning, Cat McKaig ²⁴	75%
Malaria, Elaine Roman	52%
Health Systems Strengthening, Rena Eichler	25%
NB/Community, Joseph de Graft-Johnson	60%
PVO/NGO, Laban Tsuma	100%
Immunization, Robert Steinglass ²⁵	75%
Maternal Anemia, Rae Galloway	50%
HIV/AIDS, Kelly Curran	10%
Water and Sanitation, Dan Abbott	40%
Monitoring & Evaluation, Barbara Rawlins	80%
Child Health Technical Team Leader—TBD	75%
TECHNICAL RESOURCES	
Research Advisor, Linda Bartlett	40%
Research Advisor, Kate Gilroy	15%
Research Advisor, Peter Winch	20%
Research Advisor, Abdullah Baqui	30%
MNH Advisor, Winnie Mwebesa	25%
Maternal Health Advisor, Marge Koblinsky	40%
Maternal Health Advisor, Susheela Engelbrecht	30%
Newborn Health Advisor, Stella Abwao	30%
Newborn Health Advisor, Goldy Mazia	50%
Family Planning Advisor, Holly Blanchard	65%
Family Planning BCC Advisor	60%
Child Health Advisor, Emmanuel Wansi	70%
Child Health Advisor, Serge Raharison	80%
Pooled Child Health (Dawson, Carnell, Guyon, Sairuddin, Alombah, Kwak)	100%
Immunization Advisor, Lora Shimp	70%
Immunization Advisor, Michel Othepa	77%
Pooled Immunization (Sequeira, Favim, H1N1)	70%
CSHGP Sr. PVO/NGO M&E Advisor, Jennifer Luna	75%
CSHGP HMIS Advisor, David Cantor	80%
PMI/MCP Advisor, Jennifer Yourkavitch	100%
Health Systems Strengthening Advisor, Alex Ergo	50%

²⁴ Cat McKaig has 25% LOE on ACCESS-FP through December 2010.

²⁵ Robert Steinglass has 10% LOE on a Gates-funded immunization initiative.

PROGRAM AND ADMINISTRATIVE SUPPORT

Finance Manager, Lance Brenner	100%
Finance Support, 3 positions	100%
Program Officers, 5-6 positions	100%
Program Coordinators, 5-6 positions	80%
Communications Specialist, Charlene Reynolds	100%
Administrative Assistant	100%
IT Specialist, Keith Sylvester	100%

- Note:
1. Percentages reflect the core investment/LOE ONLY.
 2. All Key Positions and Technical Leads that are fully-funded through core and field are shown in bold text.
 3. A portion of the MCHIP Director's time is budgeted under Associate Awards.

Table 14. MCHIP Technical Leads and Technical Teams

Includes technical team members and key contributors from other technical teams

**Note Koki Agarwal, Steve Hodgins, and Anita Gibson engage with all technical teams*

GLOBAL LEADERSHIP	MATERNAL HEALTH	NEWBORN HEALTH	CHILD HEALTH	IMMUNIZATION	WATER, HYGEINE, SANITATION
TL: Steve Hodgins, JSI	TL: Jeffrey Smith, Jhpiego	TL: Joseph de Graft-Johnson, Save	TL: TBD	TL: Robert Steinglass, JSI	TL: Dan Abbott, Save
Technical Team Leaders	Barbara Deller, Jhpiego	Abdullah Bacqui, JHSPH	Emmanuel Wansi, JSI	Cat McKaig, Jhpiego	Megan Wilson, PSI
	Harshad Sanghvi, Jhpiego	Becca Levine, Save	JSI STTA, incl. A. Guyon, M. Carnell, Moussa Ly	Holly Blanchard, Jhpiego	Emmanuel Wansi, JSI
	Jean Anderson, Jhpiego	Dan Abbott, Save	Cecilia Kwak, PSI	Jennifer Sequeira, JSI	Serge Raharison, JSI
	Susheela Engelbrecht, PATH	Goldy Mazia, PATH	Indira Narayan, PATH	JSI STTA	Salim Sadruddin, Save
	Yaikah Jeng-Joof, Jhpiego	Houley Diarra, Save	Kate Gilroy, JHSPH	Katherine Farnsworth, JSI	
	Cat McKaig, Jhpiego	Linda Bartlett, IIP/JHU	Katherine Farnsworth, JSI	Lora Shimp, JSI	
	David Cantor, Macro	Pat Daly, Save	Pat Taylor, JSI	Mike Favin, JSI	
	Holly Blanchard, Jhpiego	Jeffrey Smith, Jhpiego	Rae Galloway, PATH	Michel Othepa, JSI	
	Joseph de Graft-Johnson, Save	Penny Dawson, NFHP	Salim Sadruddin, Save	Pat Taylor, JSI	
	Linda Bartlett, IIP/JHU	Stella Abwao, Save	Serge Raharison, JSI		
	Marge Koblinsky, JSI	Steve Wall, Save	Steve Hodgins, JSI		
	Nancy Caiola, Jhpiego	Susheela Engelbrecht, PATH	Laban Tsuma, Macro		
	Rae Galloway, PATH	Defa Wane, Save	Tanya Guenther, Save		
	Rena Eichler, BBA	Judith Standley, Save	Eric Swedberg, Save		
	Winnie Mwebesa, Save	Indira Narayan, PATH	David March, Save		
	Edgar Necochea, Jhpiego	Angela Brasington, Save			
	Barbara Rawlins, Jhpiego	Tanya Guenther, Save			
	Senior Maternal Health Advisor (1 TBD)	Winnie Mwebesa, Save			
	Senior Maternal Health Advisor (2 TBD)				

PMTCT/ PEDIATRIC HIV	HEALTH SYSTEMS	URBAN HEALTH	CSHGP, PVO/NGO SUPPORT	FP	MALARIA & MCP	M&E
TL: Kelly Curran, Jhpiego	TL: Rena Eichler, BBA	TL: Anita Gibson, Save	TL: Leo Ryan, Macro	TL: Cat McKaig, Jhpiego	TL Malaria: Elaine Roman, Jhpiego TL MCP: Jennifer Yourkavitch, Macro	TL: Barbara Rawlins, Jhpiego
Pat Taylor, JSI	Alex Ergo, BBA	Emmanuel Wansi, JSI	David Cantor, Macro	Holly Blanchard, Jhpiego	Aimee Dickerson, Jhpiego	Becca Levine, Save
JSI STTA	Alix Beith, PATH	Joseph de Graft-Johnson, Save	Deborah Kumper, Macro	Elaine Charurat, Jhpiego	Bill Brieger, Jhpiego	David Cantor, Macro
Rae Galloway, PATH	Barbara Rawlins, Jhpiego	Mary Carnell, JSI	Debra Proznitz, Macro	Elizabeth Sasser, Jhpiego	Emmanuel Wansi, JSI	Jennifer Luna, Macro
Jean Anderson, Jhpiego	Jeffrey Smith, Jhpiego	Pat Taylor, JSI	Deborah Shi, PATH	Tsigue Pleah, Jhpiego	Theodora Biney-Amissah, Jhpiego	Reena Sethi, Jhpiego
Tigistu Adamu, Jhpiego	Leo Ryan, Macro	Richard Lamporte, Jhpiego	Ilona Varallyay, Macro	Ricky Lu, Jhpiego	Barbara Rawlins, Jhpiego	Mary Drake, Jhpiego
	Marge Koblinsky, JSI		Jeffrey Smith, Jhpiego	Jeffrey Smith, Jhpiego	Jeffrey Smith, Jhpiego	Eva Bazant, Jhpiego
	Robert Steinglass, JSI		Jennifer Bryce, PATH	Maureen Reinsel, Jhpiego	Debra Prosnitz, Macro	Tanya Guenther, Save
	Nirali Shah, BBA		Jennifer Luna, Macro	Mary Drake, Jhpiego	Ilona Varallyay, Macro	Moussa Ly, JSI
			Jennifer Yourkavitch, Macro	Mia Foreman, Macro	Debra Prosnitz, Macro	Laban Tsuma, Macro
			Florence Nyangara, Macro	Kate Epting, Jhpiego	Serge Raharison, JSI	Linda Fogarty, Jhpiego
			Joseph de Graft-Johnson, Save	Martha Appiagyei, Jhpiego	Katherine Farnsworth, JSI	Maya Tholandi, Jhpiego
			Laban Tsuma, Macro	Gloria Metcalfe, Jhpiego		Neff Walker, IIP/JHU
			Mia Foreman, Macro			Ingrid Friberg, IIP/JHU
			Peter Winch, JHSPH			Jennifer Bryce, PATH

Annex 2: MCHIP Country Investment Table

COUNTRY	ACTIVITIES IN YEAR 3	FUNDING TYPE	SOURCE	YEAR 3 AMOUNT (*ESTIMATED BUDGET)	YEAR 1 AND 2 AMOUNT (OBLIGATED)
Africa Region					
Burkina Faso					
	1) Malaria (MIP, RDT, case mgmt, ITNs)	Field Support	Malaria	\$915,000	\$1,120,000.00
DRC					
	1) Malaria community case management 2) Active management of the 3rd stage of labor/newborn	Field Support	MCH		\$909,481.00
	1) Complete establishment of two KMC centers 2) Technical support for the national EPI program 3) ICCM 4) ORT revitalization	Core	MCH/AFR SD	\$300,000.00	\$430,000.00
Ethiopia					
	1) Improve quality and accessibility of maternal and newborn health services	Field Support	FP/MCH	\$2,840,000.00	
	1) Quality of care survey follow-up	Core	MCH	TBD	Est. \$50,000.00
	1) Urban health leadership development and understanding barriers to use	Core	Urban Health	\$325,000	
Ghana					
	1) Strengthen pre-service education for HIV, PMTCT, FP, STIs, TB and malaria	Field Support	MCH/FP/HIV	\$1,092,000.00	
	1) Strengthen pre-service neonatal resuscitation curricula 2) Evaluation of PSE in PFP and PA-FP	Core	MCH	\$75,000.00 \$50,000.00	75,000.00
Guinea					
	1) FP with an emphasis on long-acting methods and PAC, PPH/AMTSL and PMTCT	Field Support	FP	\$800,000	
Guyana					
	1) Cervical cancer	Field Support	HIV	\$200,000	

COUNTRY	ACTIVITIES IN YEAR 3	FUNDING TYPE	SOURCE	YEAR 3 AMOUNT (*ESTIMATED BUDGET)	YEAR 1 AND 2 AMOUNT (OBLIGATED)
Kenya					
	1) CH/immunization 2) Water/sanitation 3) Infant feeding 4) Newborn resuscitation 5) Diarrheal disease case management	Field Support	MCH	\$650,000.00	\$1,300,000.00
	1) PFP/IYCN 2) Routine immunization coverage 3) Child health/diarrhea 4) Newborn resuscitation 5) Pilot HIV/MNCH in Bondo	Core	Africa SD	\$150,000 \$150,000 \$400,000	
Lesotho					
	1) Pre-service education 2) TBD	Field Support Field Support	HIV HIV	\$900,000 \$1,210,000.00	\$500,000.00
Liberia					
	1) Improve FP knowledge and skills of providers 2) Improve FP service delivery 3) Increase demand for FP	Field Support	FP	\$330,000.00	\$300,000.00
	1) RED family planning/immunization model	Core	MCH	\$200,000.00	
Madagascar					
	1) National level technical leadership development 2) Introduce and document community/health facility integrated package of high-impact interventions	Field Support	MCH/FP	\$1,650,000.00	\$500,000.00
Malawi					
	1) ACT IEC, ITN IEC, IPTp IEC 2) Quality Improvement in facilities 3) Community MNH services and community mobilization 4) HBB/KMC 5) Postpartum family planning 6) ORS social marketing 7) BEmONC training 8) Results-based financing 9) Strengthening private sector for FP 10) Infrastructure improvements 11) PMTCT 12) Hygiene packet procurement 13) MC	Field Support	Malaria/FP/MCH/ HIV	\$3,400,087	\$4,240,000.00

COUNTRY	ACTIVITIES IN YEAR 3	FUNDING TYPE	SOURCE	YEAR 3 AMOUNT (*ESTIMATED BUDGET)	YEAR 1 AND 2 AMOUNT (OBLIGATED)
	1) FP pre-service, KMC, PPH prevention	Core	MCH/FP	\$120,000	\$185,000.00
Mali					
	1) Integrated facility package including PFPF, FP as part of PAC services, AMTSL and ENC 2) PPH prevention through AMTSL trainings 3) National policies on MNCH/FP 4) Introduce oxytocin in Uniject™ 5) CCM integrated package	Field Support	MCH/FP	\$1,025,000.00	
	1) iCCM 2) ORT 3) NUVI 4) Integrated MNH/FP package	Core	MCH/FP	\$350,000.00	\$350,000.00
Mozambique					
	1) Strengthen MNH and key preventative FP/RH services 2) Strengthen PSE for MNH	Field Support	Malaria/MCH/FP/HIV		\$4,615,947.00
	1) Broad MNCH scope with emphasis on malaria and HIV	Associate Award		\$9,239,180	
Nigeria					
	1) Emergency obstetric and neonatal care 2) Family planning 3) Community mobilization 4) Quality improvement 5) Infrastructure improvement 6) Kangaroo Mother Care	Field Support	MCH/FP	\$1,100,000.00	\$5,050,000.00
	1) Community management of neonatal sepsis 2) GDA implementation of HW for newborn survival 3) NUVI	Core (in Africa SD funds below)	MCH/AFR SD	\$80,000.00	\$200,000 (est.)
Rwanda					
	1) Malaria in pregnancy 2) CCM	Field Support	Malaria/MCH	\$850,000.00	\$570,800.00
	1) QoC survey 2) NUVI 3) PPIUCD OR	Core	MCH	\$125,000.00	
Senegal					
	1) Document scale-up of MNH 2) EPI review—dissemination of various program documentation for MH, CH and NB	Core	MCH	\$100,000.00	\$75,000.00

COUNTRY	ACTIVITIES IN YEAR 3	FUNDING TYPE	SOURCE	YEAR 3 AMOUNT (*ESTIMATED BUDGET)	YEAR 1 AND 2 AMOUNT (OBLIGATED)
Sierra Leone					
	1) Technical assistance to Healy Foundation	Core	MCH	\$277,000	
South Africa					
	1) PMTCT 2) Male circumcision 3) Quality improvement 4) Cervical cancer	Field Support	HIV	\$1,940,000.00	\$1,439,365.00
South Sudan					
	1) Immunization	Field Support			\$416,000.00
Swaziland					
	1) Newborn circumcision	Field Support	HIV	\$125,000.00	
		Core	HIV		\$2,000,000.00
Tanzania					
	1) Male circumcision	Field Support	HIV	\$1,026,078.00	\$1,001,078.00
	1) QoC and P4P	Core	MCH	\$60,000.00	
Uganda					
	1) EPI review	Core	MCH	\$75,000.00	
Zimbabwe					
	1) National policies to increase access to MNH/FP services 2) Quality improvement of MNH/FP services 3) Improved community outreach services 4) Increase of routine immunization coverage	Field Support	MCH	\$6,050,000.00	

COUNTRY	ACTIVITIES IN YEAR 3	FUNDING TYPE	SOURCE	YEAR 3 AMOUNT (*ESTIMATED BUDGET)	YEAR 1 AND 2 AMOUNT (OBLIGATED)
Asia Region					
Azerbaijan					
	1) Materials development	Core		\$233,000.00	
Bangladesh					
	1) WRA, newborn resuscitation 2) Explore possible nested trial on CKMC 3) DA implementation (Helping Babies Breathe)	Field Support	MCH/FP	\$200,000.00	\$450,000.00
	1) Handwashing 2) Maternal anemia 3) Healthy Fertility Study	Core	MCH	\$620,000.00	
	1) Community-based MNH/FP	Associate Award			\$3,450,000.00
India					
	1) GDA Implementation (HBB) 2) Essential newborn care 3) Distributing Aquataps/research 4) PP family planning	Field Support	MCH/FP	\$4,100,000.00	\$1,276,000.00
	1) Newborn handwashing; MN assessment and activities 2) Technical support for the EPI program	Core	MCH	\$400,000.00	
Indonesia					
	1) Community-based MNH services and practices 2) Quality improvement of facility-based MNH 3) Strengthen district health management systems	Field Support	MCH	\$9,800,000.00	
		Core (CCP)			\$600,000.00
Nepal					
	1) Continue pre eclampsia/eclampsia work	Field Support	FP	\$300,000.00	\$500,000.00
Ukraine					
	1) Immunization communications	Field	MCH	\$91,000	

COUNTRY	ACTIVITIES IN YEAR 3	FUNDING TYPE	SOURCE	YEAR 3 AMOUNT (*ESTIMATED BUDGET)	YEAR 1 AND 2 AMOUNT (OBLIGATED)
LAC Region					
Bolivia					
	1) FP, PAC	Field Support	FP/MCH	\$100,000.00	\$1,180,140.00
Paraguay					
	1) MNH, Community interventions	Field Support	MCH	\$320,000.00	\$1,375,000.00
USAID Regional Bureau Activities					
AFR SD					
	1) PPH, PE/E Regional meeting 2) Pre-service Toolkit 3) Newborn sepsis management—Nigeria 4) Scaling up Newborn Resuscitation 5) iccm 6) CDD 7) Co-fund CCM in DRC 8) RED approach for MNC 9) Immunization	Bureau Support		\$1,140,000.00	\$1,256,000.00
LAC RSD					
	1) PPH prevention activities in Nicaragua, Honduras, Guatemala, Paraguay and Peru 2) OR-Cesareans in Nicaragua 3) Review of PNC framework and policies in LAC region 4) Support LAC Newborn Health Alliance 5) Scale up prevention/treatment of newborn sepsis 6) Support to scale up newborn resuscitation 7) TA to support KMC	Bureau Support		\$650,000.00	\$535,000.00