



Maternal and Child Health Integrated Program (MCHIP)

YEAR FOUR

ANNUAL IMPLEMENTATION PLAN

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ABBREVIATIONS AND ACRONYMS: TECHNICAL

ACS	Antenatal Corticosteroid
ACT	Artemisinin Combination Therapy
AMTSL	Active Management of the Third Stage of Labor
ANC	Antenatal Care
AOTR	Agreement Officer's Technical Representative
ARI	Acute Respiratory Infection
BBL	Brown Bag Lunch
BCC	Behavior Change Communication
BEmONC	Basic Emergency Obstetric and Newborn Care
BOD	Burden of Disease
CB	Community-Based
CCH	Community Child Health
CCM	Community Case Management
CDD	Control of Diarrheal Disease
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CHW	Community Health Worker
cMYP	Comprehensive Multi-Year Plans
COP	Community of Practice
CPD	Continuing Professional Development
CPG	Clinical Practice Guideline
CRT	Corporate Representative Team
D&A	Disrespect & Abuse
DD	Diarrheal Disease
DHS	Demographic and Health Survey
DIP	Detailed Implementation Plan
EIMC	Early Infant Male Circumcision
EmONC	Emergency Obstetric and Newborn Care
EMT	Executive Management Team
ENC	Essential Newborn Care
EONC	Essential Obstetric and Newborn Care
FP	Family Planning
GOI	Government of India
HEW	Health Extension Worker
HF	Health Facility
HIP	High Impact Practice
HMIS	Health Management Information System
HQ	Headquarters
HSS	Health Systems Strengthening
HTSP	Healthy Timing and Spacing of Pregnancy
iCCM	Integrated Community Case Management
IFA	Iron/Folic Acid
IPTp	Intermittent Preventive Treatment for Pregnant Women
IRB	Institutional Review Board
IRS	Indoor Residual Spraying
ITN	Insecticide-Treated Bed Net

KMC	Kangaroo Mother Care
LA/PM	Long-Acting/Permanent Methods
LAC	Latin America and Caribbean
LAM	Lactational Amenorrhea Method
LBW	Low Birth Weight
LiST	Lives Saved Tool (developed by JHU)
LLIN	Long-Lasting Insecticide-Treated Net
LOP	Life of Program
MC	Male Circumcision
MCH	Maternal and Child Health
MC-UH	Maternal-Child Urban Health
MDG	Millennium Development Goal
M&E	Monitoring and Evaluation
MER	Monitoring, Evaluation and Research
MIP	Malaria in Pregnancy
MIYCN	Maternal, Infant and Young Child Nutrition
MMR	Maternal Mortality Ratio
MNCH	Maternal, Newborn and Child Health
MNH	Maternal and Newborn Health
MOVE	Models for Optimizing Volume and Efficiency
MTE	Mid-Term Evaluation
NHMIS	National Health Management Information System
NMR	Newborn Mortality Rate
OPVO	Oral Polio Vaccine (partial vaccination, Dose 0, given at birth)
OR	Operations Research
ORT	Oral Rehydration Therapy
PAC	Postabortion Care
PCV	Pneumococcal Conjugate Vaccine
PDME	Program Design, Monitoring and Evaluation
PE/E	Pre-Eclampsia/Eclampsia
PI	Performance Improvement
PMP	Performance Monitoring Plan
PMTCT	Prevention of Mother-to-Child Transmission of HIV
PNC	Postnatal Care
PPFP	Postpartum Family Planning
PPH	Postpartum Hemorrhage
PPIUD	Postpartum Intrauterine Contraceptive Device
PPSS	Postpartum Systematic Screening
PSE	Pre-service Education
QoC	Quality of Care
RDT	Rapid Diagnostic Test
RH	Reproductive Health
RI	Routine Immunization
SBA	Skilled Birth Attendance/Attendant
SBC	Social and Behavioral Change
SBM-R	Standards-Based Management and Recognition

SMRH	Safe Motherhood and Reproductive Health
STI	Sexually Transmitted Infection
STTA	Short-Term Technical Assistance
TA	Technical Assistance
TBD	To Be Determined/Developed
TT	Tetanus Toxoid
TWG	Technical Working Group
VMMC	Voluntary Medical Male Circumcision
WASH	Water, Sanitation and Hygiene
ZTF	Zinc Task Force

DONORS, PROGRAMS AND ORGANIZATIONS

AAP	American Academy of Pediatrics
ACCESS	Access to Clinical and Community Maternal, Neonatal and Women's Health Services Program
APHA	American Public Health Association
ARC	African Health Professionals Collaborative for Nurses and Midwives
ARCI	Africa Regional Conference on Immunization
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
CDC	U.S. Centers for Disease Control and Prevention
CEDPA	Centre for Development and Population Activities
CHAI	Clinton Health Access Initiative
CI	Communications Initiative
CSHGP	USAID's Child Survival Health Grants Program
DRC	Democratic Republic of the Congo
EARN	East Africa Roll Back Malaria Network
ECSACON	East, Central and Southern Africa Health Colleges of Nursing
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
GHC	Global Health Council
GHI	Global Health Initiative
HBB	Helping Babies Breathe
HCI	Health Care Initiative
HIDN	Health, Infectious Diseases and Nutrition
IBP	Implementing Best Practices
ICDDR,B	International Centre for Diarrhoeal Disease Research, Bangladesh
ICM	International Confederation of Midwives
IECS	Instituto de Efectividad Clinica y Sanitaria (Institute for Clinical Effectiveness and Health Policy)
IMMbasics	IMMUNIZATIONbasics
JHSPH	Johns Hopkins Bloomberg School of Public Health
JHU-IIP	Johns Hopkins University Institute for International Programs
K4H	Knowledge for Health
LSHTM	London School of Hygiene and Tropical Medicine
MAMA	Mobile Alliance for Maternal Action
MCP	Malaria Communities Program
MIPc	Malaria in Pregnancy Consortium
MOH	Ministry of Health
MSH	Management Sciences for Health
NGO	Nongovernmental Organization
NICHD	National Institute of Child Health and Human Development

NUVI	New and Underutilized Vaccines Implementation
OHA	Office of HIV/AIDS (Global Health Bureau, USAID)
P4P	Pay for Performance
PAHO	Pan American Health Organization
PEI	Polio Eradication Initiative
PMI	President's Malaria Initiative
PMNCH	Partnership for Maternal, Newborn and Child Health
PMT	Partnership Management Team
POPPHI	Prevention of Postpartum Hemorrhage Initiative
PQM	Pharmaceutical Quality Management
PSM	Procurement and Supply Management
PVO	Private Voluntary Organization
RBM	Roll Back Malaria
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
SD	Sustainable Development
SHOPS	Strengthening Health Outcomes Through the Private Sector
SNL	Saving Newborn Lives
SPS	Strengthening Pharmaceutical Systems
SUN	Scaling Up Nutrition
TAG	Technical Advisory Group
TFI	Task Force on Immunization
TRAction	Translating Research into Action
UHEP	Urban Health Extension Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNICEF/ESARO	United Nations Children's Fund/Eastern and Southern Africa Regional Office
UNICEF/WCARO	United Nations Children's Fund/West and Central Africa Regional Office
UNICEM	Unidad de Investigación Clínica y Epidemiológica Montevideo (Clinical and Epidemiological Research Unit Montevideo)
URC	University Research Co.
USAID	U.S. Agency for International Development
USG	U.S. Government
VHND	Village Health Nutrition Day
VSI	Ventures Strategies Innovations
WARN	World Antimalarial Resistance Network
WHO	World Health Organization
WHO/AFRO	World Health Organization/Regional Office for Africa
WHO/EMRO	World Health Organization/Eastern Mediterranean Regional Office
WHO/IBP	World Health Organization/Implementing Best Practices
WHO/RHR	World Health Organization/Reproductive Health and Research
WHO/SAGE	World Health Organization/Strategic Advisory Group of Experts
WHO/SEARO	World Health Organization/South East Asia Regional Office
WHO/WPRO	World Health Organization/Western Pacific Regional Office

Introduction

This document represents the Annual Implementation Plan for the fourth Program Year of MCHIP: 1 October 2011–30 September 2012¹ (Program Year 4). Year 3 brought the number of countries in which MCHIP is, or has been, involved to 38, including all Global Health Initiative (GHI) Plus Phase 1 countries (Table 1). The significant growth in country programming in Years 2 and 3, combined with the guidance developed around implementation and optimal performance at scale as well as considerations of what constitutes achievement of *effective coverage*, has shaped the priorities outlined in this workplan. These priorities have been further refined by the USAID commissioned mid-term evaluation (MTE) of MCHIP.²

Overall conclusions of the MTE reflect that “MCHIP is making valued contributions to the work of other global partners in specific elements of MNCH” and that “MCHIP is successfully introducing globally identified best practices to field programs.” Country programs were assessed as “being sound and responsive to needs” and “from all accounts, MCHIP is well perceived in countries where it is working. The activities of focus have been developed in close collaboration with, and mostly at the request of, national Ministries of Health.”

Although the program has made great progress in shaping the global agenda and bringing evidence-based practices and technical expertise to support our work in the field, more work remains to be done. “...MCHIP has assembled the necessary technical expertise both at headquarters and at the field level to undertake the required work and is making good progress toward helping USAID Missions in the participating countries to introduce high-impact maternal, newborn and child health (MNCH) interventions. For the remainder of the program, MCHIP, with support from USAID, needs to put more concerted effort toward developing evidence based on experiences at the country level....” MCHIP’s country-level work cuts across the full span of MCHIP’s technical mandate. This mandate provides excellent opportunities—not only to contribute to moving forward key programs at the field level, but also to ensure that important lessons from country-level experience are known to regional and global level audiences and stakeholders. This year’s workplan reflects a particular emphasis on program learning.

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
Democratic Republic of the Congo (DRC)	Mozambique	Guatemala (bureau only)	Indonesia
Ethiopia	Rwanda	Guyana	Nepal
Ghana	Senegal	Honduras (bureau)	Timor-Leste
Guinea	Sierra Leone	Nicaragua (bureau)	
Kenya	(core/HF ³)	Paraguay	E&E
Lesotho	South Africa	Peru (bureau)	Azerbaijan (core)
Liberia	South Sudan		Ukraine
Madagascar	Swaziland		
Malawi	Tanzania		
	Uganda		
	Zimbabwe		

¹ Unless noted otherwise, work described in this document is funded through core and regional bureau funds. Criteria for identifying strategic core investments at the field level are consistent with those outlined in the PY3 workplan.

² Riggs-Perla J, Franczak N, Schwethelm B, Wegner MN. 2011. *MCHIP Mid-Term Evaluation*. Global Health Tech (forthcoming).

³ Healy Foundation

This plan begins with an overview of the MCHIP strategic approach. This overview is followed by more detailed discussion of how MCHIP understands cross-cutting issues influencing work at scale and effective coverage. Finally an overview of our program learning framework and the ways in which MCHIP realizes its global leadership mandate are outlined. Following this introductory section are cross-cutting and technical sections including dedicated sections for regional bureau (AFR/SD and Latin America and Caribbean- [LAC-]) funded activities. Each technical section addresses global leadership and long-term strategy and outlines program learning and expected results to be achieved in Year 4. Attachment 1 provides the MCHIP Year 4 Core Activity Matrix.

Note that Year 4 reflects MCHIP support for USAID's new priorities, including the New and Underutilized Vaccine Initiative (NUVI) and the Mobile Alliance for Maternal Action (MAMA). Details relating to the latter are outlined in a separate workplan; however, a summary is provided here. It is important to note that the MAMA initiative is one of a number of mHealth-related activities supported by MCHIP. However, specific funding is dedicated from USAID to the MAMA initiative, while other mHealth activities in the core workplan are covered by other core funds and are related directly to specific activities of MCHIP technical teams.

The MAMA initiative is an innovative partnership led by USAID and Johnson & Johnson, with support from Baby Center, mHealth Alliance and the UN Foundation, which uses technology to improve health and nutrition outcomes among pregnant women and new mothers and their infants in resource-poor settings.⁴ As MAMA is launched, first as a pilot in Bangladesh, South Africa and India over the next three years, it will build the evidence base on the effective application of mobile technology to improve maternal health for future applicability in other countries. The initiative is expected to foster collaborations among similar initiatives in other countries to accelerate efforts to reach millions of women with mobile phone access around the world with critical health information. At a later stage, MAMA could potentially link to other services to ensure direct impact on health outcomes beyond awareness and behavior change.

MCHIP's role in MAMA, through core funding, is to: provide leadership in monitoring and evaluation at the global level; inform and review content that is developed by Johnson & Johnson's Baby Center; provide support to the MAMA Partnership Director; and contribute to a landscape analysis in India.

MCHIP STRATEGIC APPROACH

Several key principles orient our work as MCHIP enters the fourth year of its planned five-year duration. A major area of emphasis remains contributing to scaling up high-impact interventions. Our contribution to scale-up is accomplished both through direct in-country program activities, funded primarily by field support, and through influence we are able to exercise with other implementing partners working in-country, as well as at regional and global levels. To further these efforts, Lives Saved Tool (LiST) analyses are developed to serve as a reference for partners engaged in programming discussions. The process of moving toward impact at scale is generally complex. Our involvement can be at any point along the life cycle of such efforts, from early policy advocacy, to involvement at much later phases in the scale-up process. Our involvement can range from addressing implementation challenges to optimal performance at scale. Necessarily, our work builds on and complements the work of other programs and partners, including predecessor projects, Mission-funded bilateral projects and

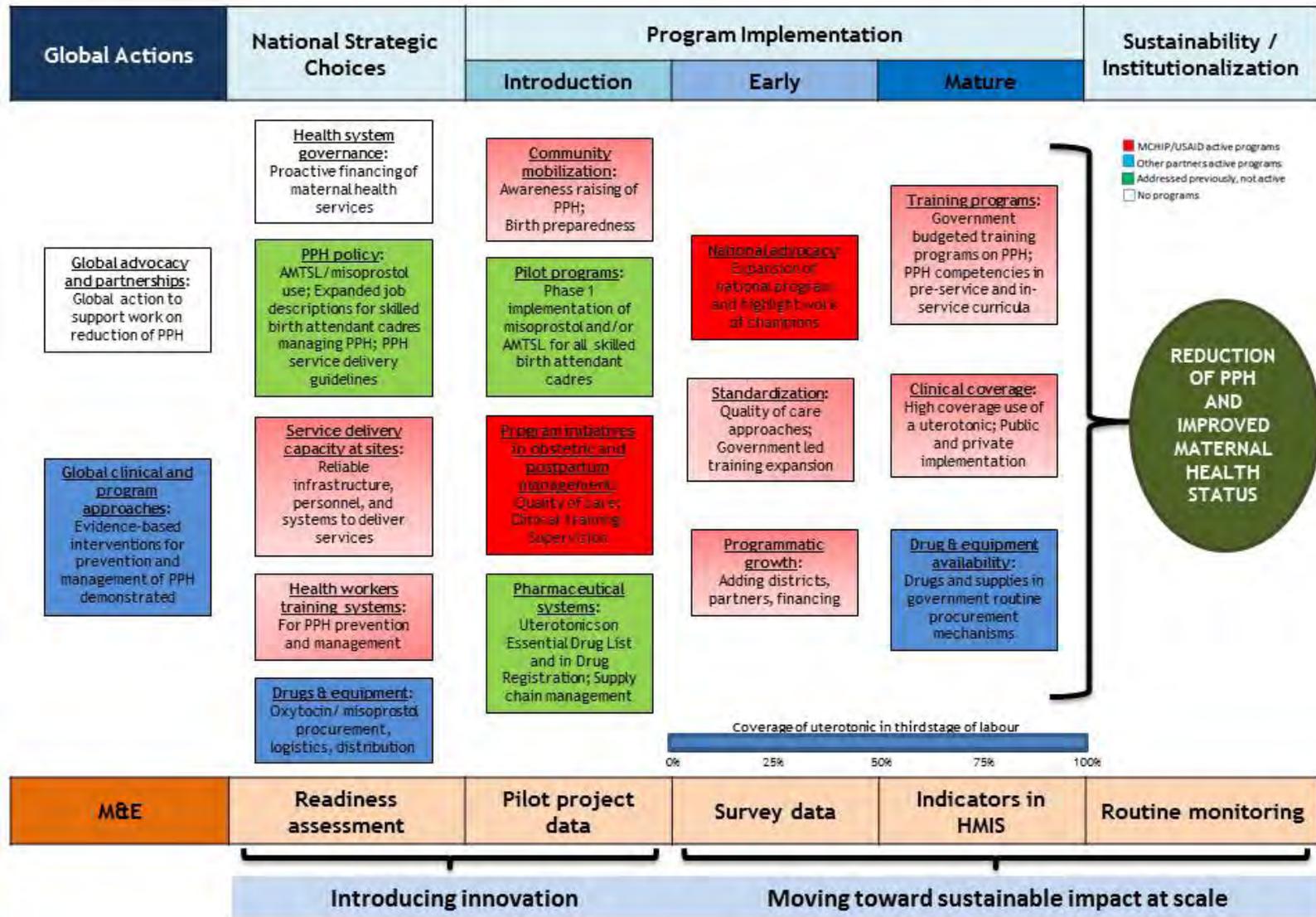
⁴ MAMA: <http://www.mobilemamaalliance.org/> and MAMA Presentation to USAID India July 29, 2011 PowerPoint presentation.

the work of multilateral partners. Our work is also consistent with the Global Health Initiative (GHI). The MTE “repeatedly found evidence in documents, site visits and stakeholder interviews that the core principles of GHI are woven throughout MCHIP, a finding confirmed by USAID key informants at headquarters (HQ) and in the field.”

Building on important work guidance developed in Year 3 and consistent with the priority recommendations from the MTE, over the remainder of the project, MCHIP will make wide use of scale-up maps (see Figure 1). These maps will function as a planning, management and monitoring tool at country level to help facilitate effective joint efforts, and at HQ level— together with our Agreement Officer’s Technical Representative (AOTR) team—to track progress of major technical initiatives across countries and over time. Operationalization and use of the scale-up maps was highlighted as one of the highest priority recommendations in the MTE.

Figure 1. Sample MCHIP Mozambique Scale-up Map

MOZAMBIQUE - PATHWAY TO IMPLEMENTATION OF PPH PREVENTION AND MANAGEMENT AT SCALE



February 2011

EFFECTIVE COVERAGE AND CROSS-CUTTING FUNCTIONS

MCHIP's primary focus is to contribute to reducing maternal, newborn and child mortality through increased coverage of key, high-impact interventions. Achieving this, however, requires attention to several important cross-cutting functions and issues.

“Coverage,” in the way we usually measure it, is often not enough to yield impact. Instead, we need “effective coverage,” meaning the proportion of those needing a service or intervention who not only receive it but have it delivered to them in a way that meets key quality requirements (for example, the vaccination needs not only to be administered; the vaccine also has to be potent).

This brings us to the related issues of **quality** of care, health worker performance, program performance and **systems**. MCHIP will continue to give serious attention to this set of critical conditions for effective delivery of care. Part of this effort consists of our contribution to global-level indicators/metrics work spanning maternal, newborn and child health. We are seeking to incorporate, both at global and country levels, new routine measurement that better captures important aspects of quality of care, particularly during the critical period from the onset of labor through 48 hours post-delivery. We are also giving continuing attention, working together with other important USAID implementers, to scalability and sustainability of the Standards-Based Management and Recognition (SBM-R) approach and other related approaches to continuous improvement of quality of care. Our support to strengthening systems also includes work on routine health information systems, particularly focusing on appropriate MNCH indicators and on effective use of data at the point where they are collected and at each level where they are reported. The analysis of efforts to incentivize quality of care in MNCH will be finalized and disseminated. Practical guidelines will be developed to help policymakers and program managers: (i) better understand the interactions between the various financing mechanisms for MNH that are in place; (ii) identify possible adverse effects of these combined mechanisms; and (iii) take concrete steps to mitigate these adverse effects and develop a more coherent financing strategy for MNH that contributes to improved MNH results. The guidelines will be based on a “map” of the various actors involved in MNH, the actions they need to take and the way financing strategies can incite needed actions.

Another cross-cutting function that is central for MCHIP is **community**-based service delivery. Most, if not all, of MCHIP's technical teams have activities that focus on provision of services by community health workers (CHWs) or through outreach strategies. This orientation is also reflected in our country-level work. Part of our global leadership role consists of effective technical advocacy at the global level to ensure that the value and effectiveness of service provision at this level is adequately recognized by key global partners. Work with CHWs has been receiving increasing attention at global level but there are still many mixed messages and areas of confusion in guidance that is circulating. Over the remainder of the project period, MCHIP expects to exercise leadership in this area along with other partners like the CORE Group. Our principal activity in this area will be to lead and contribute to a multi-partner initiative that will consist of: documenting experience across multiple national CHW programs, drawing out key lessons relevant for CHW program development and writing them up in the form of a special journal issue. This documentation will likely be supplemented by guidance developed in several other forms, intended to be user-friendly by program managers at all levels. It is expected that this work will be conducted over Years 4 and 5, to be completed by end of project.

Appropriate integration: Year 3 has seen continuing collaboration and mutual learning across technical teams. We have focused particularly on identifying service contact opportunities for rationalizing provision of services in a way that reduces unnecessary inconvenience or difficulty to the patient/client. This is a strategy that requires us to be opportunistic, adapting to the particular circumstances of the settings where we have some presence. But certain contacts that

are widely available are generally not fully exploited, for example, immunization contacts over the first year of life. We have been seeking program synergies, taking advantage of such contacts—without undermining immunization services—to improve our ability to reach infants and their mothers with counseling or services related to family planning (FP) and nutrition. However, both at global and country levels, we will continue to be vigilant, identifying other circumstances where coverage *across* services and ease of use by clients is compromised by service provision that is too compartmentalized. Building on work done in Year 3, and recommendations from the mid-term review, we will continue to provide leadership among USAID implementing projects and beyond in the area of smart, appropriate integration.

Although natural connections and synergies occur at multiple points across MCHIP's technical areas, maternal-newborn is something of a special case. For institutional and funding reasons, maternal and newborn health (MNH) will remain divided in the workplan between maternal and newborn, but we recognize this as an arbitrary and artificial distinction. In our actual work, we will ensure that activities are designed and managed in as fully integrated a way as circumstances permit, fully consistent with a life-cycle, continuum of care perspective.

The focus in MCHIP has been on provision of services, and more particularly on provision of lifesaving interventions within the context of essential obstetric and newborn care. In some instances, this has resulted in some relative lack of emphasis on the “*demand side*.” We recognize, however, that even for achievement of high coverage of the interventions we are focusing on, the proffer and acceptance of these services depends on effective attention being given to *care-seeking* and barriers that hinder it. Contacts during pregnancy, whether through formal antenatal care (ANC) or CHWs, provide an important opportunity to encourage care-seeking both for routine preventive care (ANC, health facility [HF] delivery, postpartum care, immunization) and appropriate timely care-seeking for danger signs.

Another very important determinant of maternal-newborn health outcomes, which is commonly classified as “demand side,” is *household practices*, including those that occur around labor and delivery. In many of the country settings where MCHIP works, the majority of deliveries happen at home and are not attended by skilled health workers. In these circumstances, through labor and delivery and the minutes and hours that follow, *desisting from harmful practices* (e.g., fundal pressure, setting the newborn aside on the floor as the placenta is attended to, delaying initiation of breastfeeding) and *adhering to recommended practices* (ensuring the “cleans,” adopting practices for preventing hypothermia) can have a very potent influence on mortality risk for the mother and, especially, for the newborn. The opportunity we have to influence these practices comes in the weeks and months *before* delivery, while the woman is still pregnant. An example of how this is woven into MCHIP work is the approach taken for prevention of postpartum hemorrhage (PPH) at home birth. This programmatic approach includes counseling, birth preparedness, promotion of skilled attendance and advanced provision of misoprostol for self-administration at the time of home birth, all provided through contacts during pregnancy (by a health worker or CHW).

On the “supply side,” MCHIP gives special attention to a limited set of key MNH interventions. This constitutes the “what” that is addressed on the supply side. In principle, the selection is to be prioritized based on evidence for efficacy, relative disease burden of the conditions these interventions address and expected impact. In practice, the relative emphasis across interventions is also determined by other, less technical considerations (for example, alignment with special Agency initiatives). We will seek opportunities to increase effective level of effort for high-impact interventions not currently receiving attention proportionate to expected impact (including those delivered during pregnancy). Examples of these interventions are: malaria in pregnancy (MIP), iron/folic acid (IFA), tetanus toxoid (TT), deworming, syphilis screening (VDRL), prevention of mother-to-child transmission of HIV (PMTCT); plus key areas for counseling, notably, birth

preparedness/complication readiness and essential care of the newborn—particularly immediately after delivery, in settings where most deliveries occur at home.

A number of the interventions we are prioritizing also entail important **quality** issues that determine actual effectiveness of the interventions, as delivered. MCHIP will continue engaging these quality issues (e.g., aspects of the intrapartum period captured in MCHIP’s quality of care [QoC] studies). We will also seek to draw more attention to addressing *harmful practices* that substantially contribute to maternal and newborn mortality.

Of course, to achieve population-level health impact we need more than the right set of interventions. We need to deliver them effectively at high coverage, which brings us to the “how” of the supply side. Effective service delivery requires more than merely addressing health worker knowledge and skills; it requires attention to ensuring the necessary **systems conditions**, including provision of needed commodities, functional monitoring and supervision, etc. Particular interventions are delivered through various *service delivery approaches* or strategies, adapted to the particular contexts in which we work and taking advantage of available contacts. This can entail locally appropriate distribution of tasks across different levels of care, from community, through peripheral clinic and hospital. Taking advantage of available contacts, and maximizing the input of each health worker who has contact with the woman/newborn, gives us opportunities to ensure timely provision of interventions appropriate to life-cycle stage (earlier and later pregnancy, labor and delivery, the first 24–36 hours after delivery, the rest of the first week and the period through four to six weeks after birth). At each of the life-cycle stages, key *counseling, dispensing/dosing, screening and case-management* (including management of common, life-threatening complications) *interventions* are to be delivered. In our activities, MCHIP will consistently take an integrated approach, ensuring that opportunities are not missed to deliver all the highest priority interventions effectively, across life-cycle stages and levels of care.

Associated with our commitment to achieving impact at scale, we remain particularly concerned that the services we are associated with effectively reach the most vulnerable, among whom bad outcomes are more heavily concentrated. We will address this focus on **equity** by systematically reporting our performance indicators, disaggregating by male/female and household wealth (and other dimensions of social equity where relevant), to the extent that our data sources allow.

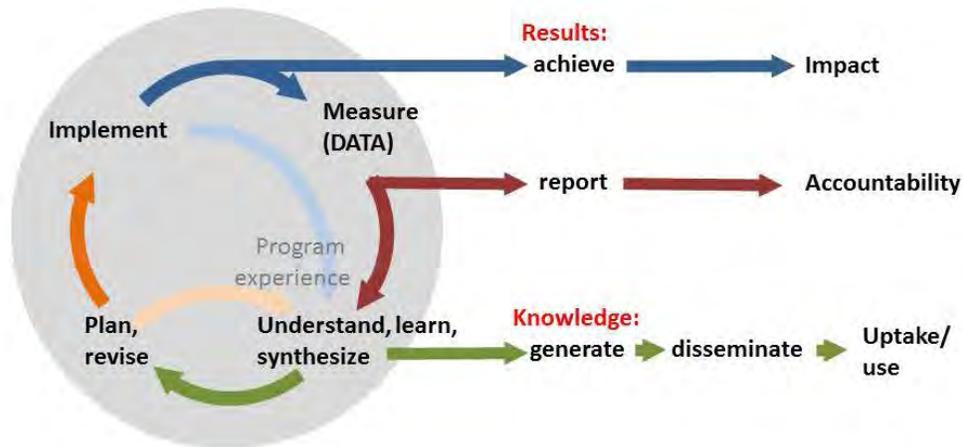
GLOBAL PROGRAM LEARNING

As mentioned previously, one of the key recommendations of the recent MCHIP MTE was that we develop a strong, explicit strategy for more adequately capturing lessons learned from MCHIP’s field experience. As we approach Year 4, we have begun systematically to *identify opportunities* for program learning that could be of relevance beyond MCHIP.

Within MCHIP we have identified several important themes of particular interest, including: *scale-up, integration of services, quality, community and equity*. We are particularly interested in any important programmatic lessons learned across these areas. At the same time, there are important lessons for us to be capturing that fall outside these themes.

The diagram below (Figure 2) gives a very general picture of ongoing work *within* MCHIP, focusing on what could be referred to as *organizational learning or performance management*.

Figure 2. Organizational Learning/Performance Management within MCHIP



In the course of our regular work, we are involved in a continuous process (represented above, beginning at the bottom right, as *understand, plan, implement, measure*) that entails:

- Seeking to understand or make sense of the setting, the programmatic issues, the needs of clients, etc.;
- Developing or modifying plans based on this understanding;
- Implementing our planned activities;
- Measuring or monitoring performance in a variety of ways;
- Analyzing, making sense of these data and drawing on our ongoing program experience as a basis for making any needed adjustments in our approach.

We carry out this process regardless of the level at which we work. And from the continuous learning emerging from this process, we see continued improvement in effectiveness and performance. However, sometimes in the course of our work, learning occurs that has potential value or usefulness for a broader set of people involved in this work, which we could call *program learning*. Our challenge then is to make this learning or knowledge available to others, helping ensure wider application and greater impact.

The “measurement” that contributes to increasing our understanding includes routine data collection/use (e.g., health management information system [HMIS], project monitoring systems), surveys, special studies, process documentation, evaluations and the like. One focus of MCHIP’s work is strengthened *measurement*, which contributes both to improved performance measurement/management *within MCHIP* as well as *globally* (e.g., QoC surveys, SBM-R, HMIS strengthening, global indicators work). One important product or output of our data collection and documentation is *results reporting*, which serves to ensure *accountability*—within the program, with regard to our donor and with the wider world.

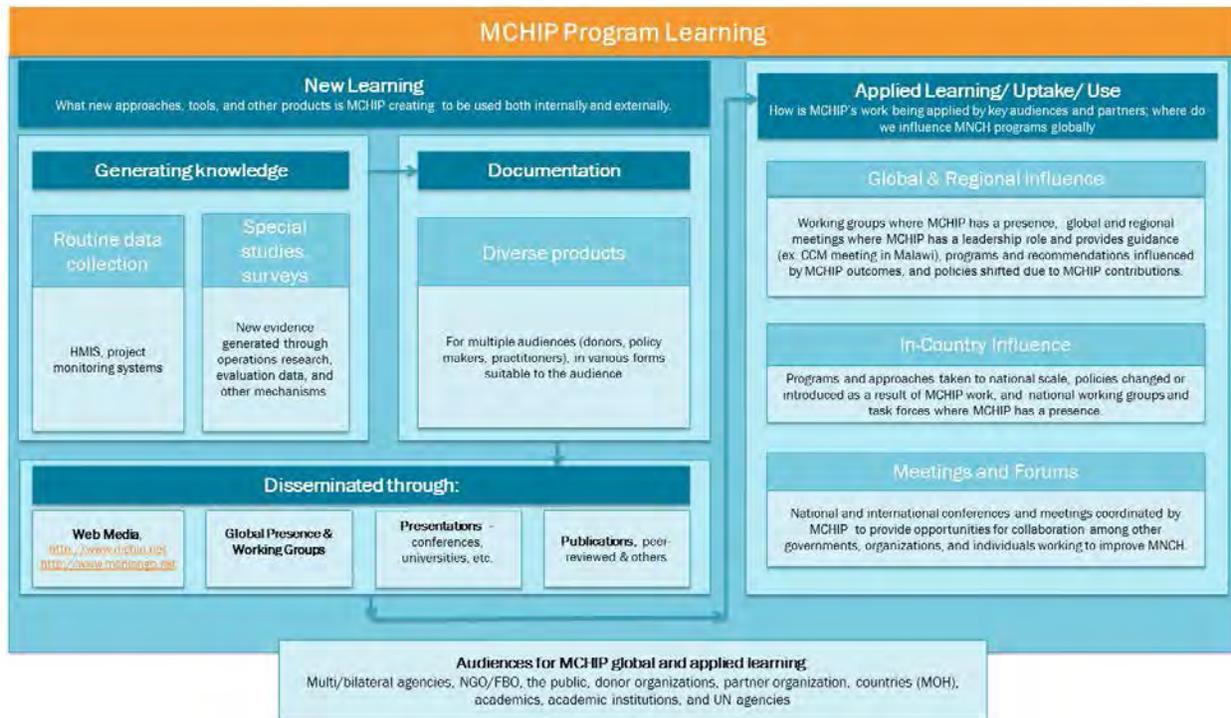
Across these functions support is needed in *knowledge management, communications* and *documentation*. Success in these areas depends upon how we use the Internet (our own Web site⁵ and other Web sites like K4H, online communities of practice), production of documents for wide dissemination, reaching and following up key audiences, etc. What has been presented

⁵ Further to discussion with the AOTR team, it is anticipated that during Program Year 4, MCHIP will continue to build the scope of www.mchip.net, specifically to provide a broader range of information on MCHIP programs, tools and resources, global leadership/program learning and technical areas of focus, and to link to other existing, relevant sites.

here is a very general picture of the program learning function. However, whether internally or externally oriented, for program learning to be effective and robust and contribute to improved programs, the following need to happen: prioritization by managers and funders; a learning culture actively cultivated; sufficient resources available; specific, related responsibilities reflected in staff work assignments; and these functions adequately reflected in workplans. A program learning meeting involving several MCHIP field staff is proposed in PY4. The primary purpose of this meeting would be to refine our program learning priorities and to discuss application and use of scale-up maps at the country level.

While Figure 2 illustrates the internal/external processes of learning that we seek to cultivate within MCHIP, Figure 3 below summarizes the mechanisms through which learning that is generated within MCHIP is documented, disseminated, and eventually applied and taken up in-country and by global stakeholders. Each technical section describes, more specifically, program learning activities to be conducted in Year 4. Reporting on these activities during Program Year 4 will reference the framework in Figure 3 to reinforce how MCHIP is working along different phases of the continuum of knowledge generation, documentation, dissemination, uptake and use, as it advances both its key technical areas of focus, while also advancing learning around the cross-cutting themes noted above.

Figure 3. Framework for MCHIP Program Learning



HOW MCHIP CONTRIBUTES TO GLOBAL LEADERSHIP

MCHIP's role in global technical leadership is an important aspect of its value-added as a project. Across the technical areas in which MCHIP works, this role continues to evolve. As described in the previous section, this role is exercised in part through program learning, as we draw from past and current experience, bringing lessons forward to enrich global best practices. Technical staff in MCHIP interact closely with counterparts from other agencies, playing leading roles across our technical areas through informal contacts, global and regional technical meetings, participation in technical working groups (TWGs), and joint initiatives. Areas of

contribution specific to technical area are highlighted in the narrative sections of each of the technical teams, later in this workplan. To summarize very briefly, these include:

- Bringing a sharper focus on key preventive and case-management interventions that should be universally practiced with regard to PPH and eclampsia/ pre-eclampsia;
- Contributing to shifting content and quality of care closer to the center of the global maternal health strategy, through technical advocacy and improved measurement;
- Bringing more concerted attention to ensuring optimally effective ANC, for example, through highly effective coverage of MIP and antenatal IFA program content;
- Providing field-grounded guidance to the global-level strategy in ensuring wide-scale adoption, extended to the most peripheral level possible, of simple, effective preventive and case-management measures addressing risk of newborn death (e.g., essential newborn care, Kangaroo Mother Care [KMC], asphyxia management, early breastfeeding, and appropriate care of the cord stump);
- Ensuring more systematic exploitation of opportunities for service delivery integration, for example, taking better advantage of contacts during infancy as an opportunity for FP and nutrition-related counseling and service delivery.
- Contributing to developing sound guidance, in collaboration with key global partners, on effective implementation of community case management (CCM) for childhood illness programs at scale;
- Developing and refining approaches to support country-level problem characterization, planning and program development addressing childhood diarrhea, in particular, and child health more broadly;
- Continuing global-level technical advocacy and practical guidance on strengthened routine immunization services, as well as effective rollout and institutionalization of new vaccines;
- Contributing to the development of sounder global guidance in community-based service delivery and the use of CHWs in primary health care; and
- Contributing to improving best practices with regard to planning, collaborating and managing for effective scale-up.

Monitoring, Evaluation and Research

OVERVIEW

Monitoring, evaluation and research (MER) is cross-cutting in nature and therefore links to all technical areas under MCHIP, including most HIDN results pathways. MER under MCHIP is essential for providing accountability to stakeholders and for contributing to program learning. The MER team generates sound evidence upon which government collaborators, USAID staff and other partners can base informed programmatic decisions and policies.

MCHIP Strategy for Monitoring, Evaluation and Research

MCHIP has identified four, major priorities related to MER:

- Developing M&E indicators, tools and resources
- Contributing to the evidence base on high-impact MNCH interventions
- Strengthening health information systems

- Building the capacity of in-country partners, MOH and other collaborators in MER

As part of its global leadership role in MER, MCHIP works with other programs and organizations to identify gaps in the available resources for conducting MNCH MER, such as indicator compendia, M&E guidance documents, assessment toolkits and M&E training resources. In turn, MCHIP identifies opportunities to work with critical global partners, such as the WHO (ICM and FIGO) and other USAID implementing agencies to contribute to the development of new indicators, data collection tools and other resources to address these gaps. Another facet of global leadership is to contribute to the documentation, synthesis and dissemination of best practices and lessons learned to global, regional and country-level stakeholders.

An additional, basic M&E function of MCHIP is to document the results of its country programs to provide accountability to the donors and MOHs, as well as guide program implementation. This function is guided by the Program's global performance monitoring plan (PMP) as well as country program performance monitoring plans.

MCHIP's MER work contributes to all of the core GHI principles but focuses primarily on the following:

- Sustainability through health systems strengthening (which includes HMIS strengthening)
- Improved metrics, monitoring and evaluation
- Promotion of research and innovation

YEAR 4 ACTIVITIES/EXPECTED RESULTS

This section is organized into two parts: global leadership for MER and country support for monitoring, evaluation and information systems. Proposed activities under these two areas are discussed briefly, and expected results for the year are presented at the end of the section.

Global Leadership

Under MCHIP, the MER team draws the best expertise from across the MCHIP partners. Taking full advantage of this unique skill set, MCHIP will build on Mozambique's Maternal and Newborn Complications (MNC) Quality of Care (QoC) survey to test and validate MNH indicators for collection through large-scale household surveys, such as the DHS and Multiple Indicator Cluster Survey (MICS). In addition, MCHIP will pilot-test the collection of additional, facility-based MNH indicators not currently reported by the national HMIS through the testing of small-scale MNH surveillance systems in Kenya and Malawi. This country-level activity is complemented by the work MCHIP initiated last year, and will continue in the coming year, to identify and reach global consensus on "benchmark indicators" for maternal health that can be integrated with the HMIS, in collaboration with WHO, CDC and others.

Operations research activities in Malawi and Ethiopia will continue in Year 4 of MCHIP. In Malawi, MCHIP will lead a performance evaluation of the scale-up of the HBB initiative as part of an integrated MNH package. In Ethiopia, MCHIP will document the effectiveness of an intervention to introduce provision of community-based KMC by Health Extension Workers (HEWs). This study will also examine the practice of other newborn care services by HEWs and mothers/family members.

As described in the introduction, in response to the recommendations of the team that conducted a mid-term evaluation of MCHIP, MCHIP will be placing greater emphasis on

program documentation and learning in Year 4. MCHIP plans to capture implementation lessons learned and results of strengthening MNCH elements of national HMIS across selected MCHIP countries. In addition, MCHIP will document its experience in applying the SBM-R quality improvement approach to MNCH services across multiple countries.

As part of MCHIP's program learning agenda, MCHIP is developing a tool for incorporating health equity into program designs, refining health equity activities in ongoing programs and documenting MCHIP's work to improve health equity. Prior to Program Year 4, MCHIP developed guidance on incorporating health equity into program designs, including a checklist for program implementers to use. The development of this tool was a collaborative process among MCHIP partners, the CORE Group and its PVO members, and involved a review of state-of-the-art literature. The tool has been designed to both refine and document health equity approaches and activities in CSHGP grantees. Now it is ready to be field-tested and used in broader MCHIP country programs. Year 4 work will develop additional components for this tool to improve measurement of health equity and presentation of information for advocacy and planning.

As in previous years, MCHIP will participate in ongoing efforts to review MNCH indicators (maternal, newborn, postpartum care, pneumonia/CCM, water and sanitation, pay for performance [P4P]-related, etc.) and help provide recommendations for improving them and testing them as appropriate. This includes participating in key M&E working group meetings (including the USAID/MEASURE Evaluation Global Bureau of Health's M&E working group, the CORE Group's M&E working group, SNL's Newborn Indicator Technical Working Group and the Countdown to 2015 working group).

MCHIP will also continue its work on developing a learning resource package (with trainer and participant manuals) and an interactive electronic training module (with video footage of simulated MNCH clinical skills) for use in training clinicians to serve as clinical observers on facility survey assessment teams, supervision teams and SBM-R/quality improvement assessment teams.

Country Support for Monitoring, Evaluation and Information Systems

In the coming year, MCHIP core funds will be used to support activities to strengthen in-country capacity and encourage MCHIP/MER staff innovations in M&E and mHealth. The Program will place stronger emphasis on routine data quality assessments conducted by its country programs, and thus will support MOH counterparts and in-country staff to apply these tools to help ensure that data used for decision-making and reporting are of acceptable quality.

MCHIP also plans to develop learning materials so that more country programs can use mHealth approaches. In-country partners and MCHIP staff can identify and use mHealth solutions for program activities, as appropriate. The cost- and time-saving benefits of using mobile technologies are recognized by many; however, few MCHIP implementers know which technologies are best for supporting which activities.⁶ Country-level, multidisciplinary teams including health/medical, M&E and information technology staff would benefit from learning about mobile health interventions that could add value to program activities. MCHIP will develop and present an mHealth orientation session for MCHIP staff, partners, CSHGP grantees and others on identifying mobile activities that could add value to MNCH interventions in the areas of data collection, and text messaging for treatment compliance and point-of-care support. Presentations will be given through a Web-based conference and a side session at the MCHIP Interventions for Impact in EONC regional meeting in Asia in the spring of 2012.

⁶ Results from 2011 MCHIP Field Partner mHealth Survey

MCHIP will continue to support the online QoC study data center. The system will be expanded to include data from two new countries conducting the survey—Mozambique and Zimbabwe.

Summary of Expected Results

Global Leadership

- High-quality evidence generated to inform MNCH program scale-up.
- Improved indicators and information available to measure progress toward MDG 4 and/or 5 and to feed into LiST.
- Program lessons learned and results documented for quality improvement (SBM-R) and HMIS strengthening across multiple countries.
- Health tool applied and equity approaches and activities documented in at least three MCHIP country programs.
- Rapid assessment tool for determining socioeconomic profile of project beneficiaries developed and tested.
- Guidance on adapting rapid household surveys to measure health equity developed.
- MNCH indicators reviewed and recommendations made for modifications and field-testing.
- Indicator reference documents produced and applied.
- High-quality training materials produced to improve the quality of observational health facility survey and supervision/monitoring data.

Country Support for Monitoring, Evaluation and Information Systems

- Strengthened ability of country programs and MOH counterparts to conduct data quality assessments increased and quality of monitoring data improved.
- Increased capacity among MCHIP staff, partners and others to identify and apply mHealth tools to MNCH data collection and programming.
- Web-based system for faster reporting and dissemination of QoC assessment results expanded and updated and information shared with stakeholders.

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 AOTR contacts to monitor progress throughout the program year. Because 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**—Provide support to the CSHGP, expand linkages to MCHIP country programs and expand MCHIP partnership expertise of MCHIP partnership
- **The CORE Group**—Diffuse program learning, support communities of practice and support selected MNCH technical priorities

TECHNICAL ELEMENTS

- **Maternal Health:** with a particular focus on Skilled Birth Attendance (SBA), PPH and pre-eclampsia/eclampsia (PE/E)
- **Newborn Health:** sepsis management (and prevention), care for newborns of low birth weight (LBW)—including Kangaroo Mother Care (KMC), and ENC—including handwashing and newborn resuscitation
- **Child Health:** iCCM (malaria, pneumonia and diarrhea) and diarrheal disease (oral rehydration therapy [ORT]/zinc)
- **Immunization:** strengthened routine immunization and new and underutilized vaccines
- **FP:** FP/MNCH integration, identification and promotion of successful models
- **Malaria:** integrated within antenatal and CCM for childhood illness, but also including support to the Malaria Communities Program (MCP)
- **HIV:** scaling voluntary medical male circumcision, PMTCT, improved collection and use of data by communities in Namibia
- **WASH:** linked to Newborn Health and Child Health sections
- **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:** MNH

PVO/NGO Support

OVERVIEW

USAID's Child Health Survival Health Grants Program (CSHGP) presently consists of 28 grantees operating in 22 countries, reaching more than 10 million women of reproductive age and children under five. The CSHGP's strategic focus on innovation and operations research (OR) has positioned US PVOs and their partners to significantly contribute to the global and national evidence base for advancing innovative solutions that address critical bottlenecks in community-oriented health; its 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 is built into these programs through the collection of 18 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.

The role of MCHIP's PVO/NGO (Private Voluntary Organization/Nongovernmental Organization) Support team is to ensure the continuation of quality in the portfolio of CSHGP grants, and to

facilitate linkages between CSHGP grantee experience and MCHIP's global and country-level efforts.

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 country level and global efforts also provide opportunities for informing CSHGP grants, by exposing grantees to state-of-the-art practice in areas such as CCM, KMC, PPH and other areas of technical focus of the project.

In MCHIP Year 4, 18 CSHGP projects will be active in 14 countries where MCHIP has (or will soon have) a country program: Bangladesh, Benin, Ethiopia, Honduras, India (2), Indonesia, Liberia (2), Mozambique, Nepal (2), Nicaragua, Peru, Rwanda, South Sudan and Uganda (2). Of these 18 CSHGP projects, Innovation Programs—which include an OR component—will be active in Bangladesh, Benin, Honduras, Indonesia, Liberia, Nepal, Nicaragua, Rwanda, South Sudan and Uganda. Of these, Bangladesh, Liberia, Ethiopia, India, Indonesia and Nepal seem to hold the most promise for mutual learning between the respective country teams in that there is either geographic overlap or complementarity; potential technical intervention synergies; and the implementation time frames for both CSHGP and MCHIP allow for practical synergies across the two groups. Specifically, practical synergies related to program learning will be explored by facilitating connections between MCHIP team members and CSHGP grantees at the MCHIP November Program Learning Meeting, where CSHGP grantees will be strategically invited; CORE group meetings, where MCHIP tools and resources will be shared to inform NGO programming and to benefit from NGO input; and at CSHGP-related events such as the CSHGP Learning Exchange meetings; DIP review discussions, and OR planning workshops (new grantee and OR workshops), in which MCHIP staff can be more exposed to CSHGP programs in their countries of interest. In terms of in-country collaboration and /or support, we will continue to send grantee reports to MCHIP country teams as they are produced, encourage MCHIP field staff to include grantees in their events, and specifically open up the Asia regional M&E meeting to participation from CSHGP grantees to foster increased south/south dialogue on issues of mutual technical interest. In addition, we will seek to highlight results of CSHGP Final Evaluations, with particular interest this year in the Expanded Impact Program Final Evaluations, through presentations at MCHIP to inform MCHIP's discussion of factors that influence scale-up.

In FY 2012, CSHGP Innovation grants will be operational in the following countries (with a new slate of up to six new Innovation grants scheduled to start in October 2011): Afghanistan, Bangladesh, Benin, Burundi, Cambodia, Ecuador, Honduras, Indonesia, Liberia, Nepal, Nicaragua, Niger, Pakistan, Rwanda, Southern Sudan and Zambia. Each of these grants has an operations research component embedded within it, focusing on topics including CHW performance, integrated service delivery, improvement in equitable access to services, mobile-health applications, and other related issues that hold promise for informing MCHIP country programs.

The presence of the CSHGP's technical support function within MCHIP creates strategic opportunities to create synergies between NGOs and MCHIP's country and global leadership efforts. The inclusion of the CORE Group as a key partner within MCHIP provides added advantages of creating a mechanism for widely diffusing the learning that is generated by CSHGP grantees and MCHIP country programs to a wider audience of NGO practitioners and CORE Group Partners, and ensuring that the broadest possible "community voice" informs MCHIP's initiatives.

To this end, PVO/NGO support team activities in Year 4 will:

- Focus analysis and diffusion of CSHGP grantee results/experience on topics that fit into MCHIP (see prior section on global program learning), USAID and larger US Government (USG) priority areas, and that have been identified in the Strategic Analysis and Diffusion Plan developed in Year 3. These areas include scale-up, smart integration (primarily focused on CCM), equity and maternal health. In Year 4, MCHIP will engage a wide group of stakeholders to further develop its learning agenda around these themes.
- Maximize the use of existing events (CORE fall/spring meetings; MCHIP country managers' meetings; Detailed Implementation Plan (DIP) review meetings; Global Health Mini-University; Global Health Council; etc.) to create opportunities for sharing learning among MCHIP representatives, CORE members and CSHGP grantees.
- 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. This support includes close backstopping of grantees during their DIP development, including review of baseline studies; review and clarification of discrepancies in baseline and final evaluation data, to ensure a high degree of validity in results that are more widely diffused; and review and support to ensure sound operations research designs and strong development of the operations research components of innovation grants.

OPPORTUNITIES FOR PROGRAM LEARNING

Program Learning

MCHIP's first three years have seen increased synergies between CSHGP Grantees, MCHIP Country Programs and the wider PVO Community (through the CORE Group's participation in MCHIP). At the MCHIP HQ level, members of the PVO/NGO support team play important roles in MCHIP's overall management structure; contribute to the CCM efforts of the Child Health team; provide leadership in training data collectors for MCHIP's Quality of Care surveys; provide M&E support to Bolivia's and Paraguay's country programs; and assist in the development of LiST analyses requested by USAID. Representatives from MCHIP technical teams have participated in the CSHGP's New Grantee Orientation and grantee DIP review meetings, led technical sessions at CORE's spring meeting, and worked to identify other opportunities for synergy with CSHGP grantees through discussions at MCHIP Strategic Planning meetings, where CSHGP projects have been highlighted in terms of how they fit geographically and technically with MCHIP country efforts. At the field level, there has been increased south-south collaboration in countries where geographic and technical complementarities overlap with similar time frames for program implementation. In Indonesia, for example, MCHIP's Country team is in regular communication with Mercy Corps CSHGP Innovation grant, so the stage is set for ongoing exchanges and sharing of learning. In Rwanda, MCHIP's Country team has met with representatives from CARE's recently funded Innovation grant, and is also connecting to the learning around scale-up of CCM that will emerge from the final evaluation of the CSHGP Expanded Impact project that is ending in September 2011. The joint learning from both the CSHGP and MCHIP programs should provide the Mission with very useful information that can feed into the new bilateral program set to start there in 2012. And in Liberia, MCHIP's Family Planning team has provided technical support to Africare's CSHGP program to help it integrate FP activities. All of these efforts represent contributions to different aspects of the generation, dissemination and application of learning outlined in the Framework for MCHIP Program Learning (Figure 3). MCHIP has identified Community Health work, Quality, Integration, Equity and Scale as program learning themes to focus on while

CSHGP has thus far prioritized: Equity, MNH and CCM through the Strategic Framework for Analysis. Equity has been identified as a common theme, with the other MCHIP themes also resonating strongly with both the CCM and MNH platforms, which allow cross-links between the key thematic opportunities prioritized for both CSHGP and MCHIP. CSHGP, CORE and the broader MCHIP will seek to host specific TAGs to help harmonize and prioritize the direction of these learning themes in Year 4.

The external mid-term evaluation of MCHIP noted the important contributions of the PVO/NGO support team and growing partnership with CORE over the first three years of the project, and recommended increased attention to “the three-way learning among MCHIP, CORE and the PVO community in order to use evidence generated by PVO/NGOs as well as shape the direction of current and future OR for key priorities in program learning where there is a foundation in place”. In Year 4, MCHIP’s PVO/NGO Support team will address this recommendation by building upon the foundation of collaboration that has been built over the first three years, while also maintaining the critical support functions that this team provides directly to the CSHGP. In light of the reduced funding levels for both the PVO/NGO support function and the CORE Group, it will be critically important to maximize opportunities for joint activities that benefit CSHGP grantees, CORE and the overall MCHIP program.

YEAR 4 ACTIVITIES/EXPECTED RESULTS

In Year 3, the PVO/NGO Support Team strengthened the overall analytical framework for synthesizing data from the CSHGP portfolio and diffusing it more widely, through developing a Strategic Analysis and Packaging Plan, and a monitoring system for the CSHGP’s operations research portfolio that allows for the reporting of progress at key points in the life of Innovation grantees. This framework of analysis is aimed at maximizing learning from CSHGP projects more broadly and is intended to develop systems integrity in learning around thematic areas and/or agenda setting for prioritization of learning themes. The framework is intended to guide learning over the next five years. We also built stronger connections between MCHIP’s program learning agenda and the CSHGP experience, by incorporating CSHGP inputs into MCHIP’s efforts in the areas of equity, scaling up, mHealth and community health worker performance. We also strengthened linkages between CSHGP grantees and MCHIP field programs in specific countries where the strongest opportunities for information sharing and technical overlap exist, including Rwanda and Liberia. Year 4 will focus on expanding our efforts in each of these areas, while also maintaining a solid base of quality across the CSHGP portfolio. Anticipated outputs and results include:

- Strategic analysis and dissemination of CSHGP portfolio data:
- CSHGP results/experience integrated into USAID 50 communications strategy.
- CSHGP communications materials developed/diffused.
- Portfolio-level Core Assessment Tool for Child Health (CATCH) data report generated and diffused.
- CSHGP Expanded Impact Projects’ experience/results regarding scaling-up diffused.
- Framework for Analysis and Learning Agendas developed for CCM, MNH, Equity and up to two other areas to be determined/developed (TBD) pending resource availability.
- Learning from Portfolio of Innovation Grants diffused.
- Connections between CSHGP grantees and MCHIP country programs facilitated, where relevant.
- Technical support to active portfolio of CSHGP grantees including CSHGP TB grantees

- Technically sound and rigorous DIPs for six, newly funded projects in countries TBD.
- Technically sound and rigorous OR designs for six innovation grantees TBD.
- Technical Support at MTE and FE stage of grants TBD.
- Support to existing CSHGP management systems:
- CSHGP Reporting Guidelines maintained/updated to ensure SOTA as informed by MCHIP as well as strengthen linkages to MCHIP priority activities for analysis and use of evidence and lessons.
- Annual program results and success stories generated and aligned with prioritized MCHIP program learning themes and USAID priorities for dissemination in CSHGP portfolio review and Report to Congress and to inform other strategic dissemination activities outlined in Activity 11.3.
- Management data on CSHGP grantees maintained.

CORE Group

OVERVIEW

CORE Group is a network of international health and development organizations that fosters collaborative action and learning to improve and expand community-focused public health practices. CORE Group is an independent organization that currently has over 55 member NGOs with extensive experience implementing community-oriented health and development programs in 180 countries. CORE Group is home to the *Community Health Network*, which brings together CORE Group member organizations, associates, partners, scholars, advocates and donors to support the health of underserved mothers, children and communities around the world. This dynamic hub includes eight technical Working Groups, a Practitioner Academy for Community Health, and an ongoing series of technical exchanges and updates through in-person and Web-based events and virtual means of communication, coordination and collaboration.

In this capacity, the partnership between MCHIP and CORE Group is mutually beneficial and provides several unique advantages to MCHIP's vision to: a) contribute to USAID's leadership role in innovative integrated community MNCH programming, and b) maximize the inclusion of NGO contributions in scale-up of proven and integrated MNCH 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 equity, quality and scale of approaches to reduce maternal, neonatal and child mortality. CORE Group serves as a catalyst for establishing broader, strategic partnerships and inspiring effective practice across a wide variety of organizations; it greatly enhances MCHIP's ability to maximize the inclusion of PVO and NGO contributions in the scale-up of proven interventions at the country level. Additionally, the partnership with MCHIP increases CORE Group's linkages to MNCH technical expertise, global leadership and impact at the country level.

Much of CORE Group's efforts are driven by its eight technical and cross-cutting Working Groups—member- and associate-led, virtually managed communities of practice that address the health needs of mothers, newborns and children, and help mitigate the impact of infectious disease. Of the eight Working Groups that CORE Group supports, three focus primarily on MNCH: Safe Motherhood and Reproductive Health (SMRH), Community Child Health (CCH),

and Nutrition; three on infectious disease: Malaria, Tuberculosis and HIV/AIDS; and two cross-cutting: Social and Behavior Change (SBC) and Monitoring and Evaluation (M&E). In each of the eight technical areas, CORE Group creates training curricula, case studies, program guides, skill building workshops and other tools to assist development practitioners in quality project design, implementation and evaluation. Not only are MCHIP representatives participating with several of the Working Groups, but where Working Group and MCHIP priorities align, activities are being jointly planned and carried out.

In addition to the formal eight technical Working Groups, CORE Group also convenes communities of practices around broader initiatives—including mHealth, Community Case Management, Maternal and Child Anemia, and immunization—that draw from expertise across Working Groups and from the wider Practitioner Academy. These initiatives work to link these practitioners with global policy initiatives and support civil society coordination and action in prioritized countries to increase community health impact at scale. CORE Group participates and promotes a community health voice with several global health partnerships, including Stop TB, Roll Back Malaria and Scaling Up Nutrition, which not only complement MCHIP efforts, but also expand the reach of key initiatives.

Each year, CORE Group hosts two Community Health Network meetings, a two-day meeting in the fall and a four- or five-day meeting in the spring. The meeting is open to CORE Group member organizations and other partners of the Community Health Network. Approximately 175–200 people attend all or part of the meeting. The meeting content is member-led and combines state-of-the-art technical updates, skill building sessions, Working Group planning time and networking time. The CORE Group meetings are key platforms to highlight MCHIP learning and initiatives, but also disseminate documents and engage with a broader group of practitioners and leaders in community health. In Year 3, the CORE Group Spring Meeting had 217 participants from 94 different organizations, with the theme, *“Equity in Health: Ensuring Access, Increasing Use.”* MCHIP and CORE Group collaborated on several sessions on key mutual learning themes including equity, community health work, integration, innovation and operations research. Several dialogue-based sessions explored the complementary equity themes of access and use, including how to: take successful approaches to scale, negotiate dense urban communities, strengthen as well as lengthen the reach of health systems through community health workers and technology, work with adolescents, use a rights-based framework and engage the community.

CORE Group’s communications strategy is an essential component to ensure that the foundation for the Community Health Network continues to evolve and more effectively build technical knowledge. This also supports the Community Health Network’s ability to disseminate resources for increasing PVO/NGO capacity at local levels in the practical application of technical interventions and approaches for community-focused health. CORE Group is increasingly positioning itself as the global “go to” organization for technical resources on community health systems, which strengthens its ability to support MCHIP program priorities and initiatives and reach out and engage those working in the field and stakeholders around the world. Together, CORE Group and MCHIP are improving their communications efforts and as a result broadening their collective impact on MNCH. CORE Group is incredibly successful in fostering improved PVO/NGO capacity by collaboratively producing and disseminating tools and related technical products, but these products and tools are only effective if they reach and are made accessible to those who need them most.

Officially, CORE Group formally established its collaborative partnership in Year 3 of MCHIP, but provided input into MCHIP products and strategies in Year 2, including the Equity Guidance and HSS framework and has been engaged in the planning to document experiences across multiple national CHW programs. Also in Year 2, CORE Group finalized and began

diffusing the *Community Case Management Essentials – Treating Common Childhood Illness in the Community – Guide for Program Managers*, co-branded with MCHIP. In Year 3, the transition of CORE Group as a partner in MCHIP was commended for being seamless and strategic, and the continuation of the partnership was recommended in the MCHIP Mid-Term Evaluation.

STRATEGY

Program Learning and MCHIP Technical Priorities and Global Leadership

CORE Group participation in and contribution to MCHIP Year 4 activities are intended to expand MCHIP's focus on improving program learning related to integration of health care delivery at the community level, and to increase the diffusion of that learning—both within CSHGP country programs and across the wide array of member organizations and other partners that participate in the CORE Group Community Health Network. MCHIP will seek to leverage existing diffusion mechanisms already in place through CORE Group—including its spring and fall meetings, strong communications platforms and participatory, Web-based 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 Group's diverse base of practitioners. The Year 4 workplan activities that involve CORE Group have been designed through joint planning between MCHIP and CORE Group to ensure that they resonate with both the strategic areas of focus within MCHIP and the organizational vision and goals of 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 community-focused MNCH, Nutrition, Malaria, HIV, Tuberculosis, Immunization and Family Planning and around key themes including scale, integration, community health work, equity and quality.

YEAR 4 ACTIVITIES/EXPECTED RESULTS

Key Activities/Expected Results for Year 4 will include:

- Program Learning:
 - Facilitated and expanded diffusion of program learning among MCHIP country programs, CSHGP and CORE Group Community Health Network, through leveraging opportunities for joint participation and contributions to technical meetings, activities, working sessions and joint efforts sponsored by each organization.
 - Improved and expanded Web-based, listserv and social media functions that foster strategic communications to support a complementary MCHIP program learning agenda, initiative leveraging and promotion.
 - Participated in and strategically engaged with the CSHGP and wider USG innovation efforts to increase related program learning, linkages and diffusion of lessons.
 - Contributed to and diffused community-focused health tools and guidance to improve program design and MCHIP-wide themes of scale, integration, community health work, equity and quality.
- MCHIP Technical Priorities and Global Leadership:
 - Participated in and promoted MCHIP's community-focused MNCH efforts including malaria, CCM, nutrition, anemia, tuberculosis, immunization and family planning integration activities.

- Strategically diffused MCHIP products, technical guidance and program learning to the CORE Group Community Health Network through participatory, Web-based forums and CORE Group semi-annual meetings.
- Diffused, increased use of and built knowledge around key CORE Group products that complement MCHIP technical initiatives including the Essential Nutrition Actions Framework, Nutrition Program Design Assistant (NPDA) Tool, CCM Essentials Guide, Helping Babies Breathe (HBB) Implementers Guide, Essential Newborn Action messages and community-based TB materials.

Funding Streams and Related Activities

Although, CORE Group's collaborative activities with MCHIP are primarily organized by program learning and key initiatives, CORE Group will receive funding through four specific streams: MCH, Malaria, Nutrition and TB. In addition to activities described above, below are brief summaries of the specific, related work that CORE Group is doing in each of these areas.

Maternal and Child Health

CORE Group's foundation for providing support for PVO/NGO and MCHIP program learning through the Community Health Network functions and its effort toward strategic inputs into MCHIP technical priority areas, including development and use of community-focused MNCH MCHIP products and guidance, are built on its overall MCH platform. CORE Group will participate in and promote MCHIP's community-focused MNCH activities including those related to malaria, CCM, nutrition, anemia, tuberculosis, immunization and family planning integration through contributions to MCHIP products, diffusion of learning and increased PVO/NGO participation, capacity building and input.

CORE Group will focus on increasing, improving and leveraging its platforms for program learning that facilitate the scaling up of "what works" for community-focused MNCH programming and opportunities for integration. In addition to broadening MCHIP's reach, CORE Group will also leverage MCHIP technical priorities through engaging CORE Group's Community Health Network and Practitioner Academy in the development and use of community-focused MNCH products, guidance and efforts, including those addressing the key program learning themes of scale, integration, community health work, equity and quality.

Work related to the key themes will include: CORE Group participating on an MCHIP Steering Committee to guide the development of a "CHW at Scale" journal supplement; taking a lead role on one or two chapters that highlight the role of NGO CHW programs such as the Care Groups, and/or innovations arising from the CSHGP grantee portfolio and continued contributions to the equity guidance and related tools; participation in the CHW Central TAG and Web site development; finalization and dissemination of the community health system framework; contribution to a rapid assessment tool to measure equity; diffusion of MCHIP PPH + PE/E (pre-eclampsia/eclampsia) tools; and dissemination of the HBB Implementers Guide, Essential Newborn Actions and Anemia Package messages.

Malaria

CORE Group will increase its collaboration and support of related MCHIP malaria activities including its participation and promotion of related community case management, malaria in pregnancy and Malaria Communities Program (MCP) efforts. Joint activities and learning will be linked to the support of the Malaria, Community Child Health, and Safe Motherhood and Reproductive Health Working Groups. The Malaria Working Group workplan will specifically include joint MCHIP CCM, MIP and MCP activities.

For CCM, CORE Group will continue to support the dissemination and use of the CCM Essentials Guide, including seeking funding to copyedit, lay out and print a French version. CORE Group will participate with the Roll Back Malaria (RBM) Case Management Working Group and serve as a Co-Focal Person for the Expanding Access to Treatment Work Stream, which will also link to the MIP and Procurement and Supply Management (PSM) Working Groups. MIP efforts will additionally be linked to the maternal and child integrated approach to anemia activities.

Nutrition

CORE Group will continue to participate in and promote nutrition- and MCHIP-related activities, with special focus on an integrated approach to address multiple causes of maternal and child anemia, including the facilitation of the related Technical Advisory Group, concurrent session at the CORE Group Spring Meeting and contributions to the development of potential program guidance. CORE Group will continue to increase the diffusion and use of the Essential Nutrition Actions trilogy in English and French and the Nutrition Program Design Assistant, including participation in related trainings and activities. In addition to these activities, CORE Group will support the related efforts of the Nutrition Working Group.

With the goal of promoting civil society leadership and co-ownership for the Scaling-Up Nutrition (SUN) process and Thousand Days Partnership activities to reduce malnutrition, CORE Group will continue to participate in a number of initiatives and activities. These include Task Force “C,” civil society engagement of the SUN Movement led by David Nabarro; dissemination of SUN information through CORE Group’s listserv; contribution to the global forums and civil society discussions; and, as feasible, support to participation in related meetings.

Tuberculosis

CORE will continue to increase use and involvement in community-based TB programming including through participation in the International Union Against TB and Lung Disease conference, Stop TB and input into related materials with a special emphasis on pediatric TB and TB/HIV integration. In addition to these activities, the CORE Group will support the related efforts of the TB Working Group and contribute to the update of TRMs as indicated.

Maternal Health

OVERVIEW

High maternal mortality remains a global concern and a local problem. 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.

Global organizations such as WHO, United Nations Population Fund (UNFPA), International Federation of Gynecology and Obstetrics (FIGO) and International Confederation of Midwives (ICM) continue to dedicate time, effort and resources to addressing this issue. USAID remains in the forefront of these efforts to improve the health of women and girls and address the inequities that underpin morbidity and mortality that result from the reproductive lives and choices of women and families.

MCHIP works in over 25 countries supporting programs to strengthen care during pregnancy, labor and delivery. Most MCHIP country programs address the pregnancy to labor and delivery continuum. The programs focus on strengthening the content and quality of focused antenatal care in addition to prevention of morbidity and mortality from maternal complications during

labor and delivery. The major causes of maternal mortality are well known, and have been the target of MCHIP's interventions from its start. MCHIP uses core resources to focus attention on interventions around labor and delivery care, namely postpartum hemorrhage and pre-eclampsia/eclampsia—which together account for more than 40% of maternal mortality and strengthening the capacity of SBAs. With more than 25 country programs focusing on maternal health, MCHIP will continue building on opportunities to influence the adoption of lifesaving interventions.

GLOBAL LEADERSHIP

MCHIP's work in Program Year 3 focused on efforts to address PPH and PE/E and ensure skilled attendance and competent care to women in pregnancy. Program Year 4 will consolidate those efforts, amplify the actions of our global and national programs and enhance our ability to report on our results and document our impact. In Year 3 we introduced and applied PPH and PE/E scale-up maps and did a multi-country analysis to better understand both local challenges and global issues. Those maps have been used to assist countries to analyze their situation and intelligently plan their activities for the coming year. Furthermore, the maternal health team has been able to draw themes from this process to focus on for the coming year. These themes include developing champions; increasing people's access to and use of advocacy, technical, programmatic and training materials; creating more detailed national scale-up plans; and identifying critical maternal health content indicators and improving the routine collection of data on use of uterotonics and magnesium sulfate. This is an example of how MCHIP will continue to demonstrate global technical leadership through global relationships and influence and country-level and local implementation and action.

In Program Year 3, MCHIP focused greater attention on results reporting in MH, especially as it is linked to performance improvement through SBM-R. This resulted in our ability to analyze the work in Mozambique and Malawi in a much clearer way to allow for easier understanding and demonstration of achievement. In Year 4 we will substantially expand that focus by presenting the Malawi and Mozambique work, developing graphing and reporting templates and guidance, and supporting multiple MCHIP country programs to extract the needed data from their already existing activities.

The success of the Africa regional meeting on *Interventions for Impact in Essential Obstetric and Newborn Care (EONC)* held in Addis Ababa, Ethiopia, in 2011, highlighted also in the mid-term evaluation, confirmed our impression that country leaders and program managers need opportunities to sit together and learn from each other about program challenges and success. They benefit from opportunities to hear from global experts, and be updated on the technical and programmatic landscape. But they also need that sense of camaraderie that ensures them that they are not working alone, or stepping out and taking undue programmatic or financial risks. By engaging stakeholders before (through national stakeholder meetings), during (through presentation of country-relevant information and fostering exchange of ideas presented in the program posters) and after (through facilitated discussions and technical assistance (TA) (on application of the meeting content) the meeting, MCHIP built a sense of community among leaders that supports their efforts to take bold actions on behalf of their people. MCHIP continues to fuel the momentum of those discussions through technical and program support to country teams. As an example, the maternal health country programs in Liberia, Kenya, South Sudan and Madagascar have already adopted key activities into their plans for FY2012 as a result of the meeting.

For this reason, MCHIP will hold a similar *Interventions for Impact in EONC* meeting in Asia in 2012. This meeting will be in approximately March or April 2012, after a series of WHO meetings to update or finalize PPH and PE/E guidelines, thus giving the participants

immediate information on the content of current global technical norms. This meeting will likely be held either in Dhaka or Kathmandu, in order for participants to hear from and learn from the remarkable successes that Bangladesh and Nepal have had in reducing maternal mortality in the past decade. Because MCHIP believes that efforts to improve maternal and newborn health go together, the Asia meeting, like the Africa meeting, will advocate for best practices in EONC, and the meeting will be held in collaboration with global partners, such as WHO, UNFPA, United Nations Children's Fund (UNICEF), the Pre-EMPT project and the Oxytocin Initiative. In addition, based on the recommendations from the mid-term review, MCHIP will reach out to members of the PVO/NGO community to engage them as participants and beneficiaries in this event.

The needs of field programs, coupled with our work to date, have demonstrated that there is a need for continued, practical program integration at the service delivery level. For this reason, we will work in Program Year 4 to ensure that providers can integrate active management of the third stage of labor (AMTSL) with newborn care and/or newborn resuscitation, through development/implementation of integrated clinical standards, training materials and supervisory checklists. Provision of PFP will also be included in these integrated approaches. The maternal health team will work together with the newborn health team to disseminate the brief on *Better Labor Management to Reduce Newborn Sepsis*, and to promote appropriate practice through the Newborn Handwashing with Soap initiative. The maternal health team continues to work with the FP team on PFP services, especially promotion of the Lactational Amenorrhea Method (LAM) and PPIUD, and advocacy for comprehensive postpartum, newborn and PFP care. In October 2011, the maternal health and child health teams will participate in a conference on bacterial infections, and will represent MCHIP as an integrated, global program that addresses public health challenges across the spectrum of care.

Our support for skilled attendance at birth is based on health workers providing competent care with a humanistic approach to childbirth. The lessons learned from the Mozambique Model Maternities Initiative will be further documented, disseminated and turned into programmatic guidance for MCHIP country programs to be able to integrate concepts of humanization of childbirth into their programs. The launch of the *State of the World's Midwifery* report has brought a renewed focus on midwifery. In Program Year 4, MCHIP will continue to focus attention on midwifery and skilled attendance through our pre-service education roadmap and toolkit and our national and regional (LAC) program efforts in support of midwives. We will also continue to identify ways to work with UNFPA and WHO on the development of training materials (AFRO) and approaches for skilled attendants in Africa. The launch of the Pre-Service Education Toolkit in late Program Year 3 has given a powerful instrument to field programs as well as partners working in this arena. The Pre-Service Toolkit, housed on the Knowledge for Health Web site (k4health.org), outlines key programmatic steps, highlights lessons learned and identifies relevant resources to assist country programs, donors and governments with pre-service education programs. The toolkit is targeted for midwives, but is useful for other cadres as well.

SKILLED ATTENDANCE AT BIRTH AND IMPROVED QUALITY OF CARE

Efforts to decrease maternal morbidity and mortality over the past two decades have focused on initiating clinical interventions, which are predominantly delivered in facilities, to address the causes of maternal death and disability. These interventions are grouped as the well-known packages of basic and comprehensive emergency obstetric and newborn care (BEmONC and CEmONC). This packaging of signal functions of BEmONC and CEmONC is useful because it creates a benchmark for training, service delivery, quality measurement and system readiness, and provides a set of evidence-based skills that should be included in pre-service education for all providers of obstetric care. 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.

MCHIP supports the *health center intrapartum care* strategy as a central strategic approach for the provision of skilled care at birth and the promotion of maternal health and survival. While this is a central strategy, it is not an exclusive one. Indeed, MCHIP's maternal health work supports community health workers and systems as part of a broad-based approach built on the household-to-hospital continuum. The core workplan, with and through the field workplans, supports efforts toward ensuring skilled attendance at birth, especially provided by midwives as the backbone of the maternal health service delivery system. MCHIP advocates for our country programs to understand and act upon recommendations summarized in the *State of the World's Midwifery* report, to which we were a contributing partner in Year 3. In support of this process, scale-up mapping of midwifery services will be conducted during Year 4 as an extension of our efforts to support and document national program scale-up. As noted in the mid-term evaluation, "MCHIP's learning agenda regarding scale-up is central to understanding how to position a USAID global project to achieve the maximum potential for program scale up at the country level."

There is a growing body of research that examines the prevalence of disrespectful and abusive care in childbirth. Disrespectful care and abuse are factors that keep women from seeking facility-based care, making skilled birth attendance and the availability of potentially lifesaving interventions less likely. An aspect of disrespectful care is the unnecessary use and overuse of technology in the birthing process—especially technology of limited or unproven benefit. Excessive and inappropriate intervention can distract providers from doing the correct interventions and misdirect scarce resources away from benefit to the woman. USAID has invested in this area through the funding of research and advocacy efforts to promote respectful care. As an implementing organization that has long supported respectful care, MCHIP intends to document our program learning on prevention of abusive and disrespectful care in childbirth, create program guidance and disseminate program tools for MCHIP country programs, and through partners including the PVO/NGO network. Through these efforts, MCHIP will work to mainstream best practices related to respectful and supportive care at birth throughout an extensive network of implementing partners and mechanisms.

MCHIP's central role in the development of the *State of the World's Midwifery* report exemplifies our role and position as a global leader in midwifery performance and education, and ensures that we are consistently at the table when there are discussions of competency, quality and workforce related to increasing skilled attendance at birth. In Year 4, MCHIP will work with WHO/AFRO and UNFPA to develop and enact a strategic approach for MNH training and education. In collaboration with a technical working group set up in Year 3, MCHIP will promote the pre-service education strategy, implementation guide, and programmatic and educational resources. An example of the utility of this package can be seen in the current activity of the Government of Bangladesh and its partners, who are working to establish a professional midwifery cadre in the country. On a recent trip to Dhaka, MCHIP noted the availability of these materials, and the local counterparts seized upon this opportunity. MCHIP will guide these and other colleagues to understand the resources available to them through USAID's and MCHIP's efforts. In addition, in Year 4 MCHIP will complete and submit a manuscript for publication documenting the impact of investments in midwifery/medical pre-service education in BEmONC and CEmONC.

In collaboration with the newborn team, the technical advocacy materials developed in Year 3 for maternal interventions to reduce newborn complications will be translated, further disseminated and used to demonstrate how maternal interventions can help play a role in

reduction of newborn morbidity. We will identify regional champions and engage them to further advocate and take these practices forward.

As AMTSL is globally adopted as the standard for prevention of PPH in facilities, implementation challenges have naturally arisen, one of which is the integration/concurrent provision of AMTSL with immediate newborn resuscitation. The maternal health and newborn health teams will work together to develop guidance on integration and will develop creative, computer-assisted teaching aids for teaching providers how to manage various scenarios, including provision of AMTSL according to new WHO guidelines, and application of active management with and without the need for management of newborn asphyxia. These teaching aids will be disseminated and orientation will be provided for MCHIP colleagues and implementers, including through the PVO/NGO network.

Through modeling of lives saved, MCHIP will explore the contribution of community-based service delivery interventions in maternal health, newborn health and family planning. With Afghanistan as a case study, the Lives Saved Tool (LiST) will be used to determine the contribution of these interventions to reduction in mortality, and a manuscript will be published about lives saved through community-based interventions. Furthermore, a community-based maternal death review system will be put in place in two countries (primarily field-funded in Rwanda and Indonesia), and relevant tools will be adapted and prepared as a global package.

Reduction of Morbidity and Mortality from PPH and PE/E

The primary focus of MCHIP's efforts in PPH and PE/E is—and will continue to be—to work with countries to drive the adoption, expansion and scale-up of critical interventions for impact. This is the underlying principle of all our program efforts. With this in mind, we expand the use of AMTSL, we develop programs for prevention of PPH at home birth using misoprostol, we create new ways to expand the use of MgSO₄, we author technical guidance briefers and we hold global and regional workshops. This is MCHIP's Maternal Health mission.

To improve service coverage and promote institutionalization of PPH and PE/E best practices, MCHIP will continue to build on Year 3 accomplishments through work with global partners to provide program leadership and advocacy. This will include support to WHO to finalize, disseminate and implement new global PE/E guidelines and to develop new PPH guidelines. MCHIP will also support, guide and engage with PPH and PE/E task forces to generate outputs designed to advance PPH and PE/E work globally.

MCHIP will continue to monitor the introduction and expansion of PPH and PE/E prevention and management activities at the global, regional and country levels, informed by the Multi-country PPH and PE/E Analysis from Year 3. As noted in the mid-term evaluation, operationalizing the use of the scale-up road maps in specific countries, and country progress in general, is an ongoing activity for the MCHIP maternal health team, in order to “ensure that MCHIP-supported interventions will become institutionalized and sustainable.” In line with these priorities, scale-up maps developed and utilized by country programs in Year 3 will be re-applied in Year 4 to chart progress and results and further guide programming at the country, regional and global levels. In consultation with USAID/Washington, country missions and other partners, MCHIP will provide country-level technical support, advocate for Mission-funded activities, and where appropriate, identify opportunities where core funding and TA can be used as a catalyst to expand PPH and PE/E prevention and management programming in focus countries, such as South Sudan, Kenya, Bangladesh and others.

MCHIP plans to determine a subset of more sensitive quality indicators from the QoC studies. We will continue to look for simplified mechanisms to track progress and map achievements.

The maternal health team will also continue to use knowledge generated by the QoC surveys to assist countries as they include ways to address identified gaps in their workplans. The February 2011 Addis Ababa maternal and newborn health meeting was frequently cited in the mid-term evaluation as an effective approach for “sparking interest in MNCH interventions.” Indeed, the meeting helped to catalyze action in at least five countries: Liberia, Kenya, Madagascar, South Sudan and Guinea. Following a similar approach for Year 4, MCHIP will collaborate with global and regional partners to organize an Asia Regional Meeting for the spring of 2012. This meeting will tell the recent story of maternal mortality reduction in Nepal, Bangladesh and potentially other Asian countries. Speakers and participants will describe the accomplishments to date in PPH and PE/E programming, share the technical approaches to PE/E prevention and management, and describe how to build PE/E programming on the PPH program platform. This meeting will be supported with field funds from country programs, core funds from MCHIP, and be co-funded by the Oxytocin Initiative, a program implemented by PATH with funding from the Bill & Melinda Gates Foundation. Other partners will include Family Care International, The Partnership for Maternal Newborn and Child Health, Women Deliver, the WHO/South East Asia Regional Office (SEARO), the WHO/Western Pacific Regional Office (WPRO), the WHO/Eastern Mediterranean Regional Office (EMRO), UNFPA, UNICEF, Venture Strategies Innovations (VSI) and others. Participants will come mostly from Asian and Middle Eastern countries and will share regional experiences of PPH and PE/E programs. Through this and other means, MCHIP will be able to follow up with participating countries on the progress of their PPH and PE/E implementation activities.

MCHIP will increase access to PPH and PE/E program materials within our overall global learning and knowledge management strategy, the importance of which is mentioned in the mid-term review. These and other newly developed materials that promote best practices and evidence-based programming will be disseminated, in collaboration with partners including the PVO/NGO network and CORE Group. New computer-based and print job aids and provider support mechanisms (such as a provider support hotline for the use of MgSO₄) will be developed and tested to broaden the array of tools available to program managers for accelerating program expansion.

One of the most compelling discussions at the Addis 2011 meeting was regarding oxytocin potency. Findings from the Oxytocin Initiative Work in Ghana suggest that the potency of oxytocin and ergometrine cannot be assumed. In PY4 we will continue the implementation, designed in PY3, of a strategic approach to the scientific assessment and measurement of oxytocin and partner with field programs to conduct this assessment in approximately seven countries. The objective of this broad assessment will be to confirm that oxytocin potency is an issue that must be dealt with both at that global level by the broad coalition of partners including WHO, UNICEF and others, as well as at the national level by governments and implementing agencies. MCHIP will work with other global projects such as Pharmaceutical Quality Management (PQM) and Strengthening Pharmaceutical Systems (SPS) so that the results of the oxytocin assessments can be acted upon by the appropriate groups. MCHIP recognizes that its mandate is not to comprehensively address drug quality and logistics systems, but instead to partner with groups and to catalyze action. MCHIP will continue to engage with partners such as VSI, Gynuity and UNFPA to advocate for an improved and reliable source of misoprostol for country programs.

MATERNAL ANEMIA

Maternal (and child) anemia prevalence is excessively high and static in many developing countries. To combat this problem and facilitate decreases in these high prevalence rates, the USAID Division of Nutrition is promoting an integrated package to address the many causes of anemia. This package will be adapted to the country situation but, in most countries, it will include interventions directed at poor dietary intake of micronutrients, inadequate health care

and water and sanitation services, and parasitic infections (soil-transmitted helminths and malaria). In Year 4, MCHIP will focus in two or three countries (proposed are Bangladesh, Rwanda and Kenya or Zimbabwe) to promote and build capacity to deliver the most effective package to address maternal anemia, and will look for linkages to address child anemia, such as promoting delayed cord clamping at birth as part of the maternal anemia control integrated package. To do this, MCHIP will work in coordination with Health, Infectious Diseases and Nutrition (HIDN) Global Programs including the new SPRING and Feed the Future programs.

Strengthening and delivering the package may include defining the package, if the country has not already done so; revising maternal health care curricula to include training on the anemia control package, including delayed cord clamping; supporting malaria control programs including intermittent preventive treatment in pregnancy (IPTp) and promoting pregnant mothers to sleep under treated bed nets; supporting deworming of mothers in their second and third trimesters; and making links to programs that can address the barrier of lack of access to animal source foods (ASF) or other micronutrient-rich foods that can improve hemoglobin status. Developing a package of behavior change communications materials to increase demand and utilization of the integrated maternal anemia control package will be part of MCHIP support as well as monitoring uptake of the package. MCHIP will link with partners that will be able to track the more rigorous indicator for the program such as change in maternal anemia.

To follow on work in Year 3, MCHIP will support in-country advocacy on the issues related to effective program implementation, specifically by supporting improved maternal anemia control implementation of the integrated package in MCHIP program and other areas. This will include the completion of a report on the use of scale-up road maps, as well as and multi-sectoral and multi-program strategy development, as tools to improve national and district maternal anemia control programs. It is thought that the use of scale-up roadmaps can help country programs coordinate the efforts of all partners, identify program gaps that need attention, and monitor program progress to ensure sustainability and institutionalization. Building on accomplishments from Year 3, MCHIP will continue to strengthen national anemia control programs in two countries (proposed are Bangladesh, Rwanda and possibly Kenya or Zimbabwe).

As highlighted in the mid-term review, MCHIP is well placed to work at the country level, given our broad program base, and thus use our experience at the country level as a “learning laboratory” to “establish globally convincing evidence about the impact, cost effectiveness and sustainability of selected MNCH programmatic approaches.” In the ongoing effort to document and diffuse MCHIP learning, in Year 4 MCHIP will document the experience of maternal anemia reduction in Nepal, collaborating with counterparts to prepare a paper for publication. MCHIP will prepare a journal article for publication from the Year 3 “deep dive” into maternal nutrition and specific morbidities and mortality. MCHIP will also follow up with MCHIP country programs for recommendations for specific nutrition interventions related to PPH, PE/E, maternal sepsis and obstructed labor.

SMART INTEGRATION OF MATERNAL HEALTH AND TUBERCULOSIS

In Year 4, MCHIP will explore creative mechanisms by which to integrate programming for TB and MNH, especially at the community level, where we already have a tested and proven-effective platform for counseling and service delivery. This advocacy will focus at the global level with WHO’s Stop TB Program, and at the country level, with field Missions to support smart integration of TB services for mothers and newborns. MCHIP will also build on discussions initiated through MCHIP participation at the STOP TB Program meeting in Geneva in Year 3 (September 2011), following up on opportunities for collaboration, in which MCHIP will be well

positioned to provide MNH representation in the broader community for the development of community TB approaches and guidelines.

Table 2 (next page) outlines MCHIP expected results for maternal health introduction and scale-up.

YEAR 4 ACTIVITIES/EXPECTED RESULTS

Table 2. MCHIP Expected Results for Introduction and Scale-Up: Maternal Health

	EXPECTED RESULT	PROGRAM YEAR 1	PROGRAM YEAR 2	PROGRAM YEAR 3	PROGRAM YEAR 4	LIFE OF PROGRAM YEAR 5 (# OF COUNTRIES)
PPH	<i>Improved advocacy and global awareness</i>			<i>PPH Scorecard, partnerships with global agencies, key task forces, Africa regional meeting, oxytocin selection and storage</i>	<i>Country program support, multi-country program analysis, scale-up mapping, oxytocin potency testing, global learning</i>	
	<i>PPH prevention programs introduced and expanded</i>	<i>Mali, DRC</i>	<i>Kenya, Mozambique, Madagascar, Liberia, India, Nigeria and Malawi</i>	<i>Zimbabwe, Nepal, Rwanda, Paraguay, Indonesia Ethiopia and Bangladesh</i>	<i>Guinea, South Sudan, Angola, Perú, Nicaragua, Guatemala, Honduras, Tanzania and Afghanistan</i>	<i>20 countries—field and core</i>
	<i>PPH treatment introduced</i>		<i>Mali, Kenya, DRC, Malawi, Mozambique, Madagascar, Liberia, India and Nigeria</i>	<i>Zimbabwe and Nepal</i>	<i>Paraguay and Bolivia</i>	<i>15 countries—field and core</i>
PE/E	<i>Global agenda for PE/E advanced</i>	<i>PE/E Technical Working Group (TWG) and Task Forces established</i>	<i>Terms of reference for both groups established at meeting in November 2009</i>	<i>Clinical guidelines with WHO; Africa regional meeting; TWGs</i>	<i>Finalization and dissemination of guidelines and resource materials, development of innovative training and support materials, improved diagnostics, increased number of countries where active PE/E programming is undertaken</i>	
	<i>Quality of Care Surveys conducted</i>	<i>Design and preparation</i>	<i>Conducted in Kenya, Ethiopia and Tanzania</i>	<i>Conducted in Rwanda, Madagascar and Zimbabwe</i>	<i>Mozambique</i>	<i>6 countries—field and core</i>

	EXPECTED RESULT	PROGRAM YEAR 1	PROGRAM YEAR 2	PROGRAM YEAR 3	PROGRAM YEAR 4	LIFE OF PROGRAM YEAR 5 (# OF COUNTRIES)
	<i>Programs for prevention and management of PE/E developed and introduced</i>		<i>Nepal</i>	<i>Mozambique and Tanzania</i>	<i>Bangladesh, Ethiopia and Indonesia</i>	<i>7 countries—field and core</i>
	<i>PE/E program implementation monitored</i>			<i>7 countries where PEE programming is ongoing</i>	<i>Nigeria, Paraguay, Tanzania, Zimbabwe, Afghanistan and Bangladesh</i>	<i>10 countries</i>
SBA	<i>Global clinical guidelines updated</i>		<i>Task shifting in maternal newborn health guidelines</i>	<i>Pre-eclampsia guidelines</i>	<i>Postnatal care guidelines; PPH guidelines</i>	
	<i>Quality of care improved</i>			<i>P4P-Quality linkage in Tanzania and Malawi</i>	<i>Better data reporting in Mozambique, Malawi, Indonesia and Rwanda</i>	
	<i>PSE global and country-level agendas advanced</i>			<i>PSE implementation guide developed and used in Madagascar, Zimbabwe, Liberia and India;</i>	<i>Bangladesh and Ghana</i> <i>Multiple country situations analyzed through the State of the World's Midwifery report</i>	
	<i>Improved delivery of high-impact interventions by strengthening SBA skills</i>	<i>Mozambique</i>	<i>Malawi, Kenya, Madagascar, India, Liberia, Mali, Lesotho and DRC</i>	<i>Zimbabwe</i>	<i>Ghana, Bangladesh, Afghanistan and Ethiopia</i>	<i>10 countries—field and core</i>
Maternal anemia	<i>Country-level barriers and facilitators for successful maternal anemia control programs identified through a national consultation</i>		<i>Bangladesh and Indonesia</i>	<i>Bangladesh and Kenya or Rwanda</i>	<i>NA</i>	<i>5</i>

	EXPECTED RESULT	PROGRAM YEAR 1	PROGRAM YEAR 2	PROGRAM YEAR 3	PROGRAM YEAR 4	LIFE OF PROGRAM YEAR 5 (# OF COUNTRIES)
	<i>National strategic plan for addressing maternal anemia developed</i>		<i>Bangladesh and Indonesia</i>	<i>Bangladesh and Kenya or Rwanda</i>	<i>Kenya, Rwanda and/or Zimbabwe</i>	5
	<i>Country-level maternal anemia control activities implemented; in Year 4, efforts will focus on improving the delivery of a package to control maternal anemia</i>		<i>Bangladesh or Indonesia</i>	<i>Bangladesh, Indonesia, Rwanda</i>	<i>Bangladesh, Rwanda and Kenya and/or Zimbabwe</i>	5

Newborn Health

OVERVIEW

Of the 7.7 million children who die every year before reaching their fifth birthday, about 3.7 million are newborns who do not survive their first four weeks of life. The majority of these newborns are 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 services consisting of appropriate content and quality of care during pregnancy, labor and delivery, and postnatal periods will contribute to sustained reduction in maternal and newborn mortality.

Three immediate causes—birth asphyxia, infections and preterm/low birth weight (LBW)—account for 86% of newborn deaths. While much is known about preventive and curative measures needed to address these causes of mortality, less is known about how to deliver the interventions in low-resource settings, especially in the poorest communities where most of these deaths occur. MCHIP applies a systematic effort along the continuum of care—starting from pregnancy through childbirth to the first month of life, and from household-to-hospital—to introduce and improve coverage of evidence-based interventions:

- Essential newborn care (ENC), including hygienic cord care, prevention and management of birth asphyxia, maintenance of warmth, immediate and exclusive breastfeeding, and handwashing with soap by birth attendants and care providers
- Management of preterm and low birth weight babies through KMC
- Management of newborn infections/sepsis

As soon as a pregnant woman is identified, MCHIP supports counseling, including promotion of ANC, birth preparedness, education on maternal and newborn danger signs, and appropriate

care-seeking practices. MCHIP also supports scale-up of antenatal and intrapartum interventions that have significant impact on newborn survival, including birth preparedness, tetanus immunization, syphilis screening, improved care of pre-eclampsia/eclampsia, skilled birth attendance, and clean and safe delivery. MCHIP thereafter focuses on the first month of life and, in particular, the most vulnerable newborn period: the first week of life. MCHIP supports delivery of these interventions through both facility- and community-based approaches to link the two delivery mechanisms. This integrated approach ensures that the woman has the required knowledge and skills to practice lifesaving behaviors during pregnancy and through the first month of life. And, through integration at the service delivery level where appropriate, MCHIP aims to increase access to and improve the quality of high-impact interventions that benefit both mother and newborn.

MCHIP's goal is to support the reduction in the global burden of newborn mortality and stillbirth and, by so doing, contribute to the attainment of Millennium Development Goal (MDG) 4. MCHIP will be a key contributor to USAID and GHI goals to reduce the under-five mortality rate by 35% and reduce newborn mortality by 30% by 2015, in 30 priority countries, and to USAID's pathway for the introduction and expansion of newborn interventions.

MCHIP STRATEGY FOR NEWBORN HEALTH

The MCHIP strategy for newborn health is to expand coverage of evidence-based interventions in 20 priority MCH countries. In Year 4, this geographic target will be surpassed as MCHIP expects to support the implementation of newborn interventions in at least 25 countries: 11 in Africa, four in Asia, two in the Middle East/Eurasia, and eight in LAC (cumulative from Year 1). Specific strategies for Year 4 include:

- Support the strengthening and integration of evidence-based newborn health interventions into existing MOH and pre-service institution systems and programs, including interventions along the household-to-hospital continuum of care;
- Support scale-up of evidence-based newborn health interventions and document the processes/outcomes in order to inform global, regional and country-level learning and practice regarding scaling up and sustaining the impact of such interventions. Year 4 will include a more robust and focused effort to document and disseminate such program learning;
- Strengthen strategic alliances with UN agencies, private sector, and professional medical and nursing associations that support implementation of newborn health programs at scale; and
- Provide global and technical leadership in newborn health.

Opportunities for Program Learning

MCHIP will address key program learning questions related to the effective implementation of newborn interventions at scale. Lessons learned and findings will be disseminated through global meetings, the MCHIP Web site, Core Group and PVO/NGO CSHGP grantees, as well as other forums.

- **Kangaroo Mother Care:** Conduct a multi-country review of KMC (both community and facility) to document effective approaches to implementation and scale-up, using a combination of core and field funds and in tandem with/or drawing from relevant findings by other partners, including Saving Newborn Lives (SNL). Countries may include: DRC, Ethiopia, Malawi, Nigeria, Tanzania, and the Dominican Republic or LAC regional effort.

- Examine the introduction and expansion of structured **antenatal and postnatal care home visits**, including the role of community mobilization, in a multi-country review, including Bangladesh, Nigeria and Malawi, with a mixture of core and field funds.
- In Nigeria, using core funds, document key lessons on introduction and scale-up of **newborn sepsis management**.
- Assess **pre-service integration of newborn resuscitation/HBB within ENC** in three MCHIP and East, Central and Southern Africa Colleges of Nursing (ECSACON) countries to inform regional curriculum development.
- Document results of **handwashing with soap formative research** in Bangladesh and Indonesia and use to: 1) inform BCC strategies, 2) engage additional stakeholders in each country, and 3) share with other MCHIP countries and partners. MCHIP will also develop an **M&E plan for the newborn handwashing GDA** to measure program success and contribute to global knowledge over the next two years.
- MCHIP will continue to **coordinate communities of practice for KMC and HBB in LAC**, which will both generate and disseminate program learning for the region, including standardized approaches and indicators.
- MCHIP will develop a **scale-up framework/map for key newborn interventions** and provide technical support to countries to facilitate their use in tracking progress during program implementation and scale-up of interventions.

In addition, MCHIP headquarters-based staff will proactively engage country-based newborn health staff to improve their own documentation processes to better capture program learning.

YEAR 4 ACTIVITIES/EXPECTED RESULTS

Global Leadership for Newborn Health

As described above, MCHIP will continue to advance learning and advocacy aimed at leveraging resources and action from governments, donors and PVO/NGOs (including CSHGP grantees) for the scale-up of high-impact newborn interventions. MCHIP will achieve this through continued global and regional technical leadership in newborn health and through strategic partnerships and alliances with UNICEF; UNFPA, which joined the LAC Newborn Health Alliance in Year 3; WHO departments of Child and Adolescent Health and Making Pregnancy Safer, and the Africa Regional Office; SNL/Save the Children; the Partnership for Maternal, Newborn and Child Health (PMNCH); Countdown to 2015; AAP; International Pediatric Association; the Child Health and Nutrition Research Initiative; The Bill & Melinda Gates Foundation (BMGF); and the Global Alliance for Prevention of Prematurity and Stillbirths (GAPPS).

MCHIP, in collaboration with WHO and SNL, will convene a technical consultation to assess progress at the country level of implementation of the joint statement on WHO/UNICEF PNC home visits. The consultation will lead to better monitoring and improved technical support for the introduction and expansion of newborn care through scheduled ANC and early PNC home visits in developing countries.

Since 2004, USAID and its partners have supported the LAC Neonatal Alliance and have 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, with special focus in the most vulnerable populations. The Alliance originally included USAID's LAC Bureau, the Pan American Health Organization (PAHO), the CORE Group, ACCESS, SNL, Health Care Improvement Project (HCI), UNICEF and BASICS. It has since expanded membership to include regional professional associations

(Pediatric, Obstetrics and Gynecology, International Confederation of Midwives, Nursing) and other new members. MCHIP is chairing the Alliance in 2011, elected unanimously by its members, and continues coordinating the LAC newborn indicators committee. The Alliance members continue to strengthen country plans of action to reduce neonatal mortality in the region, and to implement initiatives to address the leading causes of newborn mortality in LAC.

In Year 4, MCHIP expects to contribute financial support to the review process and assist with the dissemination of the WHO recommendation on chlorhexidine. Studies from Asia have shown that the application of chlorhexidine to the umbilical stump at the time of birth significantly reduces neonatal mortality. The likelihood is reasonably high that WHO will review and endorse this new evidence-based intervention in Year 4.

WHO's endorsement of chlorhexidine application on the umbilical stump will open the door for the introduction of this life-saving intervention to developing countries, in particular sub-Saharan African countries. Depending on the timing of the WHO endorsement, MCHIP will seek to work with interested countries to incorporate this intervention in their ENC package.

MCHIP will continue its collaboration with the Regional Center for Quality of Health Care (RCQHC) based at Makerere University in Kampala, and the East, Central and Southern Africa Health Community (ECSA-HC) and ECSACON. This activity provides MCHIP with the opportunity to improve the pre-service newborn care curricula in the more than 13 countries that make up the membership of the ECSA-HC. In Year 4, MCHIP and RCQHC will provide direct financial support to selected pre-service institutions in Malawi, Kenya and Tanzania. In addition, in Year 4, MCHIP will provide technical assistance for the development of scale-up maps/scale-up readiness benchmarks for key newborn interventions in collaboration with SNL for selected MCHIP countries; share technical information and best practices with the PVO/NGO community through CSHGP grantees and the Core Group; identify opportunities for hosting integrated technical meetings with the maternal health team; and continue collaboration with other MCHIP teams as relevant. The newborn team will also continue to collaborate with the family planning team to integrate postpartum family planning into postnatal care home visits to make FP more readily accessible to postpartum women and their male partners.

MCHIP will also continue its leadership role in two USAID Global Development Alliances (GDAs): ***Helping Babies Breathe*** (HBB) addresses birth asphyxia through newborn resuscitation. This is a public-private alliance of USAID, The Eunice Kennedy Shriver National Institute of Child and Human Development (NICHD), Save the Children, Laerdal Medical and the American Academy of Pediatrics (AAP). MCHIP serves as one of the implementing partners on the HBB GDA. MCHIP's leadership role under the HBB GDA will lead to better coordination of global support to improve neonatal resuscitation in the context of ENC at the country level. Using both core and field funds, MCHIP will work with in-country, regional and global partners to strengthen pre- and/or in-service neonatal resuscitation in Bangladesh, Ethiopia, Guinea, India, Kenya, Madagascar, Mali, Malawi, Mozambique, Rwanda, Zambia and Zimbabwe. ***Handwashing for Newborn Survival***, a behavior change program that helps new mothers and health workers adopt and practice handwashing with soap, is a public-private alliance of USAID, MCHIP and Unilever's Lifebuoy. This initiative includes partnerships with the London School of Hygiene and Tropical Medicine, the US Centers for Disease Control and Prevention, and International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B) to conduct formative research. Activities related to both GDAs are described under their respective technical sections below. Information from the formative research and expert consultation held in Year 3 will be used to develop a communication package on handwashing for newborn survival. The communication package would be adapted and used to improve handwashing messages in newborn programs in Indonesia and Bangladesh. Other countries would be

reached, though not supported directly, by dissemination and promotion of the communication package through various channels including the CORE group and MCHIP and SNL Web sites.

Kangaroo Mother Care

In Year 3, MCHIP completed the development of a KMC Implementation Guide, and prepared for translation into French, with publication and dissemination planned in Year 4. MCHIP will continue to support the establishment of a KMC community of practice, begun in Year 3, in collaboration with The International Kangaroo Foundation based in Bogota, Colombia, and other partners. The community of practice plans to generate and disseminate online, 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 whom countries could contact to assist them to introduce or expand KMC services.

MCHIP will continue to provide technical support to programs implementing KMC within various settings—from facility-based to ambulatory and/or community services—that will be documented in a multi-country review in Year 4 in collaboration with the SNL Program (to include following countries: Malawi, Nigeria, Rwanda, Tanzania and LAC Regional effort). KMC program learning will be a priority in Years 4 and 5, to contribute to global knowledge on care for LBW/premature babies.

Essential Newborn Care

In Year 3, MCHIP completed its MNH documentation in Senegal, having finally received MOH feedback late in the year. National dissemination was planned by the end of the year, and MCHIP will further disseminate findings/recommendations to other MCHIP countries in Year 4, as relevant.

MCHIP continued its dissemination/promotion of the WHO/UNICEF joint statement on home visits during pregnancy, childbirth and the first month of life in Year 3, including to more than 300 participants at the Addis Ababa regional meeting. In Addis, MCHIP also organized a plenary on newborn asphyxia, which included a presentation by WHO/AFRO on neonatal resuscitation in the context of ENC.

Wherever it supports ENC or HBB activities in Year 4, MCHIP will seek to strengthen—and actively reinforce to all partners and MOH counterparts the critical importance of—the **integration** of HBB/resuscitation with ENC programs. MCHIP will also strengthen the integrated ENC/HBB component of pre-service training in Malawi, Tanzania and Kenya in collaboration with ECSACON, RCQHC and Africa 2010's eventual successor.

In Year 4 MCHIP will also review and revise SBM-R tools for ENC, including resuscitation and handwashing. MCHIP in collaboration with the CORE Group will also strengthen the messaging around resuscitation in the Essential Newborn Action messages (i.e., that all babies who do not cry at birth should be dried and stimulated to breathe, provided there are no obvious signs of maceration). This message will be part of the community-based ENC delivered through home visits during pregnancy and at the time of birth.

As described in the Program Learning section above, MCHIP will undertake a multi-country review and documentation of the introduction and expansion of structured home visits during pregnancy, childbirth and the first month of life in Bangladesh, Nigeria and Malawi.

Azerbaijan

In response to a USAID/HIDN directive, MCHIP designed and initiated a new program in Azerbaijan in Year 3. The program is developing pre-service and in-service ENC and resuscitation training materials to complement recently revised newborn clinical practice guidelines (CPGs). The CPGs were developed by the MOH, with support from USAID-funded bilateral programs, to introduce evidence-based MNCH practices to providers. The 12-month MCHIP project officially started in March 2011, and will extend into Year 4, with a February 2012 end date. Key achievements in Year 3 included a stakeholders' meeting, establishment of a technical advisory group to review materials; partial production of ENC and resuscitation videos; and development of draft training materials to accompany the videos. In Year 4, the videos and training materials will be finalized and, assuming materials are approved as expected, an orientation/training of tutors and preceptors to new materials will be conducted.

Newborn Sepsis Management

MCHIP continued its active participation in a TWG on newborn sepsis management in Year 3. TWG global membership also includes USAID, SNL and Johns Hopkins University Institute for International Programs (JHU-IIP). The group is working to define a strategy for the introduction and expansion of community-based infection management of newborn sepsis. This activity will continue in Year 4 and MCHIP will help support the costs of developing a Newborn Sepsis Management Implementation Guide. In Year 3 the TWG assigned an MCHIP intern to map newborn sepsis management at the community level in sub-Saharan Africa and Southeast Asia. This activity was suspended when MCHIP learned of UNICEF's CCM survey. Results (expected by end of Year 3) will determine whether and how MCHIP will move forward with its own newborn sepsis mapping exercise in Year 4.

Using Africa Bureau and field funds in Year 3, MCHIP initiated management of newborn sepsis work in northern Nigeria in partnership with the Nigeria Society of Neonatal Medicine (NISONM). These activities will be completed in Year 3 and MCHIP will use Core/Africa Bureau funds in Year 4 to document and disseminate key lessons from the program.

Using LAC Bureau funds in Year 3, MCHIP developed strategies to implement prevention and treatment of newborn sepsis in the Dominican Republic and Paraguay using adapted collaborative methods and virtual technologies for updates and exchanges between quality improvement teams and countries. With field- and core-funded TA, MCHIP in the Dominican Republic is collecting data on the rational use of antibiotics for newborn sepsis in three referral hospitals. The instrument was revised by the MCHIP maternal health team to ensure sufficient inclusion of maternal risk factors for newborn infections. (*See LAC Narrative for more details.*)

Building on the experiences and learning in Nigeria, LAC and elsewhere, MCHIP will use core funds to catalyze improvement/expansion of sepsis management in one African country in Year 4. Liberia is under consideration.

Newborn Resuscitation

In Year 3, MCHIP provided technical assistance and support for HBB trainings in 20 countries. This effort included a regional meeting and training of HBB trainers in Addis Ababa, which produced 150 trainers and champions for HBB in East and Southern Africa, and two regional trainings in the LAC region (during a Regional Pediatric Association meeting in Panama and a Newborn Alliance meeting in Nicaragua) to produce 82 master trainers. The Addis training was conducted in coordination with RCQHC and ECSACON. In Year 3, MCHIP partially supported AAP with funds to produce an HBB training video and to provide TA/QA to MCHIP HBB programs. MCHIP supported the finalization of field-testing of HBB materials in Kenya and

Bangladesh, and assisted the two countries to develop national strategies for scaling up newborn resuscitation in the context of ENC.

MCHIP together with Africa 2010, RCQHC and ECSACON developed a concept in Year 3 to assess ENC/resuscitation pre-service curricula in East and Southern Africa, and to develop a regional program to assess, review and revise curricula, develop teaching aids, strengthen clinical sites, and train tutors and preceptors. Assessment activities expected to be completed in Year 3 were supported by MCHIP, Africa's Health in 2010, USAID/East Africa and Laerdal. In Year 4, MCHIP, USAID/East Africa, Laerdal and the successor to Africa 2010 will jointly support the development and rollout of a regional model pre-service curriculum for ENC/resuscitation. Given Jhpiego's and the MCHIP maternal health team's significant work on strengthening pre-service education in some of these same countries, the MCHIP newborn health team will share results of the assessments with them for their feedback, as appropriate.

MCHIP will continue to partner with HBB GDA partners AAP, NICHD, HCI/University Research Co. and Health Tech to introduce and expand HBB activities in Africa, Asia and LAC. In Year 4, particular emphasis will be given to the integration of HBB materials and/or associated teaching aids into existing MNH in-service and pre-service training programs using the HBB implementation guide completed in Year 3 as a tool for achieving successful integration at country level. MCHIP, in collaboration with other partners, will follow up support to countries that have adopted or adapted the HBB training materials and/or associated teaching aids. MCHIP will do this directly through TA and by providing a sub-grant to the AAP to develop a Mentor's Guide (in collaboration with the CORE Group) and to provide TA and quality assurance to existing programs. In collaboration with AAP and GDA partners, MCHIP will support the review and finalization of a French version of HBB materials, including the HBB Implementation Guide.

MCHIP is equally committed to *preventing* birth asphyxia through upgrading the knowledge and skills of service providers to detect and manage antenatal conditions, such as pre-eclampsia, that can result in birth asphyxia. In addition, the newborn and maternal health teams will develop a training video/materials aimed at guiding a birth attendant who is alone in managing the third stage of labor (AMTSL) and providing ENC, including resuscitation during the 'golden minute,' to the newborn.

Quality of Care Assessments

MCHIP's newborn team supported the QoC surveys in Year 3 through technical advice for tool development, review and dissemination of results. MCHIP will develop an additional tool for newborn sepsis management assessment in Year 4; continue to provide TA to survey implementation; and provide TA to MCHIP countries in using survey results to improve the quality of newborn care.

Handwashing with Soap for Newborn Survival

In Year 3, MCHIP collaborated with USAID and Unilever to launch the Global Development Alliance on Handwashing for Newborn Survival at a satellite event of the 2011 Global Health Council meeting in Washington, DC. This was followed by a two-day, technical consultation and behavior change workshop involving a broad range of stakeholders to review preliminary findings of formative research and to design a behavior change strategy for the GDA. The workshop furthered planning to identify activities and platforms for scale-up through MCHIP and other in-country partners in Bangladesh and Indonesia. A global package of communication materials will be produced by the GDA partnership by the end of Year 3.

In Indonesia, MCHIP established a partnership with Unilever and undertook formative research and joint activities on Global Handwashing Day (Oct 15, 2010) in Indonesia. In Bangladesh, several stakeholder meetings with participants from MCHIP, Unilever, USAID and other bilateral projects in-country have been held and an initial implementation plan created for the GDA. Due to lack of USAID Mission support in India and Nigeria, Year 3 resources were reallocated to Kenya instead, where initial planning began at the end of Year 3. However, reduced core funds in Year 4 will limit the ability to make continued progress in Kenya. Instead, MCHIP will explore whether field funds might be used to advance activities in Year 4.

In Year 4, the global handwashing BCC package will be adapted for use in each country. Country-level launches including dissemination of formative research findings and sharing of materials will be conducted in each country on or around Global Handwashing Day. Strengthened newborn handwashing materials will be integrated with MCHIP work on ENC and postnatal care (PNC) as possible in the three target countries, including HBB rollout. They will also be included in infection prevention work at the facility level as appropriate. Scale-up in the two countries through existing bilateral projects will be a focus in Year 4.

Newborn handwashing messages may also be used to strengthen the regional MCHIP-supported RCQHC/ECSACON pre-service ENC training curriculum, if the ongoing evaluation identifies this as a gap. An M&E approach will be developed in consultation with the University of Buffalo and deployed with the available resources.

Given the significant reduction in core handwashing funds in Year 4, the scope of the aforementioned activities will be highly dependent upon commitment of field funding from each country.

Table 3 (next page) outlines the expected results for newborn health introduction and scale-up.

Table 3. MCHIP Expected Results for Introduction and Scale-Up: Newborn Health⁷

Activity Title	Expected Results	Year 1	Year 2	Year 3	Year 4	Life of Program Fiscal Year 2013
ENC (and postnatal care)	Postnatal/ENC introduced (<=three districts)		India, Malawi, Mali, Nigeria and Dominican Republic	Azerbaijan, Mali, Indonesia, Dominican Republic and Paraguay	Azerbaijan, Kenya, Malawi*, Mali, Tanzania*, Kenya*, Indonesia, Dominican Republic, Paraguay and Colombia	15
	PNC/ENC expanded (>three districts)		Bangladesh and DRC	Bangladesh, India, Nigeria, Malawi, Ethiopia, Zimbabwe and Mozambique	Bangladesh, India, Nigeria, 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, Nigeria and over 20 countries through White Ribbon Annual conference and Asia best practices regional meeting	Joint statement shared with Addis HBB regional meeting attendees from 27 countries (including some listed in Year 2)		15
KMC (facility and community)	KMC introduced and expanded		Malawi, Bangladesh, Nigeria, DRC, Mali, Dominican Republic and Nicaragua	DRC, Malawi, Mali, Nigeria, Rwanda, Bangladesh, Indonesia, Dominican Republic, Nicaragua, Guatemala, Honduras, El Salvador and Paraguay	Bangladesh, Indonesia, Mali, Dominican Republic, Nicaragua, Guatemala, Honduras, El Salvador and Paraguay	15
	Community KMC programs	Bangladesh	Bangladesh and Malawi	Bangladesh, Malawi, Ethiopia, Mozambique and Indonesia	Bangladesh, Indonesia, Ethiopia and Mozambique	8

⁷ This table includes countries supported by both core and field funds.

* Through TA and support to regional ENC/HBB curriculum development in collaboration with RCQHC and ECSACON.

Activity Title	Expected Results	Year 1	Year 2	Year 3	Year 4	Life of Program Fiscal Year 2013
Newborn sepsis prevention and management	Newborn infection management introduced		Bangladesh, Nigeria and Dominican Republic	Bangladesh, Nigeria and Dominican Republic and Paraguay	Bangladesh, Nigeria, Dominican Republic, Paraguay and new country TBD (Liberia under consideration)	8
	Newborn handwashing promoted through public and private sector alliance		Indonesia and Bangladesh	Bangladesh, Indonesia and Kenya	Bangladesh, Indonesia and Kenya	8
Prevention and management of asphyxia	Introduce management of asphyxia in facility and home (stimulation only) settings		Kenya and Bangladesh	Azerbaijan, Bangladesh, India, Kenya, Ethiopia, Nigeria, Zimbabwe, Ghana, Dominican Republic, Nicaragua, Guatemala, El Salvador, Honduras, Panama, Belize and Bolivia	Azerbaijan, Bangladesh, India, Kenya, Ghana, Malawi*, Ethiopia, Tanzania*, Kenya*, Zimbabwe, Dominican Republic, Nicaragua, Guatemala, El Salvador, Honduras, Panama, Belize and Bolivia	8

Child Health

OVERVIEW

In sub-Saharan Africa, two-thirds of under-five deaths are caused by pneumonia, diarrhea and malaria. MCHIP focuses on key interventions to reduce child mortality through the introduction and expansion of integrated community case management (iCCM) of the sick child; control of diarrheal disease (DD) emphasizing treatment with oral rehydration therapy (ORT)/zinc; and key water, sanitation and hygiene (WASH), notably handwashing, messages. Under iCCM, MCHIP has provided TA for the expansion in DRC and Rwanda, the introduction of iCCM in Mali, and advocacy for a policy for CHWs to give antibiotics at community level in Kenya.

An important challenge for child health has been lack of visibility, resources and a comprehensive strategic approach to programming. Available funding at country level, including USAID bilateral projects, is not coordinated and channeled toward implementing programs that will deliver the key effective interventions at scale.

MCHIP, as a global project, will provide TA, program implementation tools and program learning for the global community to promote delivery of effective interventions at scale. MCHIP will work with global partners and countries to harness all available resources and systematically plan and introduce interventions through multiple, yet coordinated channels to

achieve national coverage of access to and use of antibiotics for pneumonia, effective antimalarials and ORT/zinc for diarrhea.

MCHIP STRATEGY FOR CHILD HEALTH

MCHIP will contribute to the global and specifically, USAID, child health agenda at global, regional and country levels in three areas, namely: 1) strategic leadership for child health; 2) iCCM; and 3) DD prevention and control with a focus on ORT and zinc use in diarrhea case management. We will work to ensure appropriate prevention messaging delivered as an integral part of diarrhea case management, focusing on key WASH practices.

The profile of child health on the global health agenda and funding for it have declined over the years. For MCHIP, Mission funding for child health has been limited, affecting the extent to which MCHIP can influence scale of country-level implementation. MCHIP will draw on the technical expertise of its extended child health team, such as, John Snow, Inc. (JSI), PSI, Save the Children, PATH, JHU-IIP, and the Global CCM Task Force to raise the profile of child health and advocate for increased funding. Additionally, MCHIP will seek expertise from other projects including the Supply Chain for Community Case Management (SC4CCM) and Strengthening Health Outcomes Through the Private Sector (SHOPS) while also joining forces with global initiatives to provide leadership and visibility to comprehensive child health programming at global, regional and country levels. MCHIP will build on an existing collaboration with WHO and UNICEF. Using the combined strength and presence at various forums, we will advocate for accelerated, full-scale implementation of effective interventions against the leading causes of under-five mortality and improved quality of care provided. This strategic role will be used to identify and sound the call for accountability at all levels for the lack of progress commensurate with the existing knowledge of causes of child mortality, e.g., control of DD when effective interventions and appropriate technology to deliver them are well known. Expertise and resources among partners like PATH, PSI and SHOPS will be leveraged to increase access to and use of ORS/zinc for treatment of diarrhea.

MCHIP will continue to play a global leadership role in advocating for policy change and resources for CCM implementation through the CCM Task Force. As Secretariat for the Task Force, MCHIP will improve communication among partners, and coordination of TA to countries to ensure introduction and rapid scale up to achieve national coverage when policy is supportive.

Within MCHIP, we will strengthen collaboration and use of partners: Save the Children and PVO/NGO partnership for iCCM, PSI for private sector/social marketing and behavior change communication (BCC) and PATH for nutrition. Accordingly, MCHIP will seek expertise for specific tasks and joint efforts at country level. For dissemination of program learning, we will strengthen collaboration with the CORE Group as a channel for reaching more countries and partners. Further, cross-team working will be forged with the immunization team for joint planning for countries introducing pneumococcal conjugate vaccine (PCV) and rotavirus vaccines and using Reaching Every District (RED) approaches to plan child health programs. The child health team will also work with the maternal and newborn teams in developing and implementing innovative approaches to performance improvement in community-based programs. In line with GHI principles, child health programs will focus on reaching the poor and marginalized through CCM and maximizing available resources through planning, with careful attention to disease burden and drivers of mortality in a given country context.

Opportunities for Program Learning

MCHIP will address the following program learning themes to improve implementation and effectiveness of iCCM programs:

- Improving CCM program management: In Mali, Zambia, Senegal and possibly DRC, using core funds, document key lessons learned and challenges associated with selecting and collecting CCM indicators and advocating their inclusion in the routine National Health Management Information System (NHMIS).
- Use of mHealth: Using core funds in Mali, document lessons learned in applying technology to improve stock management and prevent stock-out of drugs at the community service delivery point in Mali.
- Improving quality of iCCM case management: Document innovations related to developing and implementing a performance improvement system for CHWs in Mali and potentially Zambia. Other countries will be included after discussion with other CCM Task Force members.
- Publication of sources of care for under-five case management of pneumonia, diarrhea and fever/malaria for selected countries, based on secondary analysis of Demographic and Health Survey (DHS) data.

Year Four Activities and Expected Results

Global Leadership

A multi-agency Community Case Management Task Force (Global CCM Task Force), jointly led by WHO, UNICEF and USAID, and including rotating member organizations, namely Save the Children (SC), WHO's Tropical Disease Research (TDR), Karolinska Institute, University Research Co. (URC) and Management Sciences for Health (MSH), has been formalized. MCHIP is the secretariat for the Task Force. The Task Force works through the following task sub-groups: tool kit (develops tools for program management; M&E; logistics and supplies; and human resources. Each task group has a chairperson and representatives of member organizations based on interest and expertise. MCHIP provides technical leadership in developing iCCM tools (training, supervision, M&E) and indicator reference sheets; coordinates meetings of and inputs from task sub-groups; and compiles the final documents. MCHIP also convenes and coordinates meetings of the Task Force Web site design sub group, in addition to hiring a consultant to support the design of the Web site and paying the Web site monthly fees until another partner takes over the CCM secretariat role.

In Year 4, a key result for MCHIP and USAID leadership is to advance the introduction and scale-up of CCM programs in Kenya, Mali, Rwanda, and Zambia. MCHIP will continue to serve as CCM Task Force Secretariat; provide global technical support; engage CCM partners in driving expansion of CCM implementation in countries; co-lead global meetings for advocacy and follow-up of selected countries, particularly after the regional child health meetings to engage policymakers and lobby for allocating national resources for CCM expansion. Using core funding, MCHIP will lead a mapping exercise of CCM benchmarks and the development of scale-up maps in countries with national scale programs. MCHIP will build on benchmarking to continue monitoring and strengthening nationally led child health programming with a focus on Mali, Rwanda and Senegal. We will further develop, maintain and update the CCM Web site and promote its use among partners.

Sharing Lessons Learned and Challenges in Implementing National-Scale CCM Programs

Many countries are scaling up CCM programs. The learning from pilots or small-scale programs is inadequate to inform national-scale implementation.

In Year 4, the key result is to contribute to CCM learning, resource mobilization and implementation from national-scale iCCM programs. Drawing on experiences in DRC, Senegal

and elsewhere, including CORE Group member organizations, MCHIP will engage a consultant to produce a short (about 10 pages) analytic synthesis, using President's Malaria Initiative (PMI) and Africa Bureau core funding. These reports will compare and contrast lessons learned, best practices and challenges, including approaches used to overcome them. MCHIP will explore including documentation of the Malawi program (led by the Malawi USAID/Mission). The recommendations will address policymakers, program managers, technical agencies and funders of CCM programs. The final report will be shared with countries and CCM partners using forums like the Task Force, the CORE Group and the CCM Web site.

Global Leadership for Diarrhea Prevention and Control

Gains from the introduction of ORT and improved water, sanitation and hygiene are eroding due to lack of attention and inadequate resources at global and national levels. MCHIP is supporting global advocacy for increased resource allocation and improved, country-level planning and implementation of programs for prevention and treatment of diarrhea.

To strengthen coordination of diarrheal disease programs (targeting governments, donors, and technical agencies), MCHIP will review of country policies and coordination of CDD control in two countries with high burden of diarrhea in collaboration with the London School of Hygiene and Tropical Medicine (LSHTM). In most countries, WASH and health are located in different government ministries with uncoordinated plans, programs and duplication of efforts. This is reflected in post-GAPP/DD meeting action plans and was echoed by organizations (e.g., Water Aid) at the London meeting. The review will focus on specific areas that need improvement, and will provide a landscape of what and where the different elements of diarrheal prevention and treatment are located, available funding, by who, what and how the funding is allocated including NGOs that might be working in parts of the countries but not sharing technical resources with the national level. The review will map the diarrhea situation by geography, contributing factors, relevant interventions, and identify program gaps, available resources, opportunities, and partners. Informed by the review, MCHIP will provide technical assistance to reduce or address duplication in health or disease or prevention plans, identify waste and unproductive competition, bundle intervention delivery channels when appropriate. The review will furthermore clarify both performance targets and accountability, ultimately resulting in a well-coordinated program to reach the target population. It is anticipated that the results of this review will provide specific answers to key challenges which will be used to strengthen technical assistance on policy development for more comprehensive and coordinated programs.

In Year 4, MCHIP will continue to support a field trial in Orissa, India to assess the efficacy of a point-of-use water product, Aquatabs, to prevent diarrheal disease. MCHIP partner PSI will provide technical support to increase awareness, acceptance and availability of Aquatabs in one of the largest slum areas of Bhubaneswar city. More specifically, MCHIP is responsible for the promotion and uptake of Aquatabs by the target population (an estimated 1,600 households and 2,400 children under five). Outcomes of the project will be assessed through monitoring data morbidity, weight for age Z-scores, water quality testing, compliance to use of Aquatabs and survey of cost savings and absenteeism. Further details can be found in the MCHIP India Field workplan.

Improving Use of Data in Planning Child Health Programs

MCHIP is contributing to directing investment choices to the leading cause of under-five mortality, strengthening health delivery channels most accessed and used by populations, and targeting populations most in need of services.

In Year 4, MCHIP will complete child health profiles for the USAID priority/GHI countries and share them with respective USAID Missions and other partners. In addition, we will conduct

DHS secondary data analysis on sources of care (and prepare a publication) and barriers to use of available services. We will develop child health fact sheets for Guinea, Mali, possibly Zambia and other countries based on demand from USAID Missions. MCHIP will work with Macro as it revises its DHS tabulation plan, so that in future DHS reports, source of care for childhood illness is presented in disaggregated form.

Improving CCM Program Management

In Year 4, MCHIP will support use of CCM tools (benchmarks and CCM indicators) in Mali, Zambia, possibly DRC (through MSH) and Senegal to improve national program management, and national coordination of CCM. With support from JSI/Routine Health Information Network (RHINO), MCHIP will work with countries to use the results of benchmark mapping (see above under “global leadership”) to identify gaps in data collected at service delivery points, aggregate and include CCM indicators from the NHMIS in Mali, Zambia, possibly DRC (through the Integrated Health Project [IHP]/Projet de Santé Intégré [PROSANI]) and Senegal.

With Save the Children, WHO and UNICEF, MCHIP will co-host a regional meeting for advocacy and identification of TA needs for national CCM M&E and incorporating iCCM indicators in the NHMIS. Target countries include: Benin, Burkina Faso, Guinea, Liberia, Madagascar, Malawi, Mali, Niger, Rwanda, Zambia and Zimbabwe. Follow-up activities in Mali, Zambia, Senegal (and potentially DRC) will include identification of areas of weakness based on the benchmarking exercise, addressing challenges with collecting CCM indicators, and analysis and use of data and support to training information officers. MCHIP will emphasize broad participation by all partners involved in generating community-level data, including CSHGP and CORE Group partners where appropriate.

Use of Mobile Health (mHealth)

Improving management of CCM programs presents several challenges, some of which can be addressed using information technology such as mHealth. Among the challenges identified in CCM implementation in Mali and other countries is stock-out of essential drugs at service delivery points.

In Year 4, using a combination of core and field funding, MCHIP will apply mHealth to improve stock management in CCM programs in Mali, and document and share lessons with other CCM programs. MCHIP will work with other CCM partners in Mali, UNICEF and Save the Children, to pilot use of mobile phones to communicate among different levels (from community, to facility, to district, to regional, to central levels) about status of stock, availability of drugs at other facilities or distribution sub-centers, and planning of deliveries. MCHIP will also collaborate with other partners including the mHealth Alliance, UNICEF, SC4CCM, CORE Group, and the JSI Deliver project to learn how they are using mHealth in different settings, and document and share experiences.

Improving Quality of Case Management

Several approaches to improving performance are being tried but challenges remain. In Year 4, MCHIP will work with CCM Task Force members to design and implement a Performance Improvement (PI) system in selected countries. Countries will be chosen based on PI work that is already occurring, coverage and partners involved, such as Mali and Zambia. MCHIP will support operations research to assess performance standards (i.e., when to implement refresher training).

The child health team will work with other MCHIP technical areas, health systems strengthening and maternal and newborn health teams, to share the learning and create synergies in methods, tools and approaches to performance improvement.

Introduction and Scaling Up of iCCM Programs

MCHIP has provided TA to countries to advocate for policy change, and introduction and scale-up of CCM programs in DRC, Senegal, Rwanda and Mali. Working with in-country partners, MCHIP uses limited core funds to supplement field support to develop training guidelines and data collection and supervision checklists, and pay for training of community health workers and supervisors. Such efforts, under BASICS III, resulted in national-scale programs in DRC and Senegal.

In Year 4, MCHIP will advocate introduction of CCM in Guinea and Kenya and continue supporting scale-up in Mali and possibly Zambia. In Kenya, there has been resistance to use of antibiotics by CHWs. With the work in Year 3, policy change is imminent and MCHIP is positioning itself to provide the needed support to start up activities in Kenya. In Guinea, MCHIP will use the scoping visit to support strengthening of facility child health services to better understand the environment and identify potential allies for CCM advocacy. When the niche for MCHIP is identified in Zambia, we will work with Save the Children (already in the country) to provide support to scaling up CCM, including the development of an M&E system to link CCM to the NHMIS. As part of CCM introduction and scale-up in Kenya, Mali (and Zambia), MCHIP will: 1) strengthen counseling on feeding during and after illness; 2) strengthen linkages with CSHGP and CORE Group partners in Zambia and other countries; 3) explore opportunities to link CCM with community-based distribution of family planning products; and 4) collaborate with CORE Group and other partners of the RBM case management working group to improve skills of CHWs.

Technical Assistance for Integrated Diarrhea Prevention and Control

Country-level diarrhea prevention and control programs are fragmented, and the use of ORT has either stagnated or is declining in a number of countries. Where zinc has been introduced, coverage remains very low. MCHIP's mandate is to support revitalization of ORT programs and introduction and scale-up of zinc. Progress in diarrhea programs in the first three years of the program has been slow. MCHIP has reached eight of the 13 life of program (LOP) target countries.

In Year 4, using a combination of core funds for TA and field funds for actual implementation, MCHIP will innovate to accelerate scale-up of ORT/zinc programs in Kenya, Mali, Rwanda and Zimbabwe and initiate the process in Guinea and Zambia. Taking into account each individual country situation, MCHIP will use core funds to complement field funds in the following ways:

- Characterize the problem by conducting a scoping exercise to determine the state of ORT/zinc and key prevention (handwashing, counseling on feeding, including exclusive breastfeeding) activities, partners, gaps and issues with commodity availability;
- Provide TA to country partners to develop scale-up plans and maps for ORT/zinc revitalization, zinc introduction or any aspect of program implementation in Guinea, Kenya, Mali and possibly Zambia;
- Provide TA for identifying national champions, building a coalition of partners, and developing and implementing a national advocacy strategy for mobilization of resources (for example, MCHIP paying for a short-term consultant or supporting the sharing of TA between country programs);
- Provide TA and limited material support to develop and print harmonized communication materials and job aids for health workers (including CHWs) on diarrhea prevention and treatment, including promotion of appropriate care-seeking behavior;

- Subject to funding, MCHIP/PSI conduct operations research to assess barriers and opportunities for increasing access to and use of ORS/zinc and ensure that public and private sector programs address these;
- Work with PSI and/or SHOPS to support analysis and identification of opportunities for using/improving non-public sector channels for ORS and zinc, such as social marketing and private pharmacies and shops, examine availability of point-of-use water disinfection products, where appropriate
- Work with the immunization team to support countries in developing plans that include diarrhea case management in national rotavirus vaccine introduction (e.g., Zambia is set for introduction in 2013); and
- Document the process and lessons learned while creating opportunities for sharing lessons among districts and regions within countries and, where appropriate, at regional and global levels.

Table 4 (below) outlines expected results for iCCM and ORT/zinc introduction and scale-up.

Table 4. MCHIP Expected Results for Introduction and Scale-Up of iCCM and ORT/Zinc

EXPECTED RESULTS	YEAR 1-3	YEAR 4	LIFE OF PROJECT FY 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 done in DRC and Senegal and disseminated	Synthesis report of DRC and Senegal documentation Document progress against CCM benchmarks and inclusion of CCM indicators in NHMIS in selected countries such as Mali, Senegal and Zambia Document use of mHealth in reducing drug stock-outs in CCM program in Mali Document implementation of iCCM quality improvement system in Mali and other countries (to be determined by CCM partners)	5
CCM introduction and scale-up	Mali	Guinea (advocacy) Kenya	6
	DRC, Rwanda and Senegal	Mali, Rwanda and Zambia	8
Joint advocacy and technical support for ORT revitalization carried out with catalytic Initiative/Accelerated Child Survival Development (ACSD), CIFF ORT/Zn and ZTF	3 regional meetings on Global Action Plan for Prevention and Control of Pneumonia and Diarrhea Disease (GAPP/DD: with 15 country teams represented; MCHIP part of follow-up visits to Kenya and Zambia	One regional GAPP/DD meeting in Rwanda: Diarrhea highlighted in country action plans MCHIP participate in ZTF	3 or more
Number of countries with revitalization of ORT and zinc introduction	Kenya, Mali and Zimbabwe	Guinea, potentially Zambia and Tanzania	13
	<i>DRC, Rwanda and Senegal</i>	<i>Kenya, Mali, Rwanda and Zimbabwe</i>	6

Note: Table includes field-funded country programs.

Immunization

OVERVIEW

Vaccination programs prevent approximately 4 million deaths each year, and about 20% of the remaining 7.7 million child deaths⁸ could be prevented through vaccines that are currently used—or are soon to be introduced—in developing countries, including new vaccines against pneumonia and diarrhea. USAID is a major financial player in immunization, providing considerable and increasing financial support to the GAVI Alliance (GAVI), which is used primarily for the procurement of vaccines, and to polio eradication efforts. USAID is a significant technical player as well. While disease control initiatives against polio, measles and tetanus attract sizable resources from the donor community, successful introduction of new vaccines (NUVI) and eradication of polio require more than commodities. The availability of new financial resources has exposed the relative lack of technical support being provided by partners to strengthen the capacity of Ministries of Health (MOHs) to develop and implement their routine immunization (RI) programs.

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. Centers for Disease Control and Prevention (CDC), GAVI, the BMGF, civil society organizations and others) and directly with USAID Missions and partners at the country level, MCHIP focuses on: 1) supporting the effective and sustainable introduction of affordable, safe, high-quality new and/or underutilized vaccines and innovative technologies; and 2) increasing sustainable immunization coverage with all appropriate vaccines to reach the unreached by strengthening routine immunization (RI), managing the cold chain and applying the RED approach and reducing child mortality from vaccine-preventable diseases, including polio. In our Program Year 4 activities, MCHIP continues the strong contributions that it has already made at global, regional and country levels during Program Years 1–3 and via IMMUNIZATIONbasics (IMMbasics) and earlier USAID global immunization projects (such as BASICS).

Introducing new and underutilized vaccines. MCHIP provides technical support to countries as they prepare for the introduction of new, lifesaving vaccines. This includes assisting them with introduction plans, applications to the GAVI Alliance, preparations for and the phasing of vaccine introduction, and monitoring and post-introduction evaluation.

Vaccines against a number of important public health problems have now been developed or have been improved. The new **pneumococcal conjugate vaccine (PCV)** and **rotavirus vaccine** provide an opportunity to impact global child morbidity and mortality due to acute respiratory infections and diarrheal disease. Widespread use of vaccines of regional importance, such as those against **meningococcal meningitis**, could further decrease disease burden in Africa.

⁸ Rajaratnam JK, Marcus JR, Flaxman AD, Wang H, Levin-Rector A, Dwyer L, Costa M, Lopez AD, Murray CJL. Neonatal, postneonatal, childhood, and under-5 mortality for 187 countries, 1970–2010: A systematic analysis of progress towards Millennium Development Goal 4. *The Lancet*, 5 June 2010 (Vol. 375, Issue 9730, Pages 1988–2008). Accessed 8/12/2011.

On February 15, 2011, USAID Administrator Rajiv Shah reaffirmed USAID's commitment to immunization. During his speech, he stated:

“The most transformative new breakthroughs we have at our disposal are in fact, vaccines. By expanding the coverage of existing vaccines and introducing new immunizations, we believe we can save the lives of 4 million children over just the next five years. To do this, we need to deliver pentavalent vaccines, combination immunizations against diphtheria, pertussis, tetanus, hepatitis B and Hib to the 60 percent of children born every year without access to those basic protective immunizations. We also need to dramatically expand the reach of new pneumonia vaccines. Every year, 1.5 million kids die in a manner that's directly attributed to pneumonia. If countries are successfully introducing a pneumococcal conjugate vaccine widely, they can save up to 500,000 of those lives every year. Similarly, a rotavirus vaccine that combats diarrhea could save 300,000 of the 1.5 million children who die every year from diarrheal diseases.”

As part of this effort to improve immunization and introduce new, lifesaving vaccines, the Administrator stated that we as an Agency will do the following:

“Each of our missions around the world will identify opportunities to improve cold chain and delivery systems. And we will support countries in developing aggressive new plans to introduce rotavirus, pneumococcus and meningococcus vaccines.”

In order to respond to the Administrator's call to introduce new vaccines and improve routine immunization, the Bureau for Global Health (GH) has reprogrammed funding in MCHIP to provide technical assistance to countries that are applying for or are introducing new and underutilized vaccines. MCHIP has already provided technical assistance to Benin, DRC, Kenya, Rwanda, Tanzania, Timor-Leste and Zimbabwe to apply for and introduce new vaccines. In Program Year 4, MCHIP will build on this work and continue to provide assistance to countries for new vaccine introduction. To ensure that USAID MCH priority countries are ready to incorporate new vaccines and that those with low or faltering immunization coverage are strengthened, MCHIP provides TA to the USAID MCH and GHI priority countries for: multi-agency EPI reviews and coverage surveys; comprehensive multi-year plans (cMYPs) and annual workplanning; 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; health systems strengthening; and preparation of GAVI applications and supporting documents (including cMYPs) for all types of funding, including funding for new vaccines.

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. MCHIP has already formed strong partnerships with Missions in Kenya, Malawi, Rwanda and Tanzania, and we are forging additional partnerships and making contributions in additional countries to further this work.

Global and Regional Partnerships

MCHIP provides continuing **global** technical leadership to numerous bodies and serves on several standing and *ad hoc* advisory panels, including: WHO's Immunization Program Advisory Committee; WHO on its *ad hoc* Advisory Committee on Gender and Immunization; 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/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; Institute of Medicine (IOM) on its Committee on Identifying and Prioritizing New Preventive Vaccines for Development; UNICEF on its Program Advisory Committee on maternal and neonatal tetanus elimination; and the global immunization community on planning for the Decade of Vaccines (DoV) Collaboration. At the **regional** level, the Program will continue providing support to WHO regional offices, with particular attention given to the Africa Regional Office (AFRO) on its strategic policy on reaching the un-reached children with immunization services, 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.

Polio Eradication. USAID is a key supporter of the Polio Eradication Initiative (PEI), particularly in communication and surveillance. In collaboration with MOHs, WHO, UNICEF, the BMGF, 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, (notably DRC and India) as well as Kenya (to prevent importations from Uganda and Sudan) and Nigeria (short-term technical assistance [STTA] to the Expert Review Committee and USAID-funded Targeted States High Impact [TSHIP] Project). More broadly, MCHIP also works 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. 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 communication materials, data collection and survey tools, and other communication-related documents. In addition, MCHIP and CI advise a multi-agency expert group (led by UNICEF), on refining and implementing a standard set of polio communication indicators that are being used and tracked 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 (organized by CI and published in the *Journal of Health Communication* in May 2010, with contributing authors from CI, MCHIP, USAID and other organizations/affiliations) was further disseminated and used to guide communication approaches and learning for PEI and countries. CI will continue to participate in multi-agency Polio Communication Reviews, which bring experts and field teams together to address technical gaps and needs in polio-affected countries. CI staff and consultants will also continue to participate as technical experts in country multi-agency polio Technical Advisory Group (TAG) panels, notably in Afghanistan and Pakistan. For program learning and global exchange, CI has upgraded its Web page on polio to further disseminate lessons learned from research and various meetings and consultations to targeted audiences of policymakers and polio communication implementers. CI is also working with CORE on a journal article to document their impact on polio eradication efforts and is planning a paper on communication, culture and the social determinants of health, based on the polio experience.

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 is working 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 links 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. Implementation will be intensified in Program Year 4 and documented, with support from MCHIP/HQ and CI.

Opportunities for Program Learning

Through MCHIP, USAID has an ally in marshaling and managing knowledge and disseminating experience that has been accumulated over many years of consistent USAID support for new vaccine introduction, RI and polio eradication. In addition to the documentation efforts mentioned above (e.g., experience in linking other interventions with RI, epidemiology of the unimmunized child, relation of gender and sex to immunization, etc.), capturing communications lessons of polio eradication, MCHIP proposes to assess how the World Bank, GAVI Alliance, Global Fund and WHO plan to provide donor support for health system strengthening through unified country plans, and how this process is working for immunization in the first two pilot countries with approved plans: Ethiopia and Nepal. In addition, MCHIP links with an innovative BMGF learning grant (ARISE, Africa Routine Immunization System Essentials), which 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. MCHIP will also work with the recently awarded WHO project, “Using Measles Activities to Strengthen Immunization and Surveillance,” to identify practical ways for countries to use activities focused on controlling or eliminating measles to strengthen immunization and surveillance systems for the mutual advantage of these efforts. Both of these learning grants are managed by JSI, MCHIP’s lead organization for child health and immunization. MCHIP will also explore approaches to advance equity in immunization globally, nationally and sub-nationally (e.g., develop a toolkit of qualitative measures plus some quantitative indicators, linked with RED). In addition, the project will examine what has been done and the potential for sustainably linking birth registration with routine immunization.

YEAR 4 ACTIVITIES/EXPECTED RESULTS

MCHIP will continue achievements from Years 1–3 to make progress in Year 4:

- Support the introduction of new vaccines by working with countries on national introduction plans and GAVI applications; enhance preparedness for smooth introduction of new vaccines by strengthening RI systems; build the capacity of health workers and managers; and monitor and evaluate the vaccine introduction process.
- Participate with USAID and partners in global/regional advocacy and planning to mobilize resources and coordinate technical support for implementation at the country level.
- Link with field support in selected countries to implement strategies (including RED) to reach unimmunized and partially immunized children with lifesaving vaccines in MCHIP priority countries to strengthen immunization systems.

- Strengthen use of communication data for targeting under-vaccinated children (in coordination with UNICEF and partners in polio priority countries); improve tracking of pregnant women and newborns to link polio with RI data and decision-making more effectively (notably in India, Kenya and Nigeria); compile and disseminate lessons learned; identify and help to address issues with integration.
- Continue working with WHO and partners to add selected MNCH/FP interventions to the existing RI platform; link RI and the Global Action Plan for Pneumonia and Diarrheal Disease (GAPP/DD) initiatives; and expand the RED approach to support multiple interventions. (This will include field-testing in Liberia and Kenya in the use of an adapted RED approach to improve coverage/continuity of some aspects of MNCH/FP.)
- Collaborate with learning grant activities supported by the BMGF and WHO to identify and document innovations and other successful approaches to RI strengthening.

Core-supported immunization activities are also included in other pathways and strategies, including country strategies for India, Kenya, Rwanda, and Zimbabwe—with expected expansion into Tanzania and Benin—as well as those focused on FP. 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, including a field-test in Liberia.

Table 5 (below) outlines expected results for immunization introduction and scale-up.

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

EXPECTED RESULTS		PROGRAM YEAR 1 (INC IMMBASICS) - PROGRAM YEAR 3	PROGRAM YEAR 4	LIFE OF PROGRAM— FY13
Analysis of immunization in high-burden countries	Expansion and improvement	<p>Analysis conducted</p> <p>Country summaries updated and used with USAID Missions</p> <p>Literature review on unvaccinated child</p>	<p>Country summaries updated and analysis disseminated with USAID, WHO and partners</p> <p>Analysis shared with partners at global and regional levels and applied in MCHIP countries (e.g., Kenya, Rwanda, Zimbabwe and others)</p>	All MCH priority countries

EXPECTED RESULTS		PROGRAM YEAR 1 (INC IMMBASICS) - PROGRAM YEAR 3	PROGRAM YEAR 4	LIFE OF PROGRAM— FY13
RI coverage increased by one year of age in areas receiving MCHIP TA. MCHIP technical input given related to new vaccine introduction (NUVI)	Introduction and expansion	<p>WHO guidance to national policymakers on immunization introduction</p> <p>Technical input provided to multiple global and regional NUVI policies and development of learning materials</p>	<p>Activities conducted jointly with USAID, WHO and UNICEF and TA provided to countries for NUVI preparedness (i.e., applications, cMYPs, intro plans), implementation and M&E (Benin, DRC, Kenya, Malawi, Rwanda, Senegal, Tanzania, Zimbabwe, etc.)</p> <p>Communication framework for pneumonia and diarrheal disease finalized and adapted, and utilized in countries (e.g., with UNICEF and partners in Ghana, Kenya and others)</p> <p>Countries supported (with WHO and UNICEF) to integrate NUVI with GAPP/DD initiatives</p>	7 or more key global and/or regional policies
New vaccines and innovative technologies introduced	Introduction and expansion	<p>DRC, Kenya and Rwanda (pneumococcal vaccine)</p> <p>DRC (penta vaccine)</p> <p>Drafted protocol for assessing Healthcare Waste Management (HCWM) pre and post new vaccine introduction</p>	<p>8–10 new vaccine introductions:</p> <ul style="list-style-type: none"> ▪ Senegal (MenA vaccine) ▪ Benin, Malawi, Tanzania, Zimbabwe, and DRC expansion (pneumococcal vaccine) ▪ Rwanda (rotavirus vaccine) 	6–7 countries 8–10 new vaccine introductions
RI planning and management capacity at district level improved	Expansion and improvement	<p>Two regional RED adaptation workshop conducted with WHO/AFRO</p> <p>DRC, India, Kenya, Nigeria, Rwanda, South Sudan (PY1)</p>	Continuation of RI system improvements in MCHIP-supported countries (e.g., India, Kenya, Rwanda, Tanzania, Zimbabwe)	
RED+ Selected MNCH/FP interventions added to RI and RED resources leveraged toward implementation of coordinated RI improvement plans in partnership with Missions	Action research/	<p>Literature review on integrated outreach</p> <p>Liberia selected with WHO/AFRO for RED+ design and testing</p>	Benin, India, Kenya, Kyrgyzstan, Rwanda, Tajikistan, Tanzania, Ukraine, and Zimbabwe,	3 countries

EXPECTED RESULTS		PROGRAM YEAR 1 (INC IMMBASICS) - PROGRAM YEAR 3	PROGRAM YEAR 4	LIFE OF PROGRAM— FY13
Resources leveraged toward implementation of coordinated RI improvement plans	Expansion	DRC, India, Kenya, Timor-Leste and Zimbabwe Madagascar, Nigeria, and S. Sudan (PY1)	India, Kenya, Malawi, Timor-Leste and Zimbabwe) and linkages with NUVI (Benin, Kenya, Malawi, Rwanda and Tanzania)	
Routine immunization and polio eradication strategies used to mutually strengthen each other	Introduction and expansion	DRC, India and Kenya (and STTA in Nigeria and through CI in Afghanistan and Pakistan)	India, Kenya, Kyrgyzstan and Tajikistan (and STTA in Nigeria and through CI in Afghanistan and Pakistan)	5–7 endemic and re-importation countries
			Process adapted and results monitored in implementing RED+ to strengthen other MNCH interventions (Kenya, Liberia, and Zimbabwe)	3 countries

Family Planning

OVERVIEW

Although the benefits of family planning (FP) are multi-dimensional—including individual, economic, social and environmental benefits—the focus of MCHIP FP team is on associated health benefits, and activities are framed here in that context. Through the systematic integration of FP with MNCH, MCHIP FP team’s activities in global leadership and program learning will facilitate expanded access to FP for MNCH clients around the world.

Relation to Pathways: MCHIP includes FP/MNCH integration as a key strategy for reducing maternal, infant and child morbidity and mortality. MCHIP contributes to various pathways either by preventing unintended pregnancies or by promoting healthy pregnancy spacing. Healthy spacing is defined as at least a 24-month birth-to-pregnancy interval for live births or a minimum interval of six months after an abortion or miscarriage. Table 6 (below) summarizes interactions with MCHIP pathways.

Table 6. 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"> ▪ Acute respiratory infection (ARI) ▪ Immunization ▪ Oral Rehydration Therapy 	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, preterm, small for gestational age Prevention of maternal death Protection of infant/child health and development

MCHIP STRATEGY FOR FP

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 (LAM) and other key messages, and providing immediate postpartum family methods such as postpartum IUD (PPIUD) and tubal ligation. The program will assess ways to increase the number of women who transition appropriately from LAM to another modern method, continuing the efforts of previous years and work done under the ACCESS-FP program.
- Ensure that FP counseling and commodities provision 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 who want 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
- Develop and apply community-based models for FP integrated within the MNCH continuum of care
- Identify successful and effective models of integration and bring them to scale

YEAR FOUR ACTIVITIES AND EXPECTED RESULTS

By December 2010, the FP team ensured a smooth and successful transition from ACCESS-FP to the MCHIP project. The FP team continues to operate based on existing program parameters and focuses on three key areas: global leadership, FP integration with MNH, and FP integration with infant and child health. Building upon progress made in Year Three, the emphasis of Year Four activities will expand from learning about integration to leveraging field resources.

Global Leadership

Promotion of Best Practices (core)

In Year Three, the FP team delivered a number of technical presentations at the USAID High Impact Practices (HIP) meetings, USAID FP-MNCH-Nutrition Integration Technical Consultation, Global Health Conference Integration Symposium and its annual conference. The team also completed an updated summary of new literature in PPF and FP/MNCH integration and participated in WHO/Reproductive Health and Research (RHR)'s plan of action to address PPF.

In Year Four, the FP team will continue to support a variety of global activities for best practices related to FP/MNCH integration initiated under ACCESS-FP and will continue to play an active role in the global FP community. Activities include:

- Two technical presentations and representation at selected international conferences, including the Global Health Council and the American Public Health Association (APHA). In addition, MCHIP will support staff participation at the FP Conference in Dakar in November 2011, pending acceptance. MCHIP expects that at least five presentations by MCHIP and/or partner staff will be featured in these venues.
- MCHIP staff will continue to participate in various technical working groups including those that focus on postabortion care and healthy timing and spacing of pregnancies. MCHIP staff will also take part in a PPF community of practice that will work toward implementing best practices and supporting use of long-acting and permanent FP methods, with an emphasis on mobile outreach.
- MCHIP has been working with WHO/RHR and USAID to lead an initiative to develop special practice guidelines in PPF that will complement existing WHO "cornerstone" FP tools. In the coming year, MCHIP staff will continue to support this process through finalizing the draft "call to action" and participating in the development of the draft guidelines.
- An annual literature review of PPF will also be undertaken, which will produce an updated annotated bibliography. This bibliography will be posted electronically and shared with the broader FP/MNCH community.
- MCHIP will update the postpartum intrauterine contraceptive device (PPIUD) technical brief developed under ACCESS-FP and incorporate the most recent evidence-based results and experiences encountered during scale-up.
- The PPF Web site, housed at Knowledge for Health (K4H), will be updated and maintained on a regular basis.
- MCHIP will participate in the development of an FP/MNCH integration toolkit, organized by K4H.
- MCHIP will support advocacy of USAID's HIPs and contribute to dissemination of best practices and lessons learned in the areas of PPF and FP/MNCH integration.

PPFP Community of Practice (core)

MCHIP will continue to support the PPFP community of practice, including maintaining and updating of the PPFP community of practice site housed under the WHO/Implementing Best Practices (IBP) site. The PPFP community of practice currently has over 900 members representing 77 countries. In Year Three, three online discussions on Maternal, Infant and Young Child Nutrition (MIYCN)/FP integration and immunization/FP integrated service delivery were held. Currently, MCHIP is preparing for the annual PPFP Technical Meeting (to be held in September), which will focus on sharing experiences about effective approaches for FP/MNCH integration. In Year Four, experts will present state-of-the-art information and experiences with PPFP programming through at least three online technical discussions as well as at the annual PPFP meeting.

FP/MNCH Integrated Country Profiles (field and core)

In Year Three, five FP/MNCH integrated profiles developed for Liberia, Kenya, Bangladesh—as well as for Uttarakhand and Bihar states in India—were produced. In Year Four, another five descriptive country profiles for FP during the first two years postpartum will be developed for key MCHIP countries through field support with HQ coordination and oversight. These profiles will build on the profiles developed in Year Three, demonstrating missed opportunities for integration of FP by making use of existing DHS data for women two years postpartum. These PPFP profiles highlight unmet FP need, short birth-to-birth intervals, timing of key factors related to fertility return, the relationship between FP use and maternal health care, as well as method mix. Upon completion, these profiles will be used for advocacy at the country level in Rwanda, Zimbabwe, Tanzania and two additional countries will be profiled.

Additional Analyses for Global Advocacy

MCHIP will carry out three analyses to support global advocacy of PPFP and FP/MNCH integration, including:

- Application of the LiST tool to include FP in order to provide a quantitative estimate of mortality averted through contraceptive use during the first two to three years postpartum.
- Secondary analysis of the Matlab data to explore linkages within HTSP.
- Systematic review and assessment of EmONC and postpartum tubal ligation (PPTL).

The above information will be used with policymakers at global and country levels to promote the integration of FP with MNCH.

Projected Key Results in Global Leadership:

- Five technical presentations for sharing best practices in FP/MNCH integration
- Presence on key technical working groups sharing best practices in FP/MNCH integration
- Up-to-date summary of new literature in PPFP and FP/MNCH integration
- Technical brief on best practices and lessons learned in PPIUD
- Updated Web site summarizing evidence and tools related to FP/MNCH integration
- Three online 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 country profiles for key MCHIP countries disseminated to USAID leadership and other partners
- 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

Integration with MNH

These activities are largely the continuation of activities initiated under ACCESS-FP. In Year Four, MCHIP will focus on results dissemination and completion of existing work to strengthen and inform programming for integration of FP and MNH within the global community. Technical assistance will also be provided to field programs in this area, such as integration of PAC and EmONC in Ghana, Guinea and Liberia.

Leadership in PPIUD (core and field)

In Year Three, in collaboration with the Government of India, MCHIP conducted a five-day PPIUD standardization workshop in Jaipur, India, to develop regional PPIUD training capacity. In addition, quality PPIUD services were implemented in four countries through MCHIP TA (Rwanda, Paraguay, India and Guinea). The PPIUD Study Tour that took place in India generated a pool of technical expertise in the field. MCHIP plans to follow up with the participants over the year to continue to standardize practices, encourage programmatic research and provide coaching/mentoring on an as-needed basis. MCHIP will also continue its overall leadership in assuring the quality of field implementation in clinical services, follow-up with clients, demand generation and relevant materials. Effort will also be put forward to support documentation and dissemination of results from operations research in Rwanda in collaboration with the Program Research for Strengthening Services (PROGRESS) Project. Finally, through the PPIUD working group, MCHIP will continue to lead the PPIUD community of practice that includes 13 organizations and 42 members representing nine countries. The global PPFPP community of practice provides a rich exchange of advocacy materials in the pre-implementation phase, programmatic experience and provider training materials for implementation as well as materials for evaluation of programmatic experience. Expected outcomes from the group include:

- Evidenced-based practices exchanged to develop consensus based on best practices
- Materials added to the PPFPP toolkit
- Materials from the IBP PPFPP community of practice working group included
- An evidence-based program model for PPIUD scale-up developed

Healthy Fertility Study (core and field)

In Year Three, results for 12 months and 18 months were collected, analyzed and disseminated, and a LAM barrier analysis article was submitted for publication. In Year Four, the study will continue to collect data at 24, 30, and 36 months postpartum. Notably, results on women's practices in the second year postpartum will be analyzed and a report finalized. Findings from the 24-month postpartum survey are expected to further elucidate learning on integration and its effect on fertility knowledge and practices, pregnancy spacing and adverse pregnancy outcomes. Results will be disseminated within Bangladesh and globally as indicated. At least one article will be prepared and submitted to a peer-reviewed journal.

Evaluating Strengthening FP in Postabortion and Postpartum care in Ghana (core)

In Ghana, MCHIP supported the Nurse Midwife Colleges to strengthen PPFPP in PSE in 13 schools and six clinical training facilities associated with these schools. PSE for postpartum and

postabortion FP was evaluated through a comparative analysis of graduate performance in Ghana. With the SBM-R approach, a 36% and 39% increase, respectively, in classroom and clinical training quality (as measured by achievement of performance standards) was recorded. In Year Three, MCHIP completed the design of the evaluation and submitted it to USAID for review and approval. The evaluation looks at the competency of tutors and preceptors in teaching/precepting PFP, student competency in PFP services, PFP services received by postpartum women and knowledge among postpartum women about healthy timing and spacing of pregnancies (HTSP), LAM and FP in general. The sample is drawn from three sites that were supported by MCHIP and three comparison sites that have not received MCHIP support; the sample includes tutors, preceptors, students and postpartum clients. In addition, MCHIP focused on site selection, development of survey tools and the approval process. In Year Four, MCHIP will submit a research proposal to the Institutional Review Board (IRB) for approval, and will subsequently gather and analyze data, and present the findings in international forums as well as submit a journal article for publication.

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

MCHIP will continue to provide technical assistance with a focus on learning about FP integration within an integrated facility and a community package of interventions. An integrated package design and a baseline assessment were completed and implemented in two districts in selected regions of Mali. A small-scale demonstration project was also initiated in Year Three to examine matrons' ability to provide implants. Core support will ensure TA for this activity and will support the existing program with additional TA.

Projected Key Results in Integration with MNH:

- An active PPIUD community of practice exchanging tools and experience and promoting the method as part of a menu of services
- Quality PPIUD services implemented in four countries through MCHIP technical assistance
- Operations research findings for PPIUD in Rwanda disseminated
- Healthy Fertility Study in Bangladesh: The 24-month postpartum survey results will be analyzed and disseminated; results are expected to further elucidate learning on effective integration.
- In Ghana, assessing PFP messages and services mothers received when seeking services for ANC, PNC and infant-care visits and how well midwifery students understand PFP; sharing findings and lessons learned
- In Mali, learning about implant provision by lower level facility staff

Integration with Infant and Child Health

MCHIP maintains its leadership in three technical working groups (MIYCN/FP, Immunization/FP and PPIUD), participates in various working groups (PAC, HTSP and long-acting/permanent methods [LA/PM] mobile outreach) and initiates field activities in several countries. Although progress is being made in Year Three, more needs to be done in this area, especially in field applications.

Leadership in MIYCN/FP Working Group (core)

MCHIP will continue co-hosting the MIYCN/FP working group on a quarterly basis with PATH. Although PATH hopes to continue its infant and young child nutrition work in the follow-on project "SPRING," which has a mandate for integration, it is not known which organization will work on SPRING. PATH feels that integrating FP with infant nutrition has already been

established and suggests that whichever organization works on the follow-on SPRING project should maintain the ongoing collaboration.

Planned results for Year Four:

- Draft a four-page advocacy brief based on the position paper;
- Establish a sub-working group for K4H toolkit startup;
- Continue to field test the MIYCN-FP concept in Kenya (MCHIP), Rwanda (PATH), Nigeria (Centre for Development and Population Activities [CEDPA]) and in other locations; the working group will provide a forum for shared learning;
- Plan and host quarterly working group meetings that represent both field and HQ work;
- Disseminate MIYCN-FP advocacy, bibliography and counseling materials during CORE spring/fall meetings.

Integrated MIYCN/FP Model Development in Kenya (core and field)

In Kenya, MCHIP conducted initial advocacy for infant nutrition and FP integration among national stakeholders, identified focus sites where an integration model will be piloted, conducted an assessment in focus facilities and worked with local partners to develop a model for integrated MIYCN and FP service delivery during Year Three. By September 2011, MCHIP also expects to have held a message and materials development workshop with stakeholders, conducted field testing of the messages and materials, and begun preparation for training of service providers. Starting October 2011, MCHIP will begin training service providers to use job aids and to deliver key messages and materials. Shortly thereafter, monitored implementation will begin. Mid-way through Year Four, an assessment will be conducted to assess preliminary outcomes of the activity, and to identify any refinements needed to improve and strengthen the model. Pending a review of the interim assessment results, MCHIP will meet with the Division of Reproductive Health, the Division of Nutrition and other national stakeholders to develop a scale-up plan for expansion of MIYCN/FP activities in Kenya.

Leadership in Immunization/FP Working Group (core)

MCHIP will continue co-hosting the FP/immunization working group with FHI. Planned results for Year Four are:

- Plan and co-host at least two working group meetings representing both field and HQ work
- Hold bi-monthly planning calls with FHI
- Update FP/immunization advocacy brief
- Update FP/immunization bibliography
- Continue collaboration with FHI to update an FP/immunization online map of field activities
- Disseminate the immunization/FP advocacy materials, bibliography and online map during CORE spring/fall meetings and through other venues
- Collaborate with working group members on the development of a guidance document on FP/immunization integration based on lessons learned from field experience

Integrated Immunization/FP Model Development (core)

In Year Three, MCHIP initiated field activities to demonstrate immunization and FP integration. An initial assessment visit was carried out in Liberia with the MCHIP immunization team. A

stakeholders meeting was held and a concept paper developed and shared. A review of possible messaging to support the integrated model was conducted with local stakeholders- Review by USAID/W and an application to the IRB are currently pending. In Year Four, the intervention will be evaluated and shared. Lessons learned will be widely applied.

Community-based Service Delivery: PPSS through Immunization/FP Model Development (core and field)

In Year Three, postpartum systematic screening (PPSS) was replicated in India through the Village Health Nutrition Days (VHNDs) platform in Jharkhand, India, with field support, including design and preparation for operations research. By September 2011, MCHIP expects to complete selection of implementation districts for intervention and control sites, site preparation and baseline data collection. In October 2011, MCHIP will begin implementation. Special emphasis will be given to reaching postpartum women effectively and assuring that FP methods of choice are delivered during VHNDs. By the end of Year Four, findings from operations research will be synthesized in preparation for journal publication, and programmatic learning will also be documented and shared with stakeholders at district, state, country and global levels. Additionally, MCHIP plans to apply this approach, based on lessons learned from India and Nigeria, to at least one other country, possibly Guinea.

Projected Key Results in Global Leadership:

- Active working groups (MIYCN/FP and immunization/FP) working toward objectives and program experience by sharing program tools
- In Ghana, PSE understanding of PFP among midwifery students and the effect that PFP services have on FP uptake among mothers of children less than one year old documented
- In Kenya, an effective model of MIYCN/FP integration developed and implemented with significant program learning documented
- In Liberia, an effective model of FP/immunization integration developed with lessons learned and results documented
- In India, PPSS effectively applied and documented by linking FP services at the community level through the existing immunization platform

MCHIP has been successful in leveraging field resources through the Mission's contribution to FP in a number of countries, including Bangladesh, Ghana, Guinea, India, Liberia and Mali. In Year Four, MCHIP will continue its advocacy and technical leadership role at the global level and will provide quality technical assistance at the field level in order to reach overarching goals by maximizing resources and transfer of learning.

Table 7 (next page) outlines expected family planning results.

Table 7. MCHIP Expected Results for Family Planning

EXPECTED RESULTS		PROGRAM YEARS 1–3	PROGRAM YEAR 4	LIFE OF PROGRAM—FISCAL YEAR 2013
Advocacy and promotion of best practices	Global Leadership	Participated in technical presentations and in technical working groups and national/international meetings and conferences; conducted annual literature review; updated technical briefs; maintained PFPF toolkit and Web site	Participate in technical presentations and in technical working groups and national/international meetings and conferences; conduct annual literature review; update technical briefs; maintain PFPF toolkit and Web site; participate in development of FP/MNCH integration toolkit; support advocacy of HIPs and disseminate best practices; participate and lead development of PFPF special practice guidelines with WHO and USAID	Disseminate best practices globally through conference presentations, technical working group participation; develop online resources, including toolkits; complete and disseminate WHO/RHR PFPF Special Practice Guidelines
Application of LIST tool to FP	Global Leadership	Conducted initial consultation and discussion with LIST	Establish model	Advocate with policymakers at global and country levels to promote the integration of FP with MNCH
Secondary analysis of Matlab data	Global Leadership	Not applicable (new activity)	Complete analysis and disseminate results through technical meetings, working groups and online discussions	Advocate with policymakers at global and country levels to promote PFPF, including benefits of HTSP
Systematic review and assessment of EmONC and PPTL integration	Global Leadership	Not applicable (new activity)	Based on findings from the systematic review and assessment, develop a concept note for implementation and support one country implementation (pending funding availability)	Disseminate lessons learned and advocate for programmatic efforts to expand PFPF options to include PPTL
PFPF Community of Practice	Global Leadership	Conducted three online technical discussions in Year Three	Conduct three online technical discussions	Conduct nine online technical discussions, which will result in knowledge sharing of best practices and lessons learned from a myriad of programs
FP/MNCH Integrated Country Profiles	Global Leadership	Produced five country profiles	Produce five country profiles	Complete 10 country profiles, which will be used for advocacy purposes to help inform policy at various governmental levels in MCHIP priority countries

EXPECTED RESULTS		PROGRAM YEARS 1-3	PROGRAM YEAR 4	LIFE OF PROGRAM— FISCAL YEAR 2013
Translation of PAC Curriculum	Global Leadership	Disseminated PAC curriculum to West Africa and other francophone countries	Translate into Russian and disseminate	Disseminate PAC curriculum to various regions and MCHIP priority countries in West Africa, Lusophone/LAC, and Eurasia
Technical leadership in PPIUD	Integration with Maternal and Newborn Health (SBA, PPH, Newborn health)	Established PPIUD working group; developed TA resources for PPIUD; conducted PPIUD data analysis in Paraguay	Lead PPIUD working group; develop TA regional capacity for PPIUD; disseminate PPIUD analysis results for Paraguay	Increase awareness and advocacy for PPIUD; develop TA regional capacity to facilitate South-to-South learning
PPIUD OR in Rwanda	Integration with Maternal and Newborn Health (SBA, PPH, newborn health)	Provided TA to PPIUD trainings, program initiation and monitoring through supportive supervision visits	Disseminate operations research findings	Disseminate OR findings to increase awareness of efficacy of PPIUD as a viable method of PPFP
Healthy Fertility Study in Bangladesh	Integration with Maternal and Newborn Health (SBA, PPH, newborn health)	Collected, analyzed and disseminated results for 12 months; collected, analyzed and disseminated results for 18 months; submitted LAM barrier analysis article for publication	Collect 24-, 30- and 36-month postpartum data; submit one article for publication in a peer-reviewed journal	Publish two articles in peer-reviewed journals; disseminate results of integration with a community-based MNH intervention
PSE on PPFP/PAFP for midwives (SBA)	Integration with Maternal and Newborn Health (SBA, PPH, newborn health)	Conducted PSE with PPFP assessment visit in Ghana; introduced PPFP to Ghana midwifery schools; evaluated the practices of graduates in Ghana	Collect and analyze data from PPFP PSE intervention; submit and present findings in international forums	Disseminate PSE results at international conferences
Integrated MNH/FP Package (SBA, PPH)	Integration with Maternal and Newborn Health (SBA, PPH, Newborn health)	With partners, developed integrated AMTSL ENC and PPFP; made assessment visit to Mali and developed program there for PPFP strengthening with MOH, partners and bilateral for a continuum of care at the home and health facility	Continue implementing integrated package with a focus on auxiliary midwives and CHWs	15 countries, field and core to implement MNH/FP package
MIYCN/FP and Immunization/FP working groups	Integration with Infant and Child Health	Conducted literature review; developed mission statement and advocacy document; conducted ongoing working group meetings	Conduct ongoing working group meetings; share experiences within global and field programs to promote FP/MNCH integration	Conduct ongoing working group meetings; share experiences within global and field programs to promote FP/MNCH integration

EXPECTED RESULTS		PROGRAM YEARS 1–3	PROGRAM YEAR 4	LIFE OF PROGRAM—FISCAL YEAR 2013
Model Development: MIYCN/FP in Kenya	Integration with Infant and Child Health	Conducted advocacy meetings with key stakeholders including the Ministry of Health. Developed and field-tested messages and materials.	Complete message development efforts; train providers; collect endline data in Kenya	Share results and lessons learned within working groups and the international community at various conferences; potentially scale up in similar settings
Model Development: immunization/FP in Liberia	Integration with Infant and Child Health	Conducted advocacy meetings, finalized message and materials, conducted BCC assessment, completed first round of provider trainings	Continue message development efforts; train vaccinators; collect endline data in Liberia	Share results and lessons learned within working groups and the international community at various conferences; potentially scale up in similar settings
Model Development: postpartum systematic screening at community-based service delivery in India	Integration with Infant and Child Health	Prepared for OR in India. Completed selection of implementation districts for intervention and control sites, site preparation and baseline data collection	Monitor implementation through ongoing supportive supervision; collect endline data, analyze data and share results in India	Share results and lessons learned within working groups and the international community at various conferences; potentially scale up in similar settings and apply the model in at least one country

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.

The recent *World Malaria Report 2010* highlights the tremendous progress achieved in malaria prevention and control. Between 2005 and 2009 the estimated number of malaria cases has decreased from 244 million to 225 million, respectively. The number of deaths due to malaria is estimated to have decreased from 985,000 to 781,000 between 2000 and 2009, respectively. In large part these successes have been driven by a) the global commitment to support malaria prevention and control programs, b) improved diagnostic capacities and technologies, and c) country level leadership to drive programming efforts. However, without continued commitment and support, country gains could slide back as has been seen in countries like Rwanda and Sao Tome (World Malaria Report, 2010).

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 morbidity and mortality by half in 17 target countries, as well

as USAID malaria countries, by reaching 70% of at-risk populations with proven and effective malaria prevention and treatment measures.

MCHIP STRATEGY FOR MALARIA

In Year 4, MCHIP will continue to apply successful approaches and innovative strategies that are flexible and pragmatic to integrate malaria prevention and control on the platform of MCH comprehensively at the global, regional and country levels. Because MCHIP addresses malaria prevention and control as a central component of MCH, the program's implementation strategy is naturally aligned with the strategic principles of PMI, including the GHI. For example, MCHIP recognizes that, as leaders in their communities, **women are central** to addressing malaria prevention (especially among pregnant women) and control. Also, MCHIP will **strategically integrate** malaria on an MCH platform through the promotion of long-lasting insecticide-treated nets (LLINs) and delivery of intermittent preventive treatment in pregnancy (IPTp) in the context of focused ANC and case management for children as well as pregnant women. Further, MCHIP aims to **coordinate** malaria program implementation and foster partnerships between National Malaria Control Programs and Reproductive Health Programs, Child Health Programs and HIV/AIDS programs (e.g., PMTCT and MIP) to contribute to accelerated implementation and effective integration among programs. This commitment and these principles of support will contribute to improving MCH outcomes, including reducing malaria morbidity and mortality in a holistic and sustainable fashion that lends to *'scaling up for impact.'*

At the **global level**, MCHIP will continue to provide technical leadership, in collaboration with the Roll Back Malaria (RBM) Partnership—including the President's Malaria Initiative (PMI), the Global Action Plan for Prevention and Control of Pneumonia (GAPP), World Health Organization (WHO) and UNICEF. This leadership will contribute to the synthesis and dissemination of best practices and lessons learned and lead to program learning among regional and country level stakeholders. At the **regional level**, MCHIP will focus efforts on dissemination of best practices and lessons learned in MIP and CCM programming to advance effective program learning and accelerate malaria programs. Notably, although dissemination has been a key component of MCHIP's malaria strategy since Year 1, the MCHIP Mid-Term Review specifically recommends more emphasis on program learning; these efforts directly contribute to that recommendation. Dissemination efforts will target country leaders including: Malaria Control Managers, Reproductive Health Managers, Community Health Managers, and Community Leaders. These efforts will not only lead to a wider and better understanding of 'what is working well' and 'what can be done better' in malaria programming but will also give country leaders the opportunity to apply this knowledge to their country MIP and/or iCCM programs. 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, delivering MIP services, and promoting the use of insecticide-treated nets (ITNs) on the platform of MCH services and programs. These efforts will contribute to implementation of 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 artemisinin combination therapy (ACT), and cooperation with indoor residual spraying (IRS) efforts. This will lead to improving communities' access to preventive services and treatment, and will 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 MCH platforms. In

Years 1, 2 and 3, MCHIP supported a number of efforts that set the stage for scale-up of malaria programming. Table 8 summarizes MCHIP's core-supported efforts in Years 1–3 as well as our expected results in Year 4 and over the life of the program.

YEAR 4 ACTIVITIES/EXPECTED RESULTS

Malaria in Pregnancy

Around 50 million pregnant women are exposed to malaria each year and up to 10,000 mothers and 200,000 infants die because they are infected with malaria during pregnancy. Malaria in pregnancy also contributes to high morbidity, 6-14% of low birth weight infants, 8-36% of preterm births, 13-70% of intrauterine growth retardation, 3-8% of infant death and 2-15% of maternal anemia. In particular, women in their first and second pregnancies are at increased risk. Non-immune pregnant women risk acute and severe clinical disease, which results in up to 60% fetal loss and over 10% maternal deaths, including 50% mortality for severe disease. Even semi-immune pregnant women with malaria infection risk severe anemia and impaired fetal growth, even if they show no signs of acute clinical disease. HIV-infected pregnant women are at increased risk. In areas of stable malaria transmission, MCHIP supports WHO's three-pronged approach, which includes: a) uptake of IPTp during ANC at least twice during pregnancy and following quickening, b) promotion and use of LLINs, and c) prompt diagnosis and treatment for malaria. Recognizing that the majority of pregnant women attend ANC once and often twice, ANC is an important and opportune setting to address MIP prevention services with comprehensive maternal care. MCHIP promotes and supports the delivery of MIP services on a platform of focused ANC to ensure comprehensive maternal care including malaria prevention.

As countries expand their MIP programs and work toward scale-up, critical lessons are learned, as well as best practices, that should be considered, adopted and applied based on the contextual needs of each country. There is concern that MIP programs have lost momentum. 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. MCHIP, in close collaboration with PMI, will build on the successful efforts in Program Years 1 through 3 including: a) global technical leadership supporting the RBM MIP working group and other global and regional networks, which has resulted in a comprehensive analysis and better understanding of MIP in low transmission settings and dissemination of best practices and lessons learned in MIP programming in stable transmission settings; b) documentation and dissemination of best practices and lessons learned in MIP programming in three high-performing countries: Malawi, Senegal and Zambia; and c) targeted country level technical support that includes Nigeria and Rwanda. In Year 4, MCHIP will support efforts that contribute to a) increased awareness at the global and regional levels regarding the key issues affecting MIP programming, and b) dissemination of best practices and lessons learned to expand program learning—especially among Reproductive Health and Malaria Control Managers as well as community leaders. MCHIP, through field support funding, continues to provide technical and programmatic guidance for the acceleration and scale-up of MIP in the following countries: Burkina Faso, Ghana, Mozambique and Rwanda. In Year 4, MCHIP anticipates expanding these efforts as well as supporting new country efforts in countries like Guinea and Zimbabwe. Further, MCHIP will work with our country teams to support efforts that will strengthen focused ANC services to ensure integration of malaria, when appropriate.

Controlling Childhood Illness through integrated Community Case Management

The vast majority of deaths related to malaria occur among children under five years of age, and most occur in sub-Saharan Africa. Approximately one in six child deaths in Africa is caused by 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, especially severe anemia and the risk of death. Recent reduction in child mortality in some sub-Saharan Africa countries is largely attributed to successful malaria program activities such as increased use of ITNs and access to more effective antimalarials. A number of countries are reporting reductions in parasitemia and anemia with an increase in the number of children accessing treatment within 24 hours of onset of fever.

MCHIP, as Secretariat for the global CCM Task Force, jointly led by WHO, UNICEF and USAID, will continue to be a leader for global advocacy, planning, coordination and resource mobilization for CCM by providing global technical support and continuing to engage CCM partners in driving expansion of CCM in countries. In Year 4, 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. Common bottlenecks affecting program effectiveness include weak supply chain systems that impede the availability of antimalarials. ITNs and rapid diagnostic tests (RDTs) where in use and declining performance standards in full scale programs. PMI, together with the new administration's GHI guidance to integrate MCH programs, provides unique opportunities for the USG to contribute substantially to the rapid expansion of iCCM globally.

MCHIP will share lessons learned from documentation of CCM in the Democratic Republic of the Congo (DRC) and Senegal. USAID is supporting a third evaluation in Malawi. MCHIP will work with others to do a synthesis of the three documentation exercises, and will identify common themes and innovations in each program. The findings will be shared at a global CCM meeting, such as GAPP and the CCMcentral.com Web site. 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 for introduction in newly identified countries. For program learning, MCHIP will work with iCCM programs in Mali and one other country to design and test a performance improvement system. The aim is to design and test an intervention in at least two countries to improve performance of CHWs in iCCM through better supervision and motivation of CHWs and to document innovations related to developing and implementing a performance improvement system for CHWs. The documentation will be shared with other countries implementing iCCM and facing challenges with maintaining performance standards when the program goes to scale. Other countries may be included after discussion with other CCM Task Force members.

Malaria Communities Program

The Malaria Communities Program (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. MCHIP provides administrative support—similar to that provided to USAID's CSHGP—to PMI's MCP at USAID, as well as to the 20 program grantees. To strengthen project design, implementation, monitoring and evaluation, MCHIP provides technical and programmatic guidance, resources, and ongoing advice.

MCHIP's five-year vision for MCP is that all grantees implement sound community-based (CB) malaria projects that contribute to the respective communities of practices (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 in 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. In Year 4, MCHIP will continue to build on the May 2011 Regional Workshop on MIP and CCM, further strengthening grantees' technical capacity and organizational sustainability, and providing opportunities to share and disseminate program experiences. Best practices and lessons learned will be shared among grantees through continuation of the MCP Google Group and listserv, and will be disseminated to a wider audience through Elluminate sessions and an MCP close-out event.

Support to the MCP Administration includes updating the workplan and reporting guidance, reviewing annual reports and workplans, 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.

Table 8. Summary of Core Activities and Expected Results

ACTIVITIES				YEAR 4 EXPECTED RESULTS	LIFE OF PROGRAM FISCAL YEAR 2013
PROGRAM YEAR 1	PROGRAM YEAR 2	PROGRAM YEAR 3	PROGRAM YEAR 4		
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 and programmatic participation in RBM MIP working group Co-chair RBM MIP working group Technical and programmatic participation in RBM Harmonization Working Group, East Africa Roll Back Malaria Network (EARN), World Antimalarial Resistance Network (WARN) and MIPc (Malaria in Pregnancy Consortium)	Technical guidance (e.g., best practices and lessons learned) disseminated at global, regional and country levels Contribution made to the prioritization of MIP research agenda Stronger linkages forged 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
PROGRAM LEARNING—DISSEMINATION OF BEST PRACTICES AND LESSONS LEARNED					
Documentation in Zambia started	Documentation in Zambia complete Senegal documentation started Desk Review—Malawi Dissemination at global and regional malaria and MCH conferences	Documentation in Malawi and Senegal complete Dissemination through MCP workshop as well as global and regional malaria and MCH conferences	Dissemination to key stakeholders (global and country) through: <ul style="list-style-type: none"> ▪ Summary Analysis Brief targeting Reproductive Health and Malaria Control Program Managers as well as donors, and MIP implementing partners. The brief will point out the main and cross-cutting findings of the three case studies, including how the information can be used to accelerate MIP programming. MCHIP will disseminate the brief through PMI country teams, country programs, the RBM MIP working group and the other regional networks such as EARN and WARN as well as technical working sites. ▪ Elluminate—MCHIP, in collaboration with the CORE Group, will develop an 	MIP programming reinvigorated at global, regional and country levels	Contribution to: Improved IPTp uptake Increased ITN use Early ANC attendance MDGs 4, 5 and 6

ACTIVITIES				YEAR 4 EXPECTED RESULTS	LIFE OF PROGRAM FISCAL YEAR 2013
PROGRAM YEAR 1	PROGRAM YEAR 2	PROGRAM YEAR 3	PROGRAM YEAR 4		
			<p>Illuminate session targeting key stakeholders (e.g., Reproductive Health and Malaria Control Managers as well as PMI Country Teams and Community Leaders) for MCHIP and PMI priority countries. By the end of the session, participants will have a better understanding of: a) best practices and lessons learned in MIP programming, b) ways to address bottlenecks in MIP programming, c) how to apply the “case study” framework to their own countries with the aim of accelerating scale-up.</p>		
SUPPORT COUNTRIES TO ACCELERATE AND SCALE UP MIP PROGRAMMING					
<p>Documentation exercise in Zambia mapped out stage of implementation.</p>	<p>Documentation exercise in Senegal mapped out stage of implementation.</p>	<p>Documentation exercise in Malawi mapped out stage of implementation.</p>	<p>Country teams participating in MIP working group will: a) review and map out stage of MIP implementation and b) define elements for scale-up.</p>	<p>MIP programming reinvigorated at global, regional and country levels</p>	<p>Contribution to: Improved IPTp uptake Increased ITN use Early ANC attendance MDGs 4, 5 and 6</p>
INTEGRATED COMMUNITY CASE MANAGEMENT					
GLOBAL TECHNICAL LEADERSHIP—CCM TASK FORCE SUPPORTED					
<p>CCM Task Force</p>	<p>CCM Task Force and CCM OR Group, worked on toolkit, indicators and matrix.</p>	<p>Participation in GAPP, iCCM and global Malaria forums</p> <p>Participation in dissemination workshops for toolkit and best practices</p>	<p>Co-lead global/regional advocacy and planning with USAID to mobilize resources and coordinate partner support for implementation of iCCM.</p>	<p>MCHIP and USAID leadership at global, regional and country levels is recognized and has contributed to planning and implementation of national-scale programs with a focus on DRC, Kenya, Mali, Rwanda, Senegal and Zambia</p>	<p>Contribute to MDG 4, improved stakeholder engagement among CCM Task Force, ccm.org and RBM East/West Networks</p>

ACTIVITIES				YEAR 4 EXPECTED RESULTS	LIFE OF PROGRAM FISCAL YEAR 2013
PROGRAM YEAR 1	PROGRAM YEAR 2	PROGRAM YEAR 3	PROGRAM YEAR 4		
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. Global dissemination in conjunction with toolkit	Write a short analytical report for advocacy and technical audiences synthesizing the CCM documentation in DRC and Senegal, related to CCM expansion. Report will identify broader lessons learned, best practices, common challenges and innovations to overcome these challenges. With partners, implement and test a performance improvement, including supervision and motivation, system for CCM in Mali and one other country.	Lessons learned, best practices and challenges of national scale CCM programs in DRC and Senegal shared with CCM countries at global/regional child health meetings and used in new country programs Approaches to building a performance improvement, including supervision systems documented and shared through child health regional meetings	Contribute to MDG 4, expanded evidence base for CCM implementation and scale-up, and increased country-level capacity for CCM in five countries

ACTIVITIES				YEAR 4 EXPECTED RESULTS	LIFE OF PROGRAM FISCAL YEAR 2013
PROGRAM YEAR 1	PROGRAM YEAR 2	PROGRAM YEAR 3	PROGRAM YEAR 4		
MALARIA COMMUNITIES PROGRAM—SUPPORT TO PMI/MCP TEAM					
<p>Report guidance updated</p> <p>Five annual reports and 13 workplans reviewed</p> <p>TA plans created</p> <p>Assistance provided with PMI annual report</p> <p>Organization of national workshop in Benin supported</p>	<p>Report guidance updated; final report guidance created</p> <p>Annual reports and workplans reviewed</p> <p>Six TA plans created</p>	<p>Update report guidance.</p> <p>Review 18 annual reports and workplans; 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 workplans.</p> <p>Prepare information for PMI annual report.</p> <p>Organize brown bag lunches (BBLs) following site visits.</p> <p>Organize and facilitate portfolio review meeting.</p>	<p>Update report and workplan guidance.</p> <p>Review 12 annual reports and workplans; review six 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 workplans.</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>Organize and facilitate MCP close-out event at Global Health Council (GHC).</p>	<p>Report and workplan guidance updated</p> <p>Twelve annual reports and workplans reviewed; six 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>MCP close-out satellite event held at GHC</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>

ACTIVITIES				YEAR 4 EXPECTED RESULTS	LIFE OF PROGRAM FISCAL YEAR 2013
PROGRAM YEAR 1	PROGRAM YEAR 2	PROGRAM YEAR 3	PROGRAM YEAR 4		
MALARIA COMMUNITIES PROGRAM—SUPPORT TO MCP GRANTEEES					
Ad hoc support provided to grantees	Regional training event facilitated	Organize and facilitate regional event.	Conduct site visits, as requested.	Site visits conducted	Strengthened NGO capacity to implement CB malaria prevention and treatment programs
Site visits conducted	Site visits conducted	Conduct site visits, as requested.	Conduct case studies of selected themes to document best practices and lessons learned.	Case studies conducted	
Regional workshop organized	Ad hoc TA provided	Assist grantees with documenting and disseminating lessons learned through report feedback and site visits.	Assist grantees with documenting and disseminating lessons learned through report feedback and site visits.	Assistance with documentation provided	Lessons learned about CB malaria programming documented and disseminated
Program design, monitoring and evaluation (PDME) curricula adapted	Illuminate sessions designed and delivered	Design and deliver Illuminate sessions.	Assist grantees with developing abstracts to submit to international conferences.	18 abstracts developed, selection submitted to international conferences	
Illuminate created and delivered	Information packaged, prepared and disseminated	Disseminate technical information, lessons learned and best practices.	Design and deliver Illuminate sessions.	Illuminate sessions delivered	
Information package for new grantees prepared and disseminated	Technical information disseminated	Provide ad hoc TA as requested.	Disseminate technical information, lessons learned and best practices.	Technical information disseminated	
RFA disseminated			Provide ad hoc TA as requested.	Ad hoc assistance provided	
			Up to six grantees supported in developing and delivering presentations for GHC close-out event	Six grantees supported to present at GHC MCP event	
				MCP close-out event held at Global Health Council 2012 meeting	

HIV⁹

OVERVIEW

MCHIP employs a multifaceted approach to HIV including scaling voluntary medical male circumcision (VMMC), supporting Kenyan efforts to improve PMTCT and supporting USAID's evaluation of a pilot project in Namibia, which intends to strengthen collection and use of data by communities to formulate plans to address community-owned response to identified problems focused on HIV.

MCHIP STRATEGY FOR HIV

MCHIP combines multiple strategies to address HIV, with support to scaling up VMMC the primary focus. VMMC stands to avert as many as one HIV infection for every four male circumcisions (MCs) performed,¹⁰ as well as to reduce the transmission of sexually transmitted infections (STIs) such as herpes simplex virus and human papillomavirus, an established precursor to cervical cancer.^{11,12} 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 reducing the 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 male circumcision, while promoting safe sexual behavior by circumcised men and their partners. MCHIP VMMC 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.

In addition to the focus on VMMC, MCHIP has supported PMTCT activities in Kenya, although that support will not continue into Program Year 4. MCHIP remains flexible to respond to requests by USAID such as the evaluation of the pilot project in Namibia.

OPPORTUNITIES FOR PROGRAM LEARNING

MCHIP will address key program learning questions related to scale-up of VMMC and initiation of early infant male circumcision (EIMC) activities. MCHIP will also evaluate the “centership” model being tested in Namibia, described in more detail below.

- MCHIP will develop a generic scale-up framework for VMMC programs for startup to maturity. MCHIP will also provide technical support to countries to facilitate their use in tracking progress during implementation.
- MCHIP will document the efforts of MCHIP countries, such as Tanzania and Lesotho, as they initiate EIMC activities that will contribute to generic guidance for initiation and scale-up of an EIMC program.

⁹ At the time of submission of this draft workplan, funding levels to support the work described in this section had not been confirmed. This section has been drafted based on assumptions outlined in the funding overview.

¹⁰ Futures Institute (2007). *Costing Male Circumcision in Swaziland and Implications for the Cost-Effectiveness of Circumcision as an HIV Intervention*. USAID Health Policy Initiative.

¹¹ Tobian AA et al. (2009). Male circumcision for the prevention of HSV-2 and HPV infections and syphilis. *NEJM*.

¹² 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*.

- MCHIP will conduct desk review and documentation of EIMC in health system.
- MCHIP will evaluate the “centership” model being tested in Namibia to gain a better understanding of whether the intervention translates into improvements in outputs and outcomes as a function of various inputs of the intervention.

YEAR 4 ACTIVITIES/EXPECTED RESULTS

Developing, Updating and Disseminating Resources to Support the Accelerated Scale-up of VMMC

In PY3, MCHIP worked in close collaboration with WHO to conduct a regional consultation on traditional circumcision; the meeting report is available here: http://www.malecircumcision.org/publications/documents/TMC_in_the_context_of_HIV_prevention.pdf. We also developed several global resources to support adult and adolescent VMMC scale-up efforts. New products include an e-Learning course developed for the Global Health E-learning platform, titled Male Circumcision: Policy and Programming, which is available at <http://www.globalhealthlearning.org/login.cfm>. The target audience of this E-learning course includes PEPFAR staff working on HIV prevention as well as Ministry of Health and implementing partner colleagues who work on VMMC programs.

Three other products will be finalized by the end of PY3 on 30 September 2011. These include:

1. A video developed in collaboration with CHAPS colleagues in Orange Farm, South Africa, which illustrates implementation of MOVE principles in a number of settings in the region.
2. An update to the global VMMC training package, which supports the *Male Circumcision under Local Anaesthesia* reference manual. The revised training package covers MOVE principles including diathermy.
3. An Early Infant MC (EIMC) training package was developed using core funds and piloted in Swaziland using field funds. Final changes to the training package based on the pilot in Swaziland are being input now.

In PY4, MCHIP will play an advocacy and knowledge sharing role to help USAID and the PEPFAR VMMC Technical Working Group support the scale-up of VMMC as an HIV prevention measure. Planned activities include:

1. Dissemination of service delivery experiences to date during a satellite session held at the International AIDS Society (IAS) 2012 International AIDS Conference in Washington, D.C.
2. Contributing to a journal supplement focused on VMMC service delivery lessons learned.

In order to assist countries plan their VMMC programs, MCHIP will:

1. Develop a generic VMMC Operational Guide that will assist countries as VMMC programs move from initiation to maturity.
2. Provide technical assistance in roll-out and scale-up of VMMC services in southern and eastern Africa.

MCHIP will continue development and dissemination of global VMMC materials. These include:

1. Updating the draft male circumcision counseling manual developed by PSI, and working with WHO to make it an official consensus document.

2. In collaboration with WHO, updating *Male Circumcision under Local Anaesthesia* and its associated training materials. The reference manual was originally published in 2008 and needs to be updated to reflect new service delivery approaches such as MOVE.

MCHIP will also provide technical assistance to selected countries in East and Southern Africa. Using qualified staff based in the region, and working in close collaboration with the PEPFAR VMMC TWG, MCHIP will provide support to countries at a strategic and operational level as they move to scale up MC activities. In select cases, MCHIP could use core funds to support operational aspects of programming, such as planning and implementing MC campaigns, but MCHIP will encourage use of field funds to support these operational assistance visits.

Supporting the Introduction of Early Infant Male Circumcision as a Long-Term, Sustainable HIV Prevention Strategy

In the ESA region, most programs focus 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 early infant male circumcision (EIMC) as an HIV prevention intervention that offers long-term sustainability. In contrast to adult and adolescent MC, EIMC results in fewer adverse events, reduced cost per procedure, 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 the wound has healed. In Year 3, using a combination of core and Swazi field funds, MCHIP developed and pilot tested a global EIMC training package. In Y4, MCHIP will explore the use of field and core funds to support the following:

1. Develop an EIMC e-Learning course for the Global Health E-learning Web Site.
2. Develop and field test an EIMC adverse events grading and management guide.

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.

OHA—Evaluation of Centership Model

In MCHIP Year 2, the USAID Office of HIV AIDS (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 asked 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 and 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 information technology 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 asked 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 3, MCHIP activities were limited because of changes for the vision for the centership in-country, and delays in startup and initiation of the model. After several field visits to Namibia from the MSH team in April and June 2011, MCHIP was requested to scale-back its original approach to the evaluation and to support some of the initial startup costs for the centership. As a result, the evaluation will be carried out using a “case study” approach, through two visits from MCHIP representatives between October 2011 and July 2012.

Table 9 (below) outlines expected results for HIV activities.

Table 9. MCHIP Expected Results for HIV

ACTIVITIES				YEAR 4 EXPECTED RESULTS	LIFE OF PROGRAM FISCAL YEAR 2013
PROGRAM YEAR 1	PROGRAM YEAR 2	PROGRAM YEAR 3	PROGRAM YEAR 4		
HIV					
VOLUNTARY MEDICAL MALE CIRCUMCISION					
	Traditional MC meeting held in April 2010	e-Learning course online in February 2011	VMMC scale-up	MOVE disseminated	VMMC programs using international guidelines and using efficiency principles operating effectively in East and Southern Africa
	Revised global training package to include MOVE in June 2010	MOVE video in final stages of editing and review	Document and share program performance	Generic Framework for VMMC scale up developed and applied in selected MCHIP countries	
	Study tour to Swaziland by four Kenyan MOH staff	TA provided to South Africa to support development of standard operating procedures and scale-up of VMMC programming	Quality of key technical learning resource packages	Draft male circumcision counseling manual developed	Generic materials available to all countries implementing a VMMC program
	Supported participants to international conference in Durban in September 2011			Adult and adolescent male circumcision under local anesthesia training package updated	
	Organized VMMC Volunteer Doctor Program in Swaziland	Supported staffing of three long-term doctors and 13 nurses placed in public health			
	Between April and				

ACTIVITIES				YEAR 4 EXPECTED RESULTS	LIFE OF PROGRAM FISCAL YEAR 2013
PROGRAM YEAR 1	PROGRAM YEAR 2	PROGRAM YEAR 3	PROGRAM YEAR 4		
	<p>September 2010, 24 VMMC volunteers served in Swaziland in public, Mission and NGO service delivery sites</p> <p>MCHIP staffed 14 MC teams in 13 MC service delivery points in Swaziland during September 2010 Back to School Campaign (BTS) The BTS campaign performed 7,165 MCs in three weeks, achieving 110% of the BTS MC target</p>	<p>facilities in Swaziland</p> <p>VMMC volunteer doctor program continued; to date these volunteer doctors performed 1,442 VMMCs</p>			

ACTIVITIES				YEAR 4 EXPECTED RESULTS	LIFE OF PROGRAM FISCAL YEAR 2013
PROGRAM YEAR 1	PROGRAM YEAR 2	PROGRAM YEAR 3	PROGRAM YEAR 4		
EARLY INFANT MALE CIRCUMCISION					
		Finalized EIMC training package – pilot testing done in Swaziland with field funds	Introduction EIMC	EIMC eLearning course developed EIMC adverse events grading and management guide drafted EIMC programming efforts documented Draft EIMC Implementation and integration guide developed	Generic EIMC materials available to all countries initiating an EIMC program
EVALUATION OF CENTERSHIP MODEL					
			Technical Support to Evaluation of Centership Pilots in two communities in Namibia	Community-based information system and community development initiative established in two communities in Namibia Clear case study evaluation design and methodology agreed to by all partners Case studies developed for each community	

Integration of Water, Sanitation and Hygiene (WASH) with MNCH

MCHIP recognizes the key role WASH interventions play in contributing to MNCH outcomes. Considering reduced directed funding for WASH in PY4, MCHIP will continue to support specific USAID priorities in newborn and child health namely: assessing the efficacy of a point-of-use water product, Aquatabs™, to prevent diarrheal disease in India and improved birth attendance and maternal hand washing to improve neonatal survival rates. The former is outlined in more detail in the newborn health section, the latter is included in the child health technical section and associated activities are included in Attachment 1: MCHIP Year 4 Core Activity Matrix (Activities 3.2.7 and 4.1.4).

Urban Health

OVERVIEW

Over the past six decades, the world's urban population has grown nearly five-fold, from 0.74 billion in 1950 to about 3.3 billion in 2008. As a result, cities are now home to more than half of the world's population and according to the United Nations, more than 90 percent of future urban population growth will be in developing countries.

Over the next two decades, GHI countries are likely to see, for the first time, the majority of their children living in cities—a turning point that the world population reached in 2007. Africa's urban population alone is expected to double from 294 million in 2007 to 742 million in 2030¹³. Meanwhile, with the exception of a limited number of countries, the design of most government MNCH programs remains strongly biased toward addressing the specific MNCH challenges of rural populations.

MCHIP STRATEGY FOR URBAN HEALTH

Given the limited resources available, MCHIP needs to look for strategic opportunities to influence urban MNCH programming. **Ethiopia** presents an important opportunity to understand and address urban challenges more effectively, given the Government of Ethiopia's (GOE) leadership in establishing an Urban Health Extension Program (UHEP) throughout the country to improve access to and demand for health services. MCHIP will work in close collaboration with USAID's bilaterally funded Urban Health Extension Program (USAID/UHEP) to support the development of urban health leaders in Ethiopia and to design and test innovative program approaches that can improve the quality and/or utilization of evidence-based MNCH services in urban and peri-urban areas. Complementary to these efforts is finalizing and disseminating the findings of a literature review of sociocultural barriers to maternal health service utilization among Ethiopian women. The literature review searched published and unpublished works to identify gaps in the current research and literature on sociocultural barriers to care seeking in urban, peri-urban and rural areas. Although some research gaps exist, MCHIP will need to determine the added-value of conducting further study to look at cultural barriers in an urban setting. A more strategic opportunity may lie in taking the findings to date and identifying ways to integrate them into efforts to increase facility utilization (e.g., ensuring women-centered care and changing care providers' behaviors toward women who wish to adopt non-harmful birthing practices). This will be linked to the work that MCHIP Ethiopia is doing in the mostly rural settings as well as in the regional-level hospitals.

In **Kenya**, MCHIP will conduct an assessment in the three slum areas of Nairobi, which will serve to facilitate a community-/clinic-led intervention to improve access to quality maternity care services in urban settings.

YEAR 4 ACTIVITIES/EXPECTED RESULTS

- **Link Ethiopia's key UHEP stakeholders to the broader urban health professional communities of practice and create opportunities for sharing implementation experiences.** 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 and 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

¹³ United Nations Population Fund 2007

urban populations. To further this objective, MCHIP will organize a study tour/experience-sharing visit to India—one of the most urbanized countries in the developing world—for Ethiopian leaders and managers in the urban health sector (from the Federal Ministry of Health (FMOH), Regional Health Bureau (RHB) and USAID/UHEP) to understand more clearly the unique challenges posed by working with urban populations. This tour has already been fully planned; it was expected to occur in PY3, but had to be rescheduled to the first quarter of Y4. Further, MCHIP will support an Ethiopian delegation to attend the international urban health conference in Brazil (November 2011), and conduct a follow-up workshop for the Urban Health Champions group upon the delegation’s return to Ethiopia. Membership and active participation in the International Society of Urban Health will also be encouraged.

- **Design and test innovative program approaches to improve the quality and/or utilization of evidence-based MNCH services in Ethiopia’s urban and peri-urban areas.** Building upon the program learning from the India study tour and Brazil conference, as well as the Ethiopia-specific literature review, MCHIP will work with these Urban Health Champions and urban health extension professionals at community and health center levels to design and test a set of urban approaches that, if successful, could be replicated and taken to scale. Because funding for this work is limited, program innovations will be on a small scale and will be carried out in sites where USAID/UHEP or other partners are already working and can assist with implementation. We anticipate that the USAID/UHEP team will work closely with the field-funded MCHIP/Ethiopia technical team and that MCHIP/Ethiopia will provide both technical input and oversight for the proposed urban activities. The innovation(s) will be focused and simple enough to produce short-term results at low cost. Based on known barriers to use in urban areas, some of the possible innovations to be tested include: making transport vouchers available to the urban poor; providing non-financial incentives to mothers who deliver at the health facility; increasing the involvement of *kebele* (neighborhood) health committees in demand generation and problem-solving; identifying ways of making MNCH services more culturally acceptable to the urban poor; engaging private sector providers to improve the continuum of MNCH care available to the urban poor, etc.
- **Facilitate a community-/clinic-led intervention to improve access to quality maternity care services in urban settings.** MCHIP will work in selected areas of Nairobi’s three urban slums and conduct a rapid assessment/situation analysis in order to facilitate the C-CLIP process. MCHIP will work with the clinics and communities to provide refresher training for nurse-midwives, conduct updates for CHWs, work to improve community/clinic linkages, ensure availability of supplies and strengthen Young Mothers Clubs. A final evaluation/documentation and lessons learned will be written for future replication.

AFRICA BUREAU

MCHIP greatly values the opportunity to work with the regional bureaus alongside the Global Health (GH) bureau. Many efforts in this workplan are co-funded with GH and regional bureau funding to achieve greater impact.

MATERNAL HEALTH

Development of EONC Champions in Africa for Advocacy and Training

MCHIP will partner with WHO/AFRO and other collaborators to develop regional experts in EONC using the EONC Resource Kit. The Resource Kit, currently under development, will be created through extensive consultation with WHO/AFRO in order to ensure that it meets their needs. It includes tools and materials in maternal health policy, service delivery guidelines, quality improvement approaches and clinical training materials.

With the goal of developing champions with expertise in the use of and advocacy for EONC, MCHIP will develop the toolkit and ensure that a collection of champions is able to use the toolkit in their roles as trainers, advocates and leaders for maternal and newborn health. MCHIP will build a coalition of partners to work together on the expert development process, including WHO/AFRO, UNFPA, FIGO, ICM, and potentially Canadian CIDA and French Cooperation. MCHIP will lead a process by which a cohort of midwives and physicians from six Francophone and six Anglophone countries (12 in total) will be identified and guided through a series of three workshops (the series will be separate for the six Francophone and the six Anglophone countries) to develop champions with expertise in use of and advocacy for EONC. This is similar to the hugely successful process that the Maternal and Neonatal Health Program did in 2000 and 2001, which helped advance key individuals in Africa into positions of leadership. The selected participants will typically be mid-career, clinically practicing individuals who commit to full participation in a series of workshops on clinical updates and skills standardization, training and education capacity building, and advocacy and change management. Keeping the same cohort of participants throughout will foster relationships within a regional network of experts. MCHIP will provide leadership mentoring throughout the process and help to engage these individuals in project activities in the region.

Strengthening Midwifery Capacity through Enhanced Systems for Continuing Professional Development (CPD)

Strengthening health professional capacity requires attention to both the teaching of evidence-based best practices and the maintenance of competence within the existing workforce. The African Health Professionals Collaborative for Nurses and Midwives (ARC) is a group of midwifery and nursing leaders from the ECSA countries that is focusing on addressing country-identified regulation gaps through a small grants program. Collaborators include the CDC, Emory University's Lillian Carter Center for International Nursing, Commonwealth and ECSA Community, with UNFPA, West Africa Health Organization and ICM participation in development of the project. This consortium has been working on enhancing regulatory mechanisms for nursing and midwifery in Africa. The participants in this process have identified Continuing Professional Development (CPD) as an area of need that fits with MCHIP expertise in clinical training and programming. MCHIP will develop a set of two to four modules (or modify existing modules) on clinical topics and will provide orientation to the content of the modules as well as guidance on structuring of the CPD offering, including assessment/evaluation of learning, methods of implementation and evaluation of modules. The experience of how midwifery professionals access these modules will guide the development of recommendations for continuing education systems in the African context. Successes and lessons learned will be used to inform scale-up of CPD work across the region and to other areas.

MCHIP Expected Results for Maternal Health —Africa

- Africa Champions Toolkit developed
- 36 technical experts and champions updated on knowledge and skills in maternal/newborn health interventions and prepared to implement key interventions for impact
- 36 technical experts oriented to quality improvement and change management initiatives
- 36 technical experts initiating transformative projects in their places of work
- 36 technical experts updated on their skills in training, teaching and advocacy
- Participants in the African Health Profession Regulatory Collaborative (ARC) oriented to using modular continuing education packages in the development of Continuing Professional Development (CPD) structure

- Facilitate evaluation of frameworks for adaptation of targeted materials (e.g., PPH reduction, AMSTL, pre-eclampsia/eclampsia diagnosis) into existing or newly developed CPD systems
- At least three modules related to maternal/newborn health interventions for impact adopted for nursing/midwifery CPD

NEWBORN HEALTH

Using Africa Bureau and field funds in Year 3, MCHIP initiated **management of newborn sepsis in northern Nigeria** in partnership with the Nigeria Society of Neonatal Medicine (NISONM). These activities will be completed in Year 3 and MCHIP will use core/Africa Bureau funds in Year 4 to document and disseminate key lessons from the program.

MCHIP continued its active participation in a **TWG on newborn sepsis management** in Year 3. TWG global membership also includes USAID, SNL and JHU-IIP. The group is working to define a strategy for the introduction and expansion of community-based infection management of newborn sepsis. MCHIP's participation will continue in Year 4, with support of core/Africa Bureau funds. In Year 3 the TWG assigned an MCHIP intern to map newborn sepsis management at the community level in sub-Saharan Africa and Southeast Asia. This activity was suspended when MCHIP learned of UNICEF's CCM survey. Results (expected by end of Year 3) will determine whether and how MCHIP will move forward with its own newborn sepsis mapping exercise in Year 4. One planned TWG output in Year 4 will be a Newborn Sepsis Management Implementation Guide.

In Year 4, Africa/Sustainable Development (SD) funds will be used to support the improvement of **neonatal resuscitation in pre-service training** in Malawi, Tanzania and Kenya, in collaboration with RCQHC and ECSACON. MCHIP, together with Africa 2010, RCQHC and ECSACON, has developed a program to assess, review and revise curricula, develop teaching aids, strengthen clinical sites, and train tutors and preceptors. These activities are part of a regional effort to improve pre-service training, which will also be supported by Laerdal, USAID/East Africa and the successor to Africa's Health in 2010. Given Jhpiego and the MCHIP maternal health team's significant work on strengthening pre-service education in some of these same countries, the MCHIP newborn health team will share results of the assessments with them for feedback, as appropriate. And wherever MCHIP supports ENC or HBB/resuscitation activities in Year 4, MCHIP will seek to strengthen—and actively reinforce to all partners and MOH counterparts the critical importance of—the **integration** of HBB/resuscitation with ENC programs.

Africa/SD funds will support the following program learning activities in Year 4:

- In Nigeria, document key lessons from the **newborn sepsis management** program. *Cross-cutting themes addressed: community, equity.*
- Assess **pre-service integration of newborn resuscitation/HBB within ENC** in three MCHIP and ECSACON countries to inform regional curriculum development. *Cross-cutting themes addressed: integration, quality of care, scale-up.*

Table 10. MCHIP Expected Results for Newborn Health—Africa

EXPECTED RESULTS	KEY TASKS YEAR 1–3	KEY TASKS YEAR 4
Pre-service and in-service Neonatal resuscitation and essential newborn care strengthened in selected countries	<ol style="list-style-type: none"> 1. Initiated collaboration with RCQHC, ECSA-CON and Africa Health in 2010 2. Provided update on essential newborn care and oriented over 300 members of ECSA-CON on HBB training materials 3. Co-fund the training of 116 nurses and doctors from over 20 Sub-Saharan Africa countries as HBB trainers and supplied each with a set of HBB training materials. These trainers have initiated HBB training, in the process of doing so, in their countries in particular Nigeria, Ghana, Malawi, Rwanda, Mozambique, Zimbabwe, and Liberia. Most with field funds. 4. Trained 20 tutors from 17 pre-service midwifery institutions in Ghana 	<ol style="list-style-type: none"> 1. Continue to provide technical and/or financial support for pre-service work in Kenya, Malawi, Tanzania (RCQHC), Ghana and Mali (in-service training only)
Management of newborn sepsis improved in peripheral facilities in at least one Africa country	<ol style="list-style-type: none"> 1. In collaboration with Nigeria FMOH, PRIMNCH, UNICEF and Nigeria Society of Neonatal Medicine initiated activities to improve neonatal sepsis management in selected Primary health Care Centers in Katsina, Kano and Zamfara 2. Established a Technical Working Group on newborn sepsis management to assist in providing guidance on scaling-up community-based newborn sepsis management 3. In collaboration with SNL supporting the development of an implementation guide for improving newborn sepsis management based on existing research and program experience 	<ol style="list-style-type: none"> 1. Document and share the sepsis management experience in Nigeria 2. Complete and disseminate the newborn sepsis implementation guide to facilitate dialogue and action to improve newborn sepsis management at peripheral health facilities and the community

IMMUNIZATION

MCHIP works to strengthen immunization services in the Africa region and sub-regions (in close collaboration with WHO/AFRO, UNICEF/West and Central Africa Regional Office (CARO) and Eastern and Southern Africa Regional Office (SARO), USAID Missions, and other partners), including the use of RED and RED-like approaches at the country level to address operational gaps and increase coverage in areas of low performance. The application of Africa SD funds is closely linked with MCHIP global funds and Mission field support to finance MCHIP immunization technical assistance throughout Africa, in the focus countries, and linkages with global and regional initiatives. Table 11 (below) highlights the immunization results and activities planned in the Africa region and MCHIP for Program Year 4 (summarized from the Immunization Workplan).

Table 11. MCHIP Expected Results for Immunization—Africa

EXPECTED RESULTS 1 OCTOBER 2011– 30 SEPTEMBER 2012	KEY TASKS – PROGRAM YEAR 4
<ul style="list-style-type: none"> ▪ MCHIP technical support provided to Missions and with the Africa Bureau to strengthen immunization programs in focus countries and link with global/regional initiatives ▪ Technical and financial support provided/leveraged in at least three countries to expand RED and similar RED-like approaches to address low coverage and under-performance by targeting the unreached <p>Multi-party external EPI program reviews and/or country planning exercises completed with MCHIP input in three or four countries</p>	<ol style="list-style-type: none"> 1. Participate in immunization partnership teleconferences and meetings (e.g., Africa Regional Conference on Immunization [ARCI], WHO EPI Managers Meetings, GAVI Subregional working groups, AFRO/Africa Bureau collaboration) 2. Work with USAID to provide immunization updates and send advocacy packets to Missions and partners in selected high-burden and/or low-performing priority countries. 3. Couple field support and Africa Bureau funding for innovation, advocacy, leveraging and expansion of proven approaches, including RED and other RED-like approaches (e.g., DRC, Kenya, Zimbabwe). 4. Conduct joint missions with USAID, WHO and/or UNICEF for immunization activities in two or three countries. 5. Provide TA to African countries (e.g., DRC, Kenya, Tanzania, Zimbabwe, Benin, etc.) to address low coverage and under-performance. This may include technical support for rapid assessments; coverage surveys; multi-agency EPI reviews; rapid cold chain, vaccine management assessments; immunization program and data quality assessments; comprehensive multi-year planning; NUVI preparation and implementation; and annual work planning.

CHILD HEALTH

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

Support to the global effort to develop and test tools and procedures to scale-up and monitor iCCM programs while helping countries to adopt them.

As secretariat for the CCM Task-Force, MCHIP will ensure that the agenda is moving forward as planned. Global tools coupled with lessons learned and experiences from Senegal and DRC will be broadly shared and used to develop approaches to expanding quality iCCM. MCHIP will carry out mapping of country use of CCM benchmarks in target countries and develop scale-up maps, and build on progress to continue monitoring and strengthening nationally led child health programming, with focus on **Mali, Rwanda Senegal and possibly DRC**. MCHIP will participate in the last of three Africa regional GAPP/CCM meetings in Rwanda in October 2011. MCHIP will also continue providing global technical support, and co-lead global meetings for advocacy and follow-up of selected countries (Zambia and Mali), after the regional child health meetings to track progress and advocate inclusion of activities in national health plans and allocation of national resources to iCCM expansion.

Testing the use of mHealth as a tool in iCCM programs to improve stock management.

mHealth applied to improve stock management in CCM programs and lessons shared with other CCM programs. MCHIP will pilot the use of mobile technology (from community, to facility, to district, to regional, to central levels) to improve stock management and overcome bottlenecks—test in **Mali** and **possibly Kenya**. MCHIP will also with other players involved in mHealth such as mHealth Alliance, UNICEF and USAID/Deliver Project and Supply Chain for CCM (SC4CCM) to learn how they are using mHealth in different settings; document and share experiences.

Design, implement, document and share approaches to performance improvement.

MCHIP will work with Global CCM Task Force members to design, implement and document innovations related to developing and implementing a performance improvement system for CHWs in Mali. Other countries will be included after discussion with other CCM Task Force members.

Support and advocacy for increased attention to control of diarrheal disease (CDD).

MCHIP will strengthen its role with global partners in advocacy and technical leadership on CDD. MCHIP will work with the CCM and Zinc Task-Forces to advocate for renewed efforts on CDD control and to develop strategies and tools (scale-up maps for ORT and zinc) to help countries advance CDD in iCCM programs and facility based services. Resources will also be used to support integrating CDD messages and prevention activities into immunization programs where the rotavirus vaccine is being introduced (e.g. in Rwanda, Tanzania and possibly Zimbabwe). In addition, MCHIP will document and disseminate best practices in ORT/Zinc revitalization efforts from DRC, Kenya and Zimbabwe.

Expected Results

- At least two countries supported to map out the process and use of benchmarks in CCM introduction and experience used by the global CCM Task Force to refine the benchmarks and develop scale-up maps to guide and monitor expansion of programs.
- Kenya, Zambia and Mali supported to finalize and implement the post-GAPP/CCM meeting draft action plans including incorporating medium- and long-term activities in national multi-partner health plans as appropriate.
- mHealth applied to improve stock management in CCM program in Mali and lessons shared with other CCM programs.
- Design, implement, document and share approaches to performance improvement.
- Global technical leadership and advocacy result in renewed efforts and increased access to and use of ORS and zinc in diarrhea case management at health facilities and through iCCM programs, as applicable, in Kenya, Mali, Rwanda and Zimbabwe.

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, because this is the time period that has received the least amount of programmatic attention in recent years. Within the LAC countries, evidence of health inequality is striking, particularly in the area of 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.

Despite an overall national maternal mortality ratio (MMR) of 110 maternal deaths/100,000 live births for Guatemala,¹⁴ substantial inequity exists in the system, especially in the areas of health-seeking behaviors and health service utilization, and among the various national ethnic groups. A

¹⁴ WHO, UNFPA, UNICEF and World Bank. 2010. *Trends in maternal mortality: 1990 to 2008*. WHO: Geneva.

review of the breakdown of cause of death shows that over half of all maternal deaths were caused by hemorrhage, with 66.5% of all maternal deaths occurring in women without a formal education.

In Honduras, data from 2007 revealed that the MMR 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.¹⁵ One of the main challenges that the country faces in accomplishing its goal to decrease maternal mortality is the high number of home births. Home births are occurring because of 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 parteras¹⁶ in rural areas. Of all births, 30,000 (15%) are likely to present with an obstetric complication. Among women who experience obstetric complications, one-third are assisted by a less skilled provider, particularly in the departments of Colon, Coban, El Paraiso, Intibuxca, La Paz, Lempira, Olancho and Santa Bárbara.¹⁷

Honduras intends to reduce maternal mortality from 108 per 100,000 to 45 per 100,000 by 2015. To accomplish this goal, Honduras is now in the process of planning the implementation of a national policy called RAMNI (Reducción Acelerada de la Mortalidad Materna y de la Niñez). The focus of RAMNI will be to reduce maternal and infant mortality, increase the number of institutional births, increase family planning coverage and improve the quality of health care. MCHIP will work with the MOH of Honduras by implementing two interventions: 1) introduction of oxytocin in Uniject at the institutional level; and 2) introduction of oxytocin in Uniject at the community level, using traditional birth attendants linked to the health system. Uniject is a single-dose, prefilled, non-reusable injection device that simplifies intramuscular (IM) delivery of drugs, including oxytocin.

The introduction of oxytocin in the Uniject¹⁸ device (Uniject) at both the institutional and community levels in Honduras is timely and well aligned with national objectives for the reduction of maternal mortality. Oxytocin in Uniject can address some of the country's specific needs, such as: providing managers of health facilities with an alternative way of distributing and storing oxytocin in more remote areas of the country, increasing access to oxytocin for women who are not able to access facilities for childbirth care, helping to improve the correct use of AMTSL, and facilitating the process and increasing efficiency of health workers who provide this service. The MOH and collaborating partners USAID and ChildFund will introduce oxytocin 10 IU in the Uniject device for PPH prevention in one hospital, two health clinics and four communities as a way to inform the development of a national plan to introduce use of oxytocin-Uniject by *parteras tradicionales* and health care providers in facilities. Three months after its introduction, the MOH, with technical assistance from USAID partners, will evaluate the introduction. This evaluation will generate data about experience with oxytocin-Uniject and the correct use of oxytocin 10 IU in the Uniject device by *parteras tradicionales* for prevention of PPH, identify feasibility issues in facilities and communities where this device was introduced to support a PPH prevention strategy, and assess the acceptability of use of oxytocin in the Uniject. These data will also assist the MOH in developing a strategy for broader adoption for community- and facility-based prevention of PPH, the leading cause of maternal mortality in the country.

Effective implementation of evidence-based health care practices remains a significant challenge, and despite existing evidence on the benefits of prophylactic use of oxytocin during the third stage of labor, prophylactic oxytocin is still not widely used in Latin America. The **Nicaraguan** MOH

¹⁵ WHO. Country Statistics. Available at: <http://apps.who.int/ghodata/?vid=10100&theme=country>. Accessed July 25, 2011.

¹⁶ Parteras are less skilled providers, equivalent to the international term "traditional birth attendants," who attend births in the home.

¹⁷ RAMNI MOH Document 2008–2015.

¹⁸ The Uniject device is a trademark of Becton Dickinson.

and MCHIP will implement an intervention that combines multiple strategies—identification of opinion leaders, workshops to develop and implement evidence-based guidelines, academic detailing, reminders and feedback on utilization rates—to increase use of prophylactic oxytocin and reduce use of routine episiotomies. An additional barrier to the adoption of prophylactic oxytocin for AMTSL is the lack of personnel assisting birth attendants in the care of the woman and the baby; in most cases, only one birth attendant takes care of the woman, without any assistant. In this situation, the need to prepare the oxytocin injection from the vial and syringe could be a real barrier for the administration of prophylactic oxytocin. The MCHIP team has worked with the MOH to get special permission to import oxytocin in the Uniject device. The MOH in Nicaragua, with technical and financial assistance from USAID, PATH/Seattle and Managua, the Instituto de Efectividad Clínica y Sanitaria (IECS) and Unidad de Investigación Clínica y Epidemiológica Montevideo (UNICEM), will implement a multi-faceted intervention (see above) to promote and facilitate the administration of prophylactic oxytocin for management of the third stage of labor and reduce the use of routine episiotomies in one hospital and five health centers. This study will evaluate the intervention’s effectiveness in achieving its goals. The intervention will be implemented with skilled birth attendants, but the estimated impact of the intervention will be measured by evaluating birth outcomes in women giving birth vaginally in the selected facilities. Therefore, all women who have a vaginal birth in the selected facilities during the data collection periods (three months before intervention, one month after the start of the intervention, and five months post-intervention) and have agreed to participate will be included. Given the average number of vaginal births per month, we estimate that approximately 2,800 women will participate during the nine months of data collection (about 350 participants per month).

In Nicaragua, the number of cesarean deliveries has quadrupled over the last two decades; and is very high in the most urbanized locations. According to the National Demographic and Health Survey (ENDESA 2006/07), in the following locations, one of every three births reported by surveyed women was a cesarean delivery: Granada (32%), Managua (31%), Leon (31%) and Carazo (31%). All of these territories (known as departments here) are located in the Pacific Region, where 70% of the entire population lives. On the other extreme, the Caribbean coast region covers almost half of the national territory, but is home to just 10% of the national population. In this flat, lowland region with abundant rain and large rainforests, the rate of cesarean delivery is low. Based on ENDESA 2006/07, only 5% of women reported cesarean in the territory known as RAAN, and 9% in the territory known as RAAS. On average, the percentage of women in the country having a cesarean increased from 7% in 1992 to 19% in 2006/07.¹⁹ A WHO health facility-based survey conducted in 2004–2005 revealed the overall cesarean birth rate in Nicaragua to be 30.8%.²⁰

The struggle to ensure that women in Nicaragua have access to needed technologies, balanced with the governments’ need for rational health care services and promotion of evidence-based practices, translates into a need to understand root causes for high cesarean birth rates. It would be useful to fully understand the determinants of cesarean births in each setting in order to design and improve the effectiveness of interventions that address the root causes for high cesarean birth rates. MCHIP will conduct a study in Nicaragua in an effort to study providers’ perceptions of cesarean births with the hope that an intervention can be developed to address high cesarean birth rates in the country. The research team will conduct focus group discussions, and in-depth interviews to gather information from the various levels of the health care system and types of providers in Nicaragua (mainly MINSA and INSS). The goal of this formative research is to explore birth attendants’ (physicians’ and midwives’) attitudes toward cesarean birth in Nicaragua, with the aim to collaborate in the design of a feasible and culturally appropriate intervention to decrease cesarean birth rates.

¹⁹ National Development Information Institute. 2008. (DHS 2006–2007). *Encuesta Nicaragüense de Demografía y Salud 2006/07: INIDE Informe Final [Nicaragua Demographic and Health Survey 2006/07: Final INIDE Report]*. Managua, Nicaragua.

²⁰ World Health Organization. 2009. *Rising Caesarean Deliveries in Latin America: How best to Monitor Rates and Risks*. WHO/RHR/09.05. WHO: Geneva.

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 that are primarily attributable 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, as well as disrespectful and abusive care, are key issues to consider in programming for this region.

The Caribbean island nations are numerous and many are quite small. Here midwifery has typically been subsumed in the much larger nursing organizations. It is recognized that midwifery should have a stronger voice and that it should have a separate professional association, in order to facilitate its growth as an independent profession. This awareness has led to a growing interest and desire for a regional Caribbean Midwives Association, which would provide a professional network across the region. Initial discussions at a regional meeting received strong support and encouragement to continue to develop an association. MCHIP will offer organizational development assistance for this effort.

Like much of Latin America, the Caribbean nations do not have strong health workforce regulation or requirements for continuing education. Nursing is working toward a regional curriculum and reciprocity between countries, and the regional nursing leadership has encouraged midwifery to do the same. In collaboration with the regional association, MCHIP will assist with the development of continuing professional development for midwives.

Paraguay has continued to experience extreme inequality in health statistics, with the 2008–2009 MMRs ranging from 33–307 deaths/100,000 live births in different parts of the country. Maternal mortality ratios have increased in some areas, though this is likely due to more accurate reporting. One component of an effort to address persistent inequalities in access to health resources is strengthening the capacity of the health workforce and standardizing the competencies and clinical profile of anyone holding the post of midwife in the country. Presently multiple educational and professional paths are available for midwives in the country. This variability has undermined midwives' performance and thus the health system's expectation of their performance. The lack of a national system of midwifery education or institutional accreditation in the country has resulted in a wide range of unregulated pre-service programs, ranging in length from a few months to three years, with the same title given to all graduates.

The ICM/UNFPA collaboration focuses on strengthening midwifery through education, regulation and professional associations. Midwifery faculties in Paraguay from Dr. Andres Barbero Institute (DABI) have requested technical assistance in improving the capacity and quality of education. USAID has invested in this with a vision for a national curriculum and a more uniform approach to health worker production. To this end, during 2011, USAID directed MCHIP to initiate support for a process of systems strengthening, through a South-to-South collaboration between midwifery faculties in Peru and those in Paraguay. Faculty from the midwifery school of the Universidad San Martin de Porres in Lima, Peru, have successfully implemented a competency-based curriculum locally, and led the formation of a Dean's Council for national reform. Through MCHIP's support and technical guidance, USAID will further that technical exchange and cross-fertilization by enabling technical assistance from Peru to the Paraguayan MOH and Universidad Nacional in Asunción. This TA will focus on curriculum development, educational management and institution building. Throughout, the Peruvian colleagues, with MCHIP, will guide the formation and work of a similar Dean's Council in Paraguay to foster more systemic reform.

Year 4 Expected Results

- CAMBIO intervention in Nicaragua:
- CAMBIO intervention (Changing AMTSL Behavior in Obstetrics), which included introduction of oxytocin in the Uniject device and reduction of routine use 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 at the community and facility level in Honduras completed.
- Results of evaluation of the introduction disseminated.
- Introduction of oxytocin in Uniject for PPH prevention in Guatemala:

Please note: As a result of the pilot introduction of oxytocin in Uniject in Guatemala, the MOH has included oxytocin in pre-filled syringe as an alternative in the most recent national guidelines for skilled birth attendance. The MOH is planning to share the experience of the pilot introduction in the same workshops where the national guidelines will be disseminated to the public. The goal of these workshops is to inform the various participants on the new guidelines for the skilled birth attendants and on the current efforts of the government to reduce PPH and maternal mortality.

- Results of evaluation of the pilot introduction disseminated.
- Technical assistance to develop a plan for national scale-up per MOH's request provided.
- Formative research on use of cesarean operations in Nicaragua:
- Formative research conducted and analyzed on use of cesarean operation.
- Results of formative research disseminated.
- National action plan developed to reduce use of cesarean operation for non-medical or non-obstetric reasons.
- Strengthening midwifery education in Paraguay and Peru:
- High-level Midwifery Dean's Working Group developed.
- Set of midwifery competencies to produce safe entry-level practitioners (corresponding to ICM Core Competencies) accepted for all midwifery schools and graduates in Paraguay.
- Paraguayan midwifery schools incorporate best practices and competency-based methodology into midwifery teaching process in three schools.
- Skills labs equipped and functioning in three schools.
- Technical assistance, South-to-South learning and support of professional association development:
- Regional association meeting held in Trinidad & Tobago (Fall 2011).

- Planning committee develops a framework for establishing Continuing Education (CE).
- In coordination with the regional association, develop initial Distance Learning (DL) accessible CE modules or mechanisms to access existing DL content.
- Provide TA for analysis/assessment of regulation of midwifery in the region and identification of needs.
- Promotion of pre-eclampsia guidelines:
- Diffusion and adoption of best practices in prevention and management of pre-eclampsia at regional levels.
- Strengthening of regional leaders in midwifery.
 - Participation of midwife leaders in regional professional conferences.

NEWBORN HEALTH

In Latin American and the Caribbean (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 skilled birth attendance (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 because of lack of access and/or cultural barriers have the highest mortalities (e.g., 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 numbers of premature births and deaths from related complications are increasing.

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 SNL, HCI, UNICEF and BASICS. The Alliance has expanded membership to include the Regional Professional Associations (Pediatric, Obstetrics and Gynecology, International Confederation of Midwives, Nursing) and other new members. USAID and these partners have 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, with special focus on the most vulnerable populations. This plan was approved by PAHO's Directing Council in September of 2008. MCHIP is chairing the Alliance for 2011, elected unanimously by its members, and continues coordinating the LAC newborn indicators committee. The Alliance members continue to work to strengthen country plans of action to reduce neonatal mortality in the region, and to implement initiatives to address some of the causes of newborn mortality in LAC with a regional approach.

In addressing gaps in quality of care, MCHIP is continuing a strategy implemented by BASICS from 2006 to 2009, which operationalizes with partners an important element of the LAC regional strategy: the prevention and treatment of neonatal sepsis. The project incorporates distance learning methodologies with in-country support and elements of collaborative models for quality improvement. During BASICS, 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 nursery admissions caused by suspected nosocomial infections by up to 30% in some

hospitals, and to an increase in the number of newborn babies evaluated by the third day of life by 50% in some communities in Honduras. Currently the intervention continues in three referral facilities in the DR (benefiting displaced Haitian populations among others) and has started in three facilities in Paraguay (one in the poorest province in the country). There is also a potential opportunity to implement CCM of neonatal infections in Nicaragua with Save the Children, an opportunity where the MCHIP newborn team would be able to provide TA.

The results of the newborn infections activity are being shared and will continue to be shared periodically in regional meetings.

Since 2010, MCHIP has been providing technical assistance in additional newborn health priority programs (resuscitation-HBB and facility KMC) for achieving regional and country **scale-up**. MCHIP is coordinating the efforts and measurements of the KMC implementation (including a workshop in September) and providing TA for problem-solving for the following countries:

- Honduras, Guatemala, El Salvador, Nicaragua, Ecuador supporting the URC/HCI bilaterals
- Paraguay and the Dominican Republic (MCHIP-funded)
- Haiti (in collaboration with the French Government, the Kangaroo Foundation, the local USAID Mission and UNICEF)
- Peru and Bolivia (supporting the MOH)

For HBB, MCHIP is also a coordinating/support mechanism in URC/HCI countries, the Dominican Republic and regionally through trainings during professional associations and Alliance meetings. MCHIP is carrying out cultural adaptations of the graphics and doing an additional revision of the Spanish translations of educational materials, and also helping in the identification of a not-for-profit printing/distribution facility in the LAC region for potential reduction of costs.

Given the importance of looking at the mother-newborn dyad in an **integrated** manner to have an impact on MDGs 4 and 5, the Neonatal Alliance includes FLASOG (the Latin America Obstetrics and Gynecology Federation) and the LAC Regional chapter of ICM in its constituency, as well as the UNFPA Sexual and Reproductive Health Unit. In collaboration with the MCHIP maternal health team, these partners are including messages on management of maternal conditions that also impact the fetus/newborn in their presentations and discussions.

MCHIP will also continue to participate in regional meetings of the professional associations and other stakeholders as a platform to update and advocate for newborn health, evidence-based, priority interventions on behalf of the LAC Neonatal Alliance.

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

Year 4 Expected Results

- Survey on postnatal care policies and protocols carried out in at least three countries and results and recommendations disseminated. (*Activity 15.2.1*)

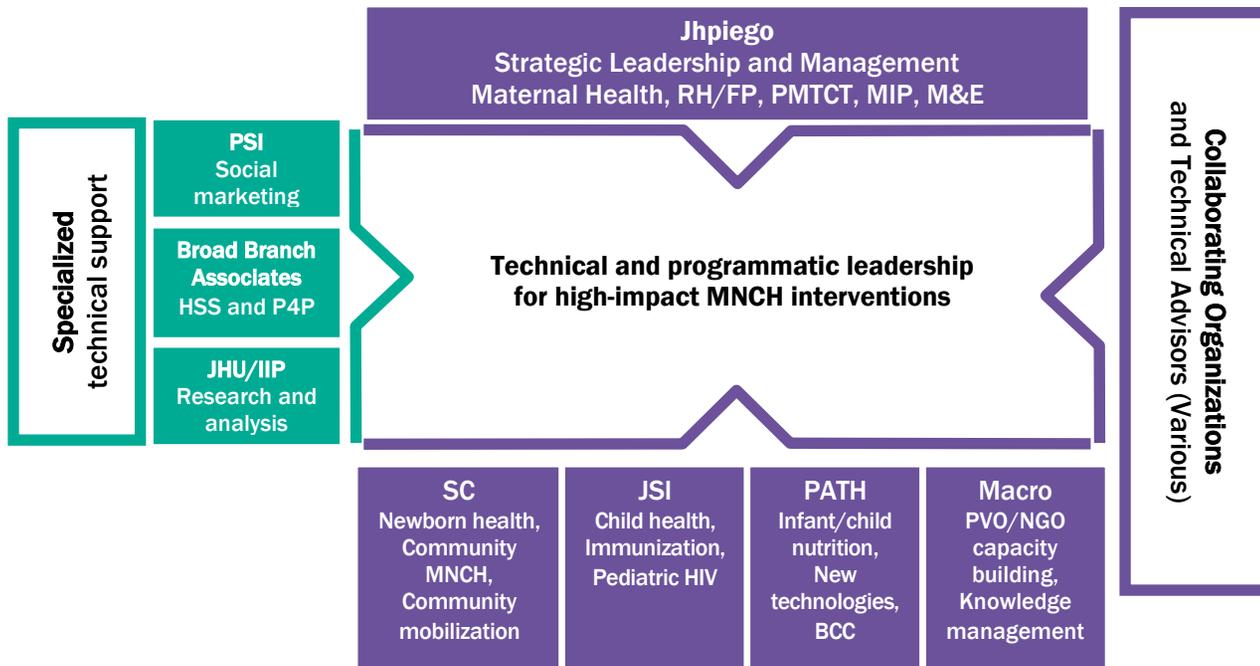
- Assistance to countries initiated for implementation and/or strengthening of postnatal care practices based on the results and recommendations of the survey. *(Activity 15.2.1)*
- Successful leading of the LAC Neonatal Alliance to promote scale-up of priority activities in newborn health in the region. *(Activity 15.2.2)*
- Technical oversight and assistance provided on behalf of the LAC Neonatal Alliance for dissemination of best practices and information exchanges on newborn health in the region. *(Activity 15.2.2)*
- Technical support contributed for the implementation/strengthening of national committees/alliances for newborn health. This includes co-organizing a South-American Forum of National Newborn Alliances in Paraguay in November of 2011 *(Activity 15.2.2)*
- In-country improvement of prevention and treatment of newborn sepsis scaled-up at facility and/or community levels in two to three countries (including community case management of newborn infections and rational use of antibiotics); lessons learned disseminated regionally. *(Activity 15.2.3)*
- Technical support to in-country partners for implementation and scale-up of the HBB curriculum under a regional coordinating mechanism (Dominican Republic, Peru, Honduras, Nicaragua, El Salvador, Guatemala, Haiti, Bolivia, Paraguay, Colombia). *(Activity 15.2.4)*
- 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, Peru, Paraguay, Ecuador, Haiti, Bolivia). *(Activity 15.2.5)*

MCHIP Management

MCHIP is structured at the central and field levels make optimal use of the strengths across the partnership, while retaining a leadership role of each partner in different technical areas. Most teams draw on the expertise from multiple partner organizations that contribute to areas well beyond their designated role.

Figure 4 below displays partner roles and responsibilities within MCHIP. Although each partner is assigned a technical leadership role, MCHIP engages 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 draws on the leaders from various partners and consists of Koki Agarwal, Anita Gibson, Steve Hodgins, Pat Taylor, Leo Ryan, Nancy Caiola, Terry Padgett and Lance Brenner.

There is also a Partnership Management Team (PMT), composed of key program and financial/ administrative representatives from each partner. The PMT meets 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 12.

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 12. 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	Stephanie Dolan

Figure 5 depicts the MCHIP organizational structure. The reporting structure is flexible. In most instances, Koki Agarwal and Anita Gibson 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 are the main points of contact. The PVO/NGO support team—through Team Leader, Leo Ryan—communicates directly with Nazo Kureshy at USAID and copies USAID AOTRs and the MCHIP management staff for broader workplan and management issues. The MCHIP management team engages various representatives from country or technical teams as necessary. MCHIP’s technical backstopping team is depicted in Table 13. As country activities expanded in Year 2, MCHIP developed a backstop plan that is still being utilized, which 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 advance global and regional priorities, support multiple aspects of program learning and work with field programs either through direct assistance or by facilitating support between/among field programs. MCHIP has proposed technical team leads for each of the areas. Their engagement also allows for meaningful participation of staff representing different partner organizations in cross-cutting working groups and discussions across technical areas. The team leaders work with the Global Leadership Team Leader to ensure technical integrity across the different interventions.

Figure 5. MCHIP Organizational Structure

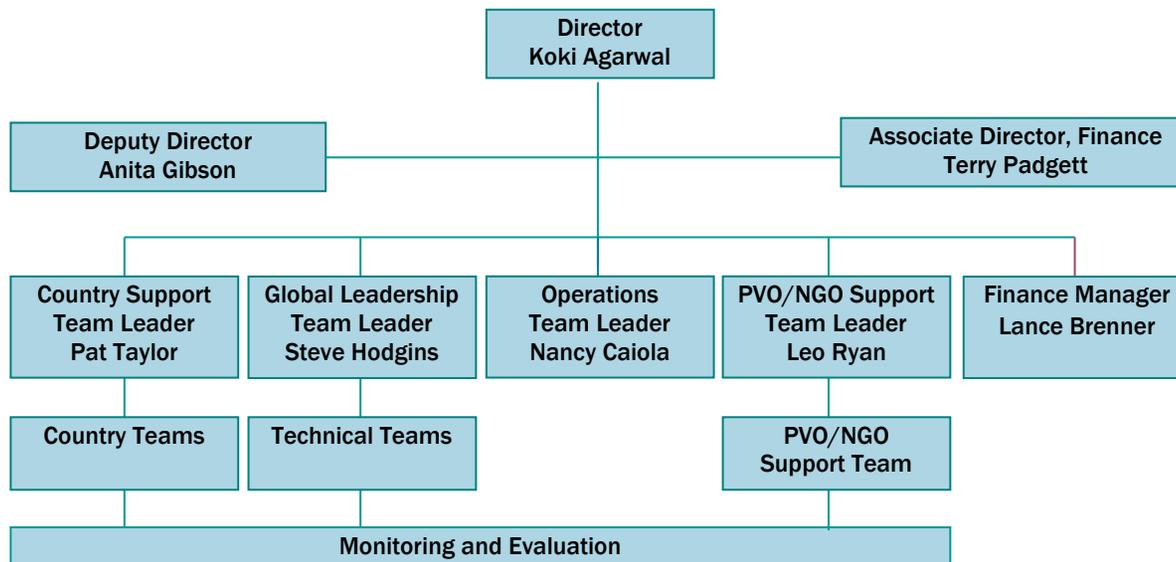


Table 13. MCHIP Headquarters Technical Backstop

TECHNICAL TEAMS	TEAM LEADERS/TECHNICAL CONTACTS
PVO/NGO Support	Leo Ryan
Maternal Health	Jeffrey Smith
Newborn Health	Joseph de Graft-Johnson/Dan Abbott (Handwashing)
Child Health	Dyness Kasungami
Immunization	Robert Steinglass
Family Planning	Catharine McKaig
Health Systems Strengthening	Alex Ergo
Community Interventions/Social Mobilization	Joseph de Graft-Johnson
Nutrition	Rae Galloway
M&E	Barbara Rawlins
HIV	Tigistu Adamu
Malaria	Elaine Roman/Debra Prosnitz (MCP)
Urban Health	Anita Gibson/Pat Taylor
Research	Steve Hodgins/Linda Bartlett

Annex 1: Financial Overview

OVERVIEW

Please see Terry Padget for details.

Table 16. Level of Effort for MCHIP Management and Key Technical Staff

MANAGEMENT TEAM	
Director, Koki Agarwal	65%
Deputy Director, Anita Gibson	90%
Country Support Team Leader, Pat Taylor	66%
Global Support Team Leader, Steve Hodgins	80%
PVO/NGO Support Team Leader, Leo Ryan	75%
Global Operations Team Leader, Nancy Caiola	46%
Finance Director, Terry Padgett	60%
Finance Manager, Lance Brenner	100%
TECHNICAL LEAD	
Maternal Health, Jeffrey Smith	50%
Maternal Anemia, Rae Galloway	25%
NB/Community, Joseph de Graft-Johnson	60%
Child Health, Dyness Kasungami	72%
Immunization, Robert Steinglass	56%
Family Planning, Cat McKaig	70%
Malaria, Elaine Roman	50%
HIV/AIDS, Tigistu Adamu	75%
Health Systems Strengthening, Alex Ergo	49%
PVO/NGO, Laban Tsuma	89%
Monitoring & Evaluation, Barbara Rawlins	80%
TECHNICAL RESOURCES	
Maternal Health Advisor, Marge Koblinsky	40%
Maternal Health Advisor, Catherine Carr	70%
Maternal Health Advisor, Sheena Currie	60%
Technical Advisor, Cherrie Evans	25%
Program Manager, Stephanie Suhowatsky	35%
SBM-R and Reporting, Bruno Benavides	25%
Oxytocin Potency, Cindy Stanton	20%
Pooled Maternal Health (Dao, Gomez, Bluestone, Reis)	65%
MCH/Nutrition Advisor, Peggy Koniz-Booher	15%
Newborn Health Advisor, Stella Abwao	35%
Newborn Health Advisor, Goldy Mazia	50%
Newborn Advisor, Winnie Mwebesa	10%
Water and Sanitation, Dan Abbott	30%
Child Health Advisor, Emmanuel Wansi	65%
Child Health Advisor, Serge Raharison	65%
Research Advisor, Kate Gilroy	20%
Pooled Child Health (Dawson, Carnell, Guyon, Sairuddin, Alombah, Dolan)	50%

TECHNICAL RESOURCES (CONTINUED)	
Immunization Advisor, Lora Shimp	66%
Immunization Advisor, Michel Othepa	68%
Immunization Advisor, Rebecca Fields	40%
Immunization Officer, Katherine Farnsworth	37%
Immunization Officer, Asnakew Yigzaw Tsegue	65%
Regional Immunization Advisor, Mamadou Diallo	25%
Pooled Immunization (Sequeira, Favim, H1N1)	59%
Family Planning Advisor, Holly Blanchard	80%
Family Planning BCC Advisor, Chelsea Cooper	50%
Program Manager, Elaine Chaurat	60%
Research Advisor, Abdullah Baqui	30%
Pooled Family Planning (Deller, Lu, Pleah)	45%
Family Planning, Malaria, Other Advisor	25%
PMI/MCP Advisor, Jennifer Yourkavitch	47%
Pooled HIV/AIDS (Curran, Mahler)	20%
CSHGP PVO/NGO M&E Advisor, Jennifer Luna	76%
CSHGP HMIS Advisor, David Cantor	69%
Child Survival Technical Advisor	62%
Child Survival Program Manager	35%
CSHGP PVO/NGO Advisor, Florence Nyngara	100%
PVO/NGO, Debra Proznitz	95%
PVO/NGO, Leah Elliott	50%
PVO/NGO, Qin Shi	46%
Research Advisor, Peter Winch	20%
Pooled PVO/NGO (Kumper, Varrallyay, Bozsa, Arscott-Mills, Dovey)	63%
Health Systems Strengthening Advisor, Rena Eichler	8%
Pooled Health Systems Strengthening	37%
Research Advisor, Linda Bartlett	28%
Research Advisor, Heather Rosen	80%
Researcher, Vandana Tripathi	75%
Monitoring & Evaluation Officer, Rebecca Levine	50%
Pooled Monitoring & Evaluation	70%
Social Researcher, Henry Espinoza	15%
Research Advisor, Henry Perry	28%

PROGRAM AND ADMINISTRATIVE SUPPORT	
Pooled Jhpiego Finance/Admin Support	80%
Procurement Administrator, Anna Manukyan	100%
Receptionist, Shantell'e Baker	100%
Program Officer, Khatidja Jivani	100%
Program Coordinator, Theodora Biney-Amisah	100%
Communications Specialist, Charlene Reynolds	100%
IT Specialist, Keith Sylvester	100%
Pooled Publication/Communications	200%

Notes:

1. Percentages reflect core-funded LOE only. The LOE of the management team represents what is included in the management pool.
2. All Key Positions and Technical Leads 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.
4. Program and Administrative Support is covered across all technical areas. Specific names can be found in Table 16 Technical Leads and Technical Teams.

Table 17 (next page) outlines MCHIP technical leads and technical teams.

Table 17. Illustrative List of MCHIP Technical Teams

Includes technical team members and key contributors from other technical teams

*Note several staff (e.g., Koki Agarwal, Steve Hodgins, Anita Gibson, Barbara Rawlins, Karen LeBan, Shannon Downey) engage with multiple technical teams

Maternal Health	Newborn Health	Child Health	Immunization	HIV
TL: Jeffrey Smith, Jhpiego PO: Carmen Crow, Jhpiego PC: Amanda Hovland, Jhpiego	TL: Joseph de Graft-Johnson, Save PO: Rachel Taylor, Save	TL: Dyness Kasungami, JSI PO: Alia Nankoe, JSI PC: Heather Casciato, JSI PC: Meghan Anson, JSI	TL: Robert Steinglass, JSI PO: Kelli Cappelier, JSI PC: Amy McDonough, JSI	TL: Tigistu Adamu, Jhpiego PO: Dave Burrows, Jhpiego
Catherine Carr, Jhpiego Sheena Currie, Jhpiego Rae Galloway, PATH Marge Koblinsky, JSI Anne Hyre, Jhpiego Rena Eichler, BBA Tegbar Yigsaw, Jhpiego Alex Ergo, BBA Cindy Stanton, IIP Linda Bartlett, IIP Vandana Tripathi, IIP Veronica Reis, Jhpiego Sue Tredwell, Jhpiego Nancy Ali, Jhpiego Stephanie Suhowatsky, Jhpiego Edgar Necochea, Jhpiego	Goldy Mazia, PATH Dan Abbott, Save Stella Abwao, Save Winnie Mwebesa, Save Bertha Pooley, Save Judith Stanley, Save Angela Brasington, Save Rebecca Levine, Save Pat Daly, Save Abdullah Baqui, IIP Defa Wane, Save Sarah Marjane, PATH Emily Fritch, PATH Selected Maternal Team Selected FP Team	Emmanuel Wansi, JSI Serge Raharison, JSI Stephanie Dolan, PSI Kate Gilroy, IIP/JHSPH Katherine McHugh, PSI Tanya Guenther, Save David Marsh, Save Eric Swedberg, Save Saifuddin Ahmed, IIP Laban Tsuma, Macro Dan Abbott, Save JSI STTA, incl. Agnes Guyon, Mary Carnell, Moussa Ly	Lora Shimp, JSI Michel Othepa, JSI Rebecca Fields, JSI Mike Favin, JSI Jennifer Sequeira, JSI Asnakew Yigzaw, JSI Alex Ergo, BBA Katherine Farnsworth, JSI Selected FP Team	Kelly Curran, Jhpiego Augustino Hellar, Jhpiego Dyness Kasungami, JSI Alice Christensen, Jhpiego Hally Mahler, Jhpiego Stacie Stender, Jhpiego Jean Anderson, Jhpiego Jeffrey Smith, Jhpiego
Harshad Sanghvi, Jhpiego Peter Johnson, Jhpiego Bruno Benavides, Jhpiego Barbara Deller, Jhpiego Cherrie Evans, Jhpiego Julia Bluestone, Jhpiego Kusum Thapa, Jhpiego Selected Newborn team Selected FP Team Selected PVO/NGO team				

HEALTH SYSTEMS	CSHGP, PVO/NGO SUPPORT	FP	MALARIA & MCP	M&E
TL: Alex Ergo, BBA	TL: Leo Ryan, Macro	TL: Cat McKaig, Jhpiego	TL Malaria: Elaine Roman, Jhpiego TL MCP: Debra Prosnitz, Macro	TL: Barbara Rawlins, Jhpiego
Rena Eichler, BBA	David Cantor, ICF Macro	PO: Elaine Charurat, Jhpiego	PO: A Dickerson, Jhpiego PC T Biney-Amisshah, Jhpiego	PO: Rebecca Levine, Save
Alix Beith, BBA	Debra Prosnitz, ICF Macro	Holly Blanchard, Jhpiego	Bill Brieger, Jhpiego	David Cantor, Macro
Lindsay Morgan, BBA	Deborah Shi, ICF Macro	Elizabeth Sasser, Jhpiego	Debra Prosnitz, Macro	Jim Ricca, Jhpiego
Robert Steinglass, JSI	Ilona Varallyay, ICF Macro	Leah Elliott, Macro	Ilona Varallyay, Macro	Jennifer Luna, Macro
Jeffrey Smith, Jhpiego	Kirsten Unfried, ICF Macro	Chelsea Cooper, Jhpiego	Emmanuel Wansi, JSI	Abdullah Baqui, IIP/JHSPH
Selected Maternal Health	David Marsh, sAVE	Jaime Mungia, Jhpiego	Dyness Kasungami, JSI	Florence Nyangara, ICF Macro
	Jennifer Luna, ICF Macro	Ricky Lu, Jhpiego	Serge Raharison, JSI	Moussa Ly, JSI
	Jennifer Yourkavitch, ICF Macro	Mary Drake, Jhpiego	Alia Nankoe, JSI	James BonTempo, Jhpiego
	Florence Nyangara, ICF Macro	Rae Galloway, PATH		Cherrie Evans, Jhpiego
	Laban Tsuma, ICF Macro	Rebecca Fields, JSI		Eva Bazant, Jhpiego
	Deborah Kumper, ICF Macro	Reena Sethi, Jhpiego		Tanya Guenther, Save
	Leah Elliot, ICF Macro	Barbara Deller, Jhpiego		Mary Drake, Jhpiego
	Peter Winch, IIP/JHSPH	Selected Maternal Health		Laban Tsuma, ICF Macro
	Marge Koblinsky, JSI	Selected Newborn Team		Maya Tholandi, Jhpiego
	Cesar Vitora	Selected Immunization Team		Heather Rosen, IIP/JHSPH
			Aleisha Rozario, Jhpiego	
			Jennifer Bryce, IIP	
			Cindy Stanton, IIP/JHSPH	
			Marge Koblinsky, JSI	
			Alex Ergo, Broad Branch	
			Jennifer Callaghan, IIP/JHSPH	
			Shivam Gupta, IIP/JHSPH	
			Reena Sethi, Jhpiego	
			Bob Bozsa, ICF Macro	
			Ingrid Friberg, IIP/JHU	
			Amanda Makulec, ICF Macro	