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MOMENTUM INTEGRATED HEALTH RESILIENCE

Annual Report, Program Year One

USAID
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MOMENTUM
A Global Partnership for Health and Resilience

MOMENTUM works alongside governments, local and international private and civil society organizations, and other stakeholders to accelerate improvements in maternal, newborn, and child health services. Building on existing evidence and experience implementing global health programs and interventions, we help foster new ideas, partnerships, and approaches, and strengthen the resiliency of health systems.

MOMENTUM Integrated Health Resilience is funded by the U.S. Agency for International Development (USAID) as part of the MOMENTUM suite of awards and implemented by IMA World Health (IMA), with partners JSI Research &Training Institute, Inc. (JSI), Pathfinder International, GOAL USA Fund, CARE, and Africa Christian Health Associations Platform (ACHAP), along with Premise Data, Harvard T.H. Chan School of Public Health Department of Global Health and Population, Johns Hopkins Bloomberg School of Public Health Department of International Health, and Brigham Young University as resource partners, under USAID cooperative agreement #7200AA20CA00005. For more information about MOMENTUM, visit www.usaidmomentum.org.

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Abbreviations and Acronyms

ANC	Antenatal care
AOR	Agreement Officer's Representative (USAID)
ARC-D	Analysis of the Resilience of Communities to Disasters
ASRH	Adolescent sexual and reproductive health
CARE	Cooperative for Assistance and Relief Everywhere, Inc.
CBO	Community-based organization
CHW	Community health worker
CLA	Collaborating, Learning, and Adapting practices
COP	Chief of party
CoP	Community of practice
CSO	Civil society organizations
DMPA-SC	Depot-medroxyprogesterone acetate-subcutaneous
DRC	Democratic Republic of the Congo
E2A	Evidence to Action Project
EmONC	Emergency obstetric and newborn care
ENAP	Every Newborn Action Plan
ENAP-E	Every Newborn Action Plan in Emergencies
EPI	Expanded Program on Immunization
EPMM	Ending Preventable Maternal Mortality
EVD	Ebola Virus Disease
F2C	Fragility, Crisis Sensitivity and Complexity assessment
FBO	Faith-based organization
FP/RH	Voluntary family planning and reproductive health
Gavi	Gavi: The Vaccine Alliance
GBV	Gender-based violence
GMP	Growth monitoring and promotion
H-D nexus	Humanitarian-development nexus
HFA	Health facility readiness assessment
HIP	High impact practice
HMIS	Health management information system
IAWG	Inter-Agency Working Group on Reproductive Health in Crises
iCCM	Integrated Community Case Management of Childhood Illness
ICFP	International Conference on Family Planning
IMNCI	Integrated Management of Newborn and Childhood Illness
IHR	Integrated Health and Resilience
IPC	Infection prevention and control
IYCF	Infant and young child feeding
JHU	Johns Hopkins University
JSI	JSI Research & Training Institute, Inc.
KAP	Knowledge, attitudes, and practices
KM	Knowledge management
LMICs	Low- and middle-income countries
M&E	Monitoring and evaluation
MAMI	Management of at-risk mothers and infants <6 months of age
MCGL	MOMENTUM Country and Global Leadership
MCHN	Office of Maternal and Child Health and Nutrition (USAID)
MCHIP	Maternal and Child Health Integrated Program

MCSP	Maternal and Child Survival Program
MEL	Monitoring, evaluation, and learning
MERL	Monitoring, evaluation, research, and learning
MIHR	MOMENTUM Integrated Health Resilience
MKA	MOMENTUM Knowledge Accelerator
MMH	Maternal mental health
MNCH	Maternal, newborn, and child health
MNH	Maternal and newborn health
MOH	Ministry of health
MOMENTUM	Moving Integrated, Quality Maternal, Newborn, and Child Health and Family Planning and Reproductive Health Services to Scale
MPHD	MOMENTUM Private Healthcare Delivery
M-RITE	MOMENTUM Routine Immunization Transformation and Equity
MSSFPO	MOMENTUM Safe Surgery in Family Planning and Obstetrics
NGO	Nongovernmental organization
NPI	New Partnerships Initiative
OCA	Organizational Capacity Assessment tool
OPI	Organizational Performance Index tool
PBC	Provider behavior change
PHE	Population, health, and environment
PMP	Performance Monitoring Plan
PNC	Postnatal care
PPH	Postpartum hemorrhage
PPP	Public-private partnership
PRH	Office of Population and Reproductive Health (USAID)
PSEA	Preventing sexual exploitation and abuse
PSS	Psychosocial support
PY	Program year
QoC	Quality of care
R4S	Resilience for Social Systems
R4SHealth	Resilience for Social Systems (Health)
RED/REC	Reaching Every District/Reaching Every Community
RH	Reproductive health
RMC	Respectful maternity care
SBC	Social and behavior change
SMT	Senior management team
SPA	Service Provision Assessment
SRA	Security risk assessment
TA	Technical assistance
TAG	Technical advisory group
TOC	Theory of change
TWG	Technical working group
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WASH	Water, sanitation, and hygiene
WHO	World Health Organization

Executive Summary

MOMENTUM Integrated Health Resilience (MIHR) was launched in May 2020, with the majority of core staff hired by the fall of 2020. In Program Year One (PY1), MIHR opened seven country programs following the issuance of descriptions for MIHR programming and technical assistance by USAID Missions. MIHR successfully submitted and received approval or provisional approval for PY1 work plans by the respective Missions. In PY1, MIHR largely focused on start-up activities, including strengthening the capacity of country teams to implement project activities. The project's start-up was undertaken amid the global COVID-19 pandemic and most activities, both core and field, were conducted remotely.

During PY1, MIHR successfully positioned itself as a thought leader in the global dialogue on voluntary family planning and reproductive health (FP/RH), maternal, newborn, and child health (MNCH), immunization, and nutrition in fragile settings and at the humanitarian-development nexus. Participating in a wide range of technical working groups, consultations, communities of practices (CoPs), and other forums, MIHR technical experts contributed to discussions, considered evidence, and in several cases, helped draft global guidance documents and publications.[1] MIHR played a leadership or co-leadership role in multiple global and regional groups,[2] and prioritized discussions and coordination that were specific to fragile settings and the project's health resilience mandate. MIHR ensured that a gender and social inclusion lens was applied to all global thought leadership and project activities.

Under its **Voluntary Family Planning/Reproductive Health (FP/RH)** activities, MIHR participated in and contributed to global technical leadership activities, including contributing to the development or review of FP/RH guidance, assessment tools, and training materials for adaption or adoption for fragile settings. Under USAID's direction, MIHR also took up co-leadership of the Task Shifting Technical Working Group in collaboration with MOMENTUM Safe Surgery in Family Planning and Obstetrics (MSSFPO). By the end of PY1, terms of reference for the working group had been drafted and planned meetings are expected to ramp up in PY2.

Under its **Maternal and Newborn Health** (MNH) and **Quality of Care** (QoC) work, MIHR focused on laying the foundation for core and field-funded interventions. This included identifying emerging global programming priorities and incorporating them into MIHR-supported work in partner countries. MIHR was engaged in global technical dialogue to enhance bi-directional learning, consolidate various needs assessment toolkits, and adapt selected global technical guidance to improve MNH for fragile settings, while ensuring that QoC was infused throughout technical areas.

MIHR's **Child Health** work was mainly concentrated on starting up core and field-funded interventions, with significant work with country teams to identify priority interventions. Work on the development and

1 Examples: Social Norms Atlas, with chapter on Provider Behavior Change (PBC), published online in 2021, https://www.alignplatform.org/sites/default/files/2021-05/social-norms-atlas_final_v2.pdf; article on Social and Behavior Change (SBC) Programming in Public Health Emergencies drafted with Breakthrough Research; a commentary on provider behavior change in practice developed with Breakthrough ACTION and the SBC for Service Delivery CoP. The latter will be submitted for publication in PY2. MIHR also contributed in PY1 to the "Commitment to Immunizing Zero-Dose Children," a MOMENTUM-wide strategy statement that is aligned with the goals of IA2030 and Gavi 5.0 and USAID's own commitment to immunization.

2 Please refer to Appendix F for a summary of these global leadership activities.

prioritization of a set of QoC measures, originated under the Maternal and Child Health Survival Program (MCSP), continued through MIHR.

As part of agenda setting, MIHR began developing its **Community Health** strategy to guide the design and implementation of community health activities in MIHR partner countries. MIHR participated in global community health learning and networking forums and facilitated cross-country learning among partner countries through organized, virtual peer-to-peer learning opportunities.

MIHR provided global technical leadership on **Immunization** policy and strategy, such as providing feedback on technical guidance to the World Health Organization (WHO) and Gavi: The Vaccine Alliance (Gavi) "zero-dose" strategy; this was done jointly with other MOMENTUM awards. Close collaboration with the other MOMENTUM awards in PY1 resulted in a joint brief and presentations, such as at the MOMENTUM Share Fair.

Under its **Nutrition** work, MIHR began adapting the Management of At-Risk Mothers and Infants <6 months of age (MAMI) Care Pathway tools, and shared its concept note with the MAMI Global Network. In PY2, MIHR will integrate MAMI activities into its facility and community-based service delivery activities in South Sudan. In Niger, preliminary work is expected to begin by end of PY2 and will be based on South Sudan results and learning. During PY1, MIHR also developed a concept note for Smart Growth Monitoring and Promotion (GMP), which was shared with USAID.

Under **Capacity Strengthening** activities, MIHR focused on developing and adapting strategies, approaches, guidelines, tools, and templates for use with local organizations and institutions implementing FP/RH/MNCH project activities. The materials reviewed included those from successful USAID projects in readiness for adaptation to fragile settings. MIHR also developed a draft social accountability strategy. The strategy will outline priority social accountability protocols and mechanisms to guide MIHR partner country teams and local partners in undertaking structured and systematic capacity strengthening initiatives.

Under **Result 3**, MIHR worked to build systems to ensure availability of relevant data, learning, and adaptive management for monitoring and evaluation (M&E), planning, decision-making, and course corrections. Most data available to the MIHR core team come from country programs. As Mission-funded activities started, they were supported in collecting, managing, and analyzing needed data. The plans for implementing monitoring, evaluation, research, and learning (MERL) activities are described in more detail in the project's MERL Plan.

In this inaugural year, MIHR began laying the groundwork for its activities under **Result 4**, including exploring opportunities for public-private partnerships and philanthropic and non-health organization engagement in fragile settings. With the objective of augmenting and sustaining the capacity of health workers to deliver essential health care services in remote and hard-to-reach areas, MIHR began mapping potential local, public, private, and faith-based organizations in two countries, Democratic Republic of the Congo and South Sudan. This work will continue in PY2 and will be expanded to other MIHR partner countries. As work increases in this area, MIHR will develop models of layering FP/RH/MNCH with non-health organization programming.

As part of its PY1 core work plan, MIHR developed an addendum and received approval for additional activities under New Partnerships Initiative (NPI) funding and United Nations Population Fund (UNFPA) re-programmed funds, to ensure continuity of FP/RH care in fragile settings. Mission concurrences were received, and implementation began in PY1 for UNFPA activities in South Sudan and Mali. By the end of PY1,

MIHR was working toward obtaining Mission concurrences for Burkina Faso, Mali, and Niger to implement activities under NPI.

While MIHR has been largely successful in its start-up activities, including defining its strategic priorities, the project has faced challenges such as the global COVID-19 pandemic. Country scoping, planning, hiring, on-boarding, supervising, and providing ongoing technical backstopping that country staff need have been challenging to implement virtually and from a distance. Still, valuable knowledge was gained in the process of adapting routines to meet this challenge.

As a complexity-aware project, MIHR expects its priorities and strategies to continue evolving and changing in future years as its core and country teams, and the project's USAID clients, learn more about increasing access, quality, and use of evidence-based FP/RH/MNCH information, services, and interventions in fragile settings, and what it means to improve health resilience capacities.

Progress Achieved

This annual report for Moving Integrated, Quality Maternal, Newborn, and Child Health and Family Planning and Reproductive Health Services to Scale (MOMENTUM) Integrated Health Resilience (MIHR) covers the start of the project in May 2020 through the end of Program Year One (PY1) on 30 September 2021. The MIHR cooperative agreement, supported by the United States Agency for International Development (USAID), is designed to strengthen the quality and resilience of voluntary family planning (FP), reproductive health (RH), and maternal, newborn and child health (MNCH) care and service delivery in fragile settings, as part of the MOMENTUM suite of awards.

During PY1, project efforts included recruiting and orienting staff, creating project guidance, templates, and other structures, and adjusting to ever-changing COVID-19 realities, both domestically and internationally. Seven USAID Missions issued program descriptions for MIHR technical assistance (TA). As COVID-19 travel restrictions limited core team country support, technical staff conducted remote scoping and work planning with country stakeholders, and recruited and collaborated with country staff and partners virtually through such web conferencing tools as Zoom and Teams. As of 30 September 2021, USAID had fully or provisionally approved all or part of the seven MIHR PY1 country work plans: South Sudan, Democratic Republic of the Congo (DRC), Mali, Burkina Faso, Tanzania, Sudan, and Niger. A DRC concept note to support COVID-19 vaccine roll-out was also approved. PY2 work plans for most of the seven countries had also been submitted to their respective USAID Missions at the time of this report.

MIHR achieved progress in several areas during PY1, setting a solid foundation for future work by:

- Engaging with key global technical working groups (TWGs), communities of practice (CoPs), and MOMENTUM-wide committees; MIHR and its country partners contributed to important policy dialogues across the spectrum of FP/RH/MNCH activities and programming.
- Adapting or developing program guidelines, assessment and implementation tools, reference documents, templates, and other materials to lay the foundation for the project's lifespan.
- Embedding the concepts of fragile and conflict-affected settings and health resilience capacity strengthening into MIHR's core and country programming, and moving toward a nuanced understanding of what operating in the humanitarian-development nexus (H-D nexus) means for MIHR and others. This understanding of and approach to health resilience was then asserted by MIHR within the context of the H-D nexus for FP/RH/MNCH programming to the global community.
- Strengthening and measuring individual, household, facility, and community resilience capacities and readiness to deal with unexpected shocks and stresses.
- Planning (and starting) new activities under New Partnerships Initiative (NPI) funds and United Nations Population Fund (UNFPA) re-programmed funds, to ensure continuity of FP/RH care in fragile settings.
- Publishing technical briefs and blogs on the MOMENTUM website; establishing routine "Learning Breaks" for MIHR staff and Learning Sessions as a regular part of technical team meetings that enhanced knowledge management (KM) across the project; and encouraging core and country staff and partners to share approaches and challenges. Topics in PY1 for these activities included remote scoping, the H-D nexus, Reaching Every District/Reaching Every Community (RED/REC), raising youth voices, digital health, and building health equity.
- Developing, revising, and working toward finalizing conceptual project documents, such as health resilience guidelines, and gender, youth, and social accountability strategies.

- Putting the project's MERL systems into place, including the capacity for field research, as demonstrated by the successful completion of the South Sudan Social Norms Assessment.

Result Area 1: Access to and Equitable Use of Quality Information, Care, and Interventions

Result Area 1

Scaled-up and sustained access to and equitable use of evidence-based, quality MNCHN/FP/RH information, services/care, and interventions in public and private health sectors.

The summaries below provide a snapshot of core-level MIHR technical activities for PY1. More country-specific and Mission-funded activities are noted in Appendix B. Note that most of the tools and guidance mentioned below were still in development and adaptation at the end of PY1.

Maternal Health and Newborn Health

As part of global thought leadership activities, MIHR participated in a number of ad hoc TWGs and consultations, including a Maternal Mental Health (MMH) consultation, World Health Organization (WHO) ad hoc consultations, Every Breath Counts participation, Service Provision Assessment (SPA) Quality of Care (QoC) indicator revisions, and an Ending Preventable Maternal Mortality (EPMM) consultation on coverage milestones, among others. In these, MIHR served as a technical resource partner to incorporate considerations for fragile contexts in the technical discussions and to generate, share, and support implementation of best practices and lessons learned on strengthening health resilience capacities to improve MNCH.

MIHR co-chaired and actively participated in the postpartum hemorrhage (PPH) Community of Practice annual meeting in late PY1. MIHR was incorporating emerging evidence shared during the PPH CoP meeting into field programming, in particular the barriers of using misoprostol for PPH prevention at the community level, and its advanced distribution in settings of limited skilled birth attendance. MIHR was also promoting PPH prevention, early detection, and a treatment bundle to reduce preventable maternal morbidity and mortality from PPH. In PY2, MIHR will be implementing an activity around PPH in South Sudan.

PSYCHOSOCIAL SUPPORT TOOLKIT

In PY1, MIHR assembled a postpartum depression screening and psychosocial support (PSS) toolkit draft to strengthen the capacity of MNCH/FP/RH and nutrition care providers. The toolkit incorporates clinical situations requiring special attention (e.g., depression during antenatal care [ANC] and postnatal care [PNC] periods, gender-based violence, and violence against children), strategies to strengthen clients' and parents' health resilience, and strategies to identify and address caregiver fatigue and community health worker (CHW) burnout. At the end of PY1, work was underway to finalize the toolkit by incorporating PSS guidance for fragile settings, including youth-friendly approaches and elements of respectful maternal and newborn care.

The toolkit will help MIHR to strengthen provider skills and understanding of 1) respectful, youth-friendly maternity care, including the mother and baby dyad; 2) strategies to address provider fatigue and burnout, and 3) providing basic preventive/promotive psychosocial support to mothers in the context of fragile settings, where the majority of pre- and postpartum women are at risk of developing common perinatal mental health disorders and associated poor MNCH outcomes.

MIHR also actively participated in MMH technical consultations, organized by MOMENTUM Country and Global Leadership (MCGL), WHO, and UNFPA. MIHR was planning in PY1 to incorporate findings of an MMH landscape analysis, other resources, and lessons, particularly from fragile and crisis-affected contexts, to inform its MMH and PSS programming at core and field levels. This includes MMH and PSS integration into ANC, PNC, and nutrition service delivery points (including through MAMI Care Pathway 3). MIHR also held collaborative meetings with Jhpiego on USAID/Afghanistan's Urban Health Initiative to share initial thinking on "Caring for the Carers" interventions between the projects.

WHO SAFE CHILDBIRTH CHECKLIST AND PNC CHECKLISTS

In PY1, MIHR was finalizing the Safe Childbirth Checklist draft to reflect newer clinical recommendations around intrapartum care; diagnosis, classification, and management of preeclampsia/eclampsia; prevention and management of PPH; maternal and newborn infection; and respectful maternal and newborn care. Similarly, MIHR refined available PNC checklists to be used as provider decision-support tools. These checklists include but are not limited to essential clinical practices for postnatal care of mothers and their babies, validated postnatal depression screening tests,[3] and a postpartum counseling checklist. Discussions were underway to implement the PNC checklists in Mali. However, based on feedback received from the USAID MCH technical team, MIHR will defer introduction of the PNC checklists until the third quarter of PY2 due to the ongoing revision of the PNC guidance by WHO.

Child Health

In PY1, MIHR staff moderated a bilingual technical webinar, organized by the Child Health Task Force (CHTF), WHO QoC Network for MNCH, and UNICEF on delivering quality essential maternal, newborn, and child health services during COVID-19. The webinar aimed to enhance learning about strategies to address service continuity of essential integrated management of newborn and childhood Illness (IMNCI) and integrated community case management (iCCM) services in low- and middle-income countries (LMICs).

MIHR joined the CHTF iCCM Subgroup Advisory Committee to guide the President's Malaria Initiative (PMI) Impact Malaria and iCCM subgroup activities on institutionalizing iCCM. The advisory committee will support the design, analysis, and review of the landscaping and country case studies and provide technical input for the iCCM toolkit development. This work will be continued in PY2 with a focus on supporting stronger iCCM programs in MIHR partner countries and other fragile settings.

Throughout PY1, MIHR core child health staff participated in the scoping and development of several country work plans, including for South Sudan, DRC, Mali, and Niger, as well as in the development of several assessment tools, such as health facility assessments and community surveys.

[3] E.g., Edinburg Postnatal Depression Scale or the broader PHQ9 tool.

Voluntary Family Planning and Reproductive Health

In PY1, MIHR participated in and contributed to global technical leadership and many other activities around FP/RH. MIHR contributed to discussions and the development or review of FP/RH guidance, assessment tools, and training materials that can be adapted or adopted for fragile settings. Among other efforts, MIHR contributed to the development of the WHO Academy mobile learning course on FP/RH care in pharmacies. In PY2, MIHR will use this course to strengthen the capacity of providers at pharmacies and drug stores to provide quality FP counseling and services, and document lessons learned in implementing this promising FP high impact practice (HIP) in fragile settings. Other tool examples included MIHR consolidated health facility readiness, private health sector, and quality of care assessments; such tools contain FP/RH measures for use in fragile settings.

During PY1 Q4, MIHR developed "20 Essential Resources for Family Planning and Reproductive Health in Fragile Settings" in collaboration with USAID's Knowledge SUCCESS. The collection brings together curated resources to help individuals understand the complexities of fragile settings, and opportunities for collaboration and coordination where both humanitarian and development assistance may be present. It offers practical tools for implementing partners and examples of effective programming relevant to FP/RH. The final product was scheduled to be launched on the Knowledge SUCCESS website during the first quarter of PY2.

The project also organized and hosted a number of internal and external webinars, for example, lessons learned in certain humanitarian settings that can be adapted for use in similar or fragile contexts. A link to documents and other materials is found in the Appendix F table summarizing MIHR global leadership activities.

GLOBAL FP/RH LEADERSHIP

As part of global technical leadership for FP/RH, MIHR contributed to discussions in the Method Choice CoP Technical Advisory Group (TAG), the development of the framework to transition to the Contraceptive and Method Choice CoP, and to the Women's Rights Commission key informant interviews on COVID-19 and FP in fragile settings.

MIHR contributed to the Contraceptive-Induced Menstrual Changes (CIMC) technical consultation, which discussed the effect of menstrual changes on the uptake and/or continuation of contraceptive methods, and identified how to frame conversations on CIMC as part of counseling for initiation and continuation of modern contraceptive methods. MIHR also reviewed the consultation report.

The MIHR team contributed to preparations for and hosting a panel session on FP in humanitarian settings during the ICFP 2021 "Not Without FP" forum: *Emergency preparedness to ensure continued access to contraception in a crisis* in early 2021. Three countries shared their experience on how various shocks and stresses affect access to FP/RH care. MIHR used these experiences to inform programming in partner countries. MIHR also contributed to preparations and hosting of a Self-Care Everywhere panel session during the Self-Care Trailblazers Group Learning and Discovery Series, through the Inter-Agency Working Group on Reproductive Health in Crises (IAWG) Voluntary Contraception Sub-Working Group.

Additional FP/RH global leadership activities are listed under Appendix F.

ADAPTING SPECIFIC FP/RH TECHNICAL GUIDANCE

MIHR held discussions with country teams to incorporate WHO guidance on *Providing Family Planning Services During an Epidemic*,[4] and a new chapter in "Family Planning: A Global Handbook for Providers," that places emphasis on maintaining continuity of FP/RH care as an essential service, with adherence to medical eligibility criteria during the COVID-19 pandemic and other shocks and stresses.

In this inaugural project year, MIHR also synthesized evidence from pilot studies and data on use of depot-medroxyprogesterone acetate-subcutaneous (DMPA-SC) across different settings, in order to adapt and scale up this method for self-care and administration by CHWs in sites in South Sudan. This was planned for implementation early in PY2.

MIHR supported the scale up of self-care FP methods in fragile settings in South Sudan; the provision of contraceptive supplies by community health workers and self-administration by clients has the potential to promote health resilience in fragile settings across other countries as well. MIHR organized and presented on the use of DMPA-SC at a September 2021 webinar for World Contraception Day, as mentioned elsewhere in this report (KM section and Appendix F).

QUALITY OF CARE TOOL DEVELOPMENT

MIHR collated FP/RH markers from the MEASURE Evaluation *Quick Investigation of Quality User's Guide for Monitoring Quality of Care in Family Planning* and other resources to incorporate into the quality of care baseline assessment tool for fragile settings, for testing in South Sudan in PY2. MIHR will use the tool to identify gaps in quality of care and develop responsive action plans. MIHR will use UNFPA reprogrammed funds and FP/RH core resources to implement responsive actions based on the findings. More on the toolkit containing this assessment is found below in the Quality of Care section.

Immunization

GLOBAL TECHNICAL LEADERSHIP ON IMMUNIZATION POLICY AND STRATEGY DURING COVID-19

In PY1, as the global COVID-19 response was taking shape, one of MIHR's top priorities was staying abreast of and contributing to global guidance on immunization in fragile and conflict settings. The project participated in several ongoing forums for global thought leadership and policy dialogue, most relevantly as a member and advisor on the Immunization Agenda 2030 (IA2030) Strategic Priority 5 (SP5) working group on outbreaks and emergencies. Although a new USAID project, MIHR team members were able to bring the project's perspective and voice to relevant meetings and consultations because of their prior involvement in the forums.

ZERO-DOSE COLLABORATION

MIHR collaborated with IA2030 and other MOMENTUM projects on a "zero-dose" technical brief, conference abstracts, and joint presentations.[5] The largest numbers of the world's zero-dose children are believed to live

[4] See https://www.who.int/publications/i/item/providing-family-planning-services-during-an-epidemic.

[5] "Zero-dose" is defined as those children who have not received even a first dose of a diphtheria, tetanus, and pertussis (DTP)-containing vaccine; the "under-immunized" are children who have not completed a basic series of childhood vaccinations by the first year of age.

in countries affected by conflict and other types of fragility. As these are the types of countries that MIHR supports, the project's work in PY1—both with policy and technical groups and with the other MOMENTUM projects—focused on developing strategies for reaching zero-dose and under-vaccinated children, and orienting core staff and country teams to them. MIHR also participated in initial discussions with the IA2030 SP5 working group on its own zero-dose theory of change for reaching zero-dose and under-immunized infants, their families, and communities with immunization and other FP/RH/MNCH services. This IA2030 theory of change and zero-dose operational guidance will be completed in PY2 with MIHR technical support and partners, including Gavi: The Vaccine Alliance (Gavi), WHO, International Federation of Red Cross and Red Cresent Societies (IFRC), Médecins Sans Frontières (MSF), UNICEF, and the International Vaccine Access Center (IVAC), and will be widely disseminated through global immunization partners.

MIHR also worked with MOMENTUM awards MCGL, MOMENTUM Private Healthcare Delivery (MPHD), and MOMENTUM Routine Immunization Transformation and Equity (M-RITE), to share strategies on future directions and coordinate technical support, prepare joint abstracts for upcoming conferences, deliver a joint presentation at the Tech21 meeting, and write blogs with M-RITE (such as those for World Vaccination Week in April 2021). MIHR and MCGL were also exploring the use in PY2 of Demographic and Health Survey (DHS) and geospatial databases to estimate the number of zero-doses children living in sub-national areas (regions/districts). MIHR also collaborated with M-RITE, MCGL, and other partners to celebrate World Immunization Week (April 24-30, 2021) as part of WHO activities themed "Vaccines Bring Us Closer." MIHR contributed to the production of a toolkit and blogs for the event.[6]

REACHING EVERY DISTRICT/REACHING EVERY COMMUNITY CAPACITY BUILDING

MIHR started orienting country and core teams to the zero-dose concept, and to immunization program toolkits designed to find and reach zero-dose and under-immunized children with immunization services, including Reaching Every District/Reaching Every Community *(*RED/REC). MIHR also identified and disseminated specific RED/REC tools in certain countries, including the 2017 WHO integrated microplanning guide, and worked with the DRC and Burkina Faso country teams to adapt it.

ADVANCING CROSS-COUNTRY LEARNING

To help advance cross-country learning on data-driven analysis and immunization at the HD-nexus, MIHR conducted an online collaborative meeting (on the last day of PY1) for country teams to exchange information on their RED/REC situational analyses and common immunization data gaps, including denominator problems. Country plans and activities to adapt and integrate RED/REC, zero-dose strategies, immunization tools, strategies for integration, and approaches to achieve more resilient immunization delivery system in the HD-nexus were shared between teams in the DRC, South Sudan, Burkina Faso, and Mali. As a result, these teams will begin to use situational analyses to identify areas for immunization improvement in their respective zones/districts and facilities, and begin to tailor RED/REC to local contexts.

By the end of PY1, the DRC had started supportive supervision and collected baseline information for DTP1-DTP3 drop-out rates and zero-dose children; Mali had used RED/REC for COVID-19 micro-planning; South Sudan began engaging communities (through civil service organizations [CSOs] and district leadership) to

[6] See https://www.who.int/campaigns/world-immunization-week/2021.

identify zero-dose children; and Burkina Faso had developed its PY2 plan, with core support, to include RED/REC adaptations.

Water, Sanitation, Hygiene, and Infection Prevention and Control

While MIHR did not receive requests to conduct formal trainings to build the capacity of implementing partners in water, sanitation, and hygiene (WASH) and infection prevention and control (IPC) in PY1, the project did work with MIHR's in-country Sudan team to use evidence to design WASH programs in fragile settings. This included analysis of existing national and project-specific data, as well as gathering additional data about human and animal defecation practices and children's exposure to feces in migratory groups in MIHR's target areas. Ultimately (and with USAID input), it was decided not to pursue animal-inclusive activities, but to focus instead on water. However, the exercise was useful for selecting interventions most appropriate to the local contexts. MIHR has not yet worked with partners to strengthen health worker capacity in IPC.

Nutrition

CONCEPT NOTE ON ADAPTATION OF MAMI CARE PATHWAY TOOLS

The concept note was reviewed by USAID and feedback was used to modify a scope of work (SOW) for an international MAMI consultant. Both documents (concept note and SOW) were shared with the MAMI Global Network, and a highly qualified MAMI consultant was hired. MAMI activities will be integrated into facility- and community-based service delivery.

CONCEPT NOTE ON SMART GROWTH MONITORING AND PROMOTION

MIHR conducted extensive background research on successes and challenges with growth monitoring and promotion, and developed a Smart Growth Monitoring and Promotion (Smart GMP) concept note that was shared with USAID. USAID staff provided additional input on the concept note through a one-hour technical meeting, and were to provide written comments on the concept note early in Q1 of PY2.

PROPOSED ACTIVITIES FOR NURTURING CARE FRAMEWORK

The Nurturing Care Framework for early childhood development (ECD) uses state-of-the-art evidence about child development and the effective policies and interventions that improve ECD. The framework was developed by WHO, UNICEF, and the World Bank, working with the Partnership for Maternal, Newborn & Child Health, the Early Childhood Development Action Network, and other partners. In discussions with multiple headquarters technical staff, several potential initiatives, which fit well under the nurturing care rubric, were identified and proposed in the MIHR PY2 work plan.

INFLUENCING EXTERNAL DIALOGUE ON NUTRITION AND WASH

MIHR staff represented the project externally and contributed to dialogue about infant feeding in emergencies and One Health. Specifically, through monthly conferences with the Infant Feeding in Emergencies core group, MIHR identified activities and developed a work plan to establish and strengthen communities of practice and to improve nutrition in fragile settings. MIHR led the CORE Group's One Health

activities, including informational sessions at the CORE Group's annual conference, a webinar for Earth Day, and a journal club. MIHR staff also co-planned the CORE Group Practitioners' Conference.

COVID-19

MIHR's COVID-19 activities focused primarily on vaccine rollout in partner countries.

The MIHR Immunization Lead assisted country teams in the DRC and Mali in proposal writing and implementation of COVID-19 vaccination introduction, including microplanning, in MIHR-supported regions of the two counties.

The MIHR DRC country team received approval to redirect Mission MCH funding to support a COVID-19 vaccine roll out in North Kivu in PY1. A communication and advocacy survey was conducted in North Kivu with support of the MIHR core SBC Lead. As part of the microplanning process, 11 sites for a COVID-19 response were identified in Butembo, Beni, Katwa, and Kalunguta. MIHR started the procurement process by identifying infection prevention and control supply needs at the end of PY1; procurement and distribution were expected for October 2021.

MIHR also supported the Mali country team on communication and COVID-19 microplanning in Gao district, using the RED/REC approach.

MIHR disseminated WHO guidance on response to moderate and acute emergencies to each MIHR partner country, to help them adapt their needs on immunization services during emergencies, such as COVID-19. Similarly with partner countries, MIHR disseminated and discussed two GAVI sets of guidance to maintain, restore, and strengthen routine immunization, both during COVID-19 and with a gender focus.

Quality of Care

Through PY1, MIHR engaged with the QoC Network, Child Health Task Force, and other relevant technical and professional platforms to provide technical inputs as warranted. MIHR actively participated and/or contributed to SPA's technical working group for maternal and newborn care, and pediatric and nutrition working groups to revise SPA's QoC questionnaires around MNCH, FP, and nutrition from the lens of assessment tool implementation in fragile settings. The result of these activities helps to further operationalize standards for improving QoC for MNH, pediatrics, and small and sick newborns in fragile settings.

In close consultation with the USAID MNCH team, MIHR actively participated in and promoted, from the lens of fragile settings, the MNCH QoC measurement agenda for the next 5 years in WHO's life course on quality of care metrics with the Maternal Newborn Child and Adolescent Health and Ageing working group. The group's main purpose is to improve quality of care measurement coordination across the life course by developing and promoting the use of a harmonized methodology, framework, guidance, and tools for quality of care measurement. The group also supports the implementation of global and national quality of care measurement efforts for MNCAH.

In PY1, MIHR initiated and was leading the MOMENTUM-wide QoC thematic working group to coordinate and integrate QoC efforts across the MOMENTUM suite by leveraging experiences and resources, and coordinating interventions at the global and field levels. MIHR has become an active member of the IAWG

sub-working group on MNH as part of building QoC. MIHR was also contributing to the Respectful Maternity Care (RMC) task team to: identify promising practices and missed opportunities for RMC; develop a brief on RMC in humanitarian settings; and support the development and adaptation of a maternal mental health and psychosocial support (MMHPSS) toolkit (that includes a self-care component for providers). MIHR is also an active member of several technical groups, whose involvement directly or indirectly contributes to QoC:

- Every Newborn Action Plan in Emergencies/Humanitarian Settings (ENAP-E) working group,
- Monitoring and implementation TWG of the Global RMC Council,
- PPH Community of Practice,
- Reproductive Health Supply Coalition (RHSC),
- Maternal Health Supplies Caucus,
- WHO's Small and Sick Newborn indicator group, and
- WHO's Life Course Quality of Care Measurement Coordination Working Group (LCQM-CWG).

TECHNICAL COLLABORATIONS

MIHR engaged with the WHO QoC Network, the Child Health Task Force, and other relevant technical and professional platforms in PY1 to provide technical inputs to review a WHO multi-country study to field test recently developed core pediatric quality of care indicators. MIHR also collaborated with MKA and the CHTF monitoring and evaluation (M&E) subgroup to review and prioritize pediatric quality of care and SPA child health measures. MIHR also contributed to joint CHTF M&E and QoC sub-groups' review of draft core markers and catalog of metrics for pediatric QoC. Other activities included detailed feedback on WHO's draft protocol on field testing the feasibility of core pediatric QoC indicators in fragile settings.

QUALITY OF CARE ASSESSMENT TOOLKIT

Through PY1, MIHR worked to compile and revise a modular QoC assessment toolkit for use on an as-needed basis across partner countries. The tools in the kit will be adapted for specific contexts and program scopes to best examine and monitor quality of care. To build the kit, MIHR compiled and prioritized available QoC assessment tools from various sources. This includes SPAs, a Maternal and Child Survival Program (MCSP) Country Assessment Tool, and USAID ASSIST's Quality of Integrated Reproductive, Maternal, Newborn, Child, and Adolescent Health and HIV Services: Assessment Toolkit,[7] among others. These were revised to incorporate updated global technical guidance and adaptations to fragility-specific barriers to QoC, including the effects of shocks and stresses on provider behavior/biases, burn out, and availability and quality of adolescent-friendly FP/RH/MNCH services.

For FP/RH activities in the QoC assessment toolkit, MIHR incorporated appropriate measures into consolidated FP/RH/MNCH quality of care baseline assessment tools for fragile settings, across the continuum of service provision, from program readiness (availability of commodities, equipment, supplies and information, education, and communication [IEC] materials; staffing competencies; and supportive supervision), the process of provision of care (voluntarism and informed choice; interpersonal and

[7] June 2020. Found on the Development Experience Clearing House at https://dec.usaid.gov/dec/content/Detail_Presto.aspx?ctID=ODVhZjk4NWQtM2YyMi00YjRmLTkxNjktZTcxMjM2NDBmY2Uy&rID=NTYzOTg5&inr=VHJ1ZQ%3d%3d&dc=YWRk&rrtc=VHJ1ZQ%3d%3d&bckToL=.

information exchange) and client outcomes (knowledge, satisfaction, method uptake and continuation). In PY2, MIHR will develop responsive action plans, based on assessment findings.

The toolkit also includes tools used on a routine basis to assess QoC. MIHR prioritized a small number of process and proxy-outcomes, along with their metadata, to regularly measure MNH QoC. This data collection on quality of integrated service delivery includes postpartum family planning, immunization, and nutrition services across the ANC, childbirth, and PNC continuum. This toolkit is aligned with relevant global and cross-MOMENTUM MNCH QoC measures.

ADDITIONAL TOOL AND DATA APPLICATIONS

MIHR also drafted three generic data collection tools for routine monitoring. These include tools for measuring:

- Compliance with ANC and PNC clinical recommendations.
- Compliance with care recommendations around childbirth.
- Maternal and newborn care outcomes.

MIHR staff also drafted a concept note to operationalize the routine monitoring of QoC and cross-country learning, with accompanying draft tools, for review and approval through MIHR and USAID channels.

During PY1 in South Sudan, MIHR mapped the availability of data elements for three of the assessment tools vis-a-vis the country's standardized medical documentation, and was in the process at the end of PY1 of adapting the tools to the country's specific context. The QoC assessment toolkit will be instrumental in understanding the gaps in QoC in South Sudan and similar fragile settings, and will be used by frontline health workers, national governments, implementing partners, and MERL teams, to inform quality improvement interventions across health system levels and countries.

In PY1, MIHR received USAID Mission approval in South Sudan to assess experience of care as an integral part of the core-funded QoC assessment activity.

In PY2, MIHR will use the results of the baseline assessment on FP/RH QoC in both the public and private health sectors in Mali and South Sudan to co-create action plans that are responsive to identified gaps. To strengthen health system capacity and institutionalize high quality, clinical professional development opportunities for HCWs, existing training materials, such as the Training Resource Package (TRP) in Family Planning, the WHO Global Family Planning Handbook, and the WHO Academy mobile learning course on counseling and prescribing in pharmacies, will complement context-specific learning resource packages in order to transfer knowledge and skills to improve gaps for counseling and provision of modern methods of contraception. Such capacity strengthening activities will also include gender competency for HCWs, to equip them with the necessary knowledge and skills to provide FP/RH care to diverse groups of clients, including adolescents, men, and persons with disabilities. MIHR will use the HRH2030 "Defining and Advancing a Gender-Competent Family Planning Service Provider: Competency Framework and Technical Brief"[8] as the basis of this effort.

[8] Chemonics, 2020. Found at https://test-chemonics.pantheonsite.io/wp-content/uploads/2019/05/HRH2030-Gender-Competencies-Brief_2nd_Edition.pdf.

As necessary, MIHR will collaborate with other partners to strengthen commodity supply chain management and address issues related to equipment and supplies, including advocacy to the government and other stakeholders. These actions and outcomes will help to ensure that QoC is a key, integrated component of MIHR work through the project life.

FRAGILE SETTING ADAPTATIONS

A major part of MIHR's QoC work was to review and adapt quality of care frameworks and related implementation tools for use in fragile settings. MIHR also mapped available tools and measures to monitor experience of care across MNCH, and drafted a pediatric experience of care tool based on the prioritized core experience of care for WHO Pediatric QoC Standards.

Through MKA, MIHR was coordinating across the MOMENTUM suite on MNCH experience of care efforts. MIHR also organized a call with a UNICEF representative working on newborn experience of care, in order to share experiences and discuss the MNCH experience of care across the MOMENTUM suite.

Social and Behavior Change

Under its social and behavior change (SBC) activities, MIHR undertook several global leadership and engagement activities (listed in Appendix F). Extended SBC AOR (Agreement Officer's Representative) technical team meetings were established for ongoing communication between MIHR and USAID, which will take place quarterly moving forward into PY2.

STORY COMPETITION

During the final quarter of PY1, MIHR core and field staff collaborated to submit a summary of an intervention in South Sudan to the "10 Stories, 10 Lives, One Message" global competition led by Breakthrough ACTION. The purpose of the competition is to "gather 10 first-hand accounts that show how SBC approaches have been used by real people and organizations to improve family planning and reproductive health outcomes."[9] The story summary, titled "Adolescent-Parental Communication on Sexual Reproductive Health and Rights," was selected as one of five second-place winners. The team then collaborated to complete beneficiary and provider interviews, and submit the full story at the end of PY1. It is anticipated that Breakthrough ACTION will release and promote the stories at the end of Q1 in PY2.

TECHNICAL DOCUMENTS AND TOOLS

USAID provided feedback on a proposed "SBC for Fragile Settings" technical brief, and an agreement was reached to modify this into a roadmap. This roadmap, which will be produced with both core and country staff, will provide key considerations focused on MIHR's resilience capacities that promote proactive responses for SBC during shocks and stresses to prevent disruption in demand and care seeking, instead of reactive responses to these crises. MIHR will update the draft roadmap and share with USAID in Q1-2 of PY2.

[9] See https://breakthroughactionandresearch.org/announcing-the-winners-of-the-10-lives-10-stories-one-message-competition/.

MIHR contributed to prototyping diagnostic and programmatic tools linked to the Provider Behavior Ecosystem, led by Breakthrough ACTION. Tools will be adapted for use in selected MIHR partner countries in PY2.

MIHR contributed a draft journal article related to provider behavior change (PCB) and FP/RH, intended to be submitted to a peer-reviewed publication. MIHR also contributed to a draft journal article on lessons learned in SBC in public health emergencies. Both will be submitted in PY2 for peer review. Recommendations from both articles will be piloted by MIHR as appropriate and relevant in selected partner countries. In other publications, the Learning Collaborative's Social Norms Atlas was finalized and socialized in PY1, and MIHR was a main contributor to the provider behavior chapter.[10]

TECHNICAL LEADERSHIP

As part of its technical leadership activities, MIHR supported knowledge and information sharing activities, such as webinars on SBC and adaptive management for Mercy Corps and the Amplio Community of Practice. MIHR also led the MOMENTUM SBC thematic group, and was involved in leading the CORE Group quarterly meeting as co-chair of the Systems for Health working group.

MIHR also presented on the role of SBC in improving the uptake of modern contraception at the SBC for Service Delivery CoP. MIHR will continue participating in the CoP activities for experiential learning and sharing. Throughout PY1, MIHR was an active participant in various communities of practice, working groups, and other forums.

SBC adaptations and any related guidance will be expanded in PY2, as MIHR is still in the formative phase in many partner countries. MIHR will use country SBC experiences to document lessons learned and adaptive management activities for global, regional, and cross-country learning.

Service Delivery

Service delivery is integrated into all activities and technical areas under Result 1, and thus the topic is addressed throughout.

UNFPA Reprogrammed Funds

MIHR developed and submitted UNFPA reprogrammed funds and New Partnership Initiative work plan addendums to USAID in PY1 Q3. (A description of the latter is found under the Result 2 section on capacity strengthening.) In PY1, Mission concurrences to begin implementing activities under the UNFPA reprogrammed funds were received for South Sudan and Mali. In South Sudan, activities were underway to implement DMPA-SC-related activities. Planning was also in progress for implementation of the community health assessment and QoC activities. In Mali, plans were underway to conduct a private sector baseline assessment, to better understand the availability and demand for MNCH/FP/RH services through the private sector in Gao and Timbuktu. MIHR was also developing plans to implement the project's Fragility, Crisis Sensitivity, Complexity (F2C) assessment. To assist in this, MIHR engaged Johns Hopkins University (JHU), a resource partner, and discussions on F2C activities were ongoing by the end of PY1. MIHR was working on

[10] See the publications table below under the "Science and Research" heading.

obtaining additional Mission concurrences for Burkina Faso and Niger; MIHR anticipates receiving concurrence from both country Missions in PY2, and starting implementation of activities soon thereafter.

Gender and Youth

An MIHR Gender Strategy to provide systematic guidance to MIHR's gender integration was finalized in PY1, and activities aimed at addressing gender were implemented at core and country levels. The Gender and Youth Lead and other staff disseminated and socialized the Gender Strategy in part through a virtual gender awareness workshop in May 2021 for core staff. The workshop's goal was to foster a project culture that is gender-aware through enhancing the capacity of all MIHR staff to promote and model gender responsive attitudes, behaviors, and practices. MIHR staff participated in post–workshop group discussions and developed a gender integration checklist to support field teams in integrating gender awareness throughout the program cycle. The teams also developed an internal illustrative activity framework that will help inform and support the integration of gender issues into work plans, activities, and budgets for global and country-level staff. A virtual training workshop will be rolled out to country-based staff in PY2.

TOOLS AND COMMUNICATIONS

MIHR was at work in PY1 on youth-related strategies and tools to strengthen health systems toward helping youth become self-reliant and resilient. As a member of the cross-MOMENTUM youth CoP, MIHR collaborated and met with other MOMENTUM awards to discuss MOMENTUM youth strategies broadly and potential synergies across suite projects. An MIHR Youth Statement, which will guide support to youth and adolescents in MIHR partner countries, was drafted and in internal review at the end of PY1.

MIHR participated in cross-MOMENTUM gender and youth communication activities in PY1. MIHR led and collaborated with MCGL and MOMENTUM Safe Surgery in Family Planning and Obstetrics (MSSFPO) youth leads to develop a youth-oriented blog that was published on International Youth Day to share MOMENTUM's contributions to advancing youth health and elevating youth voices. MIHR also published an equity blog that contributed to knowledge sharing on breaking down barriers to health equity with insights on gender equity. (See blog details in Appendix D.) MIHR was also providing input into a gender brief led by MKA, with input from all MOMENTUM gender leads. The gender brief will provide an overview of how MOMENTUM is focusing on gender from the outset of its activities and within program areas, where gender has often been overlooked.

PARTNERS AND NETWORKS

MIHR continued to build networks and relationships with partners outside the MOMENTUM suite to share knowledge and bring youth and gender lessons for adaptation to fragile settings. MIHR initiated a relationship with the HCDExchange CoP; the exchange offers adolescent sexual and reproductive health (ASRH) practitioners and advocates a community forum, human-centered design (HCD) thinking, and workshop learning opportunities. MIHR will build linkages between country teams and the CoP for further engagement and learning, once Youth Community Action Teams are developed in PY2. MIHR has also recently developed and will grow a relationship with the International Planned Parenthood Federation to learn and share ideas on male engagement in order to build the proposed PY2 male engagement activities.

MIHR actively participated in IAWG meetings, webinars, and virtual meetings, and contributed to technical discussions on integration and articulation of gender and youth issues. Working with the IAWG on ASRH, a

plan was developed to have young people selected into co-chair positions on the IAWG ASRH sub-working group. A process to disseminate an IAWG ASRH toolkit in humanitarian settings was also developed. The Gender and Youth Lead continued to work with the MIHR SBC, FP/RH, MNH, CH, and Resilience leads to integrate gender and youth issues into work plans and budgets at both core and country levels.

Gender-based Violence

The prevention, response, and treatment of gender-based violence (GBV), especially through integration with other services, was a focus area throughout PY1. Three comprehensive sections on GBV were incorporated into the MIHR Gender Strategy, which will be rolled out to partner countries early in PY2. The MIHR GBV Lead contributed to an updated guidance document (French language version) on providing evidence-based care for GBV survivors in a clinic setting; this was focused on the DRC but is applicable to other Francophone countries. Guidance documents on ensuring continuity of GBV services (both prevention and response/treatment) during COVID-19 were also identified and disseminated to relevant country teams.

MIHR successfully adapted and piloted sections of the GBV Quality Assurance Tool-Minimum Care Version for use in the MIHR Health Facility Assessment tool. Data obtained will be used for programmatic purposes (identifying gaps in services as well as providing information on the feasibility of future integrated, facility-based GBV interventions). Based on the preliminary findings in two countries (Mali and South Sudan), priorities in PY2 will be training providers on integrated GBV care for survivors, including referrals, and linking facilities to supply chains to ensure the availability of emergency contraception and post-exposure prophylaxis (PEP). Relevant findings from the social norms assessment in South Sudan, which was completed in PY1, will also be incorporated into cross-country SBC activities and strategies for GBV prevention.

MIHR GBV and professional development guidelines for core and country team members were in review at the end of PY1. These will provide principles and standardized approaches/strategies to GBV prevention, mitigation, and response to ensure an evidence-based and systematic approach to program design. The aim is to reduce the tolerance of communities to violence and decrease the vulnerability of individuals, especially girls, boys, and women. The guidelines will be disseminated and promoted for all programming during PY2.

Resources that serve to guide curricula development and other actions include WHO's 2020 "Clinical management of rape and intimate partner violence survivors: Developing protocols for use in humanitarian settings" (https://apps.who.int/iris/bitstream/handle/10665/331535/9789240001411-eng.pdf?ua=1) and the 2015 WHO/UN Office on Drugs and Crime document "Strengthening the medico-legal response to sexual violence (https://www.who.int/reproductivehealth/publications/violence/medico-legal-response/en/). The francophone document on evidence-based care for GVB survivors was informed by the 2017 "Interagency Gender-Based Violence Case Management Guidelines: Providing care and case management services to survivors of gender-based violence in humanitarian settings" (https://reliefweb.int/sites/reliefweb.int/files/resources/interagency-gbv-case-management-guidelines_final_2017_low-res.pdf). Other documents that can be valuable to translate global clinical guidance for GBV integration into national, facility, and community-based guidelines and training curricula include the 2021 WHO "Resource package for strengthening countries' health systems response to violence against women" (https://www.who.int/publications/i/item/WHO-SRH-21.5) and the 2021 "Caring for women subjected to violence: A WHO training curriculum for health-care providers revised edition" (https://www.who.int/publications/i/item/9789240039803).

Gender-based violence modules from the GBV Quality Assurance Tool-Minimum Care Version have been incorporated into the MIHR core health facility readiness assessment and have been adapted for South Sudan. Integrated training on FP and GBV was being reviewed and selected from existing training curricula. Staff were identifying gaps in training curricula that MIHR may need to fill. A menu of GBV measures and questions were also selected for use in knowledge, attitudes, and practices (KAP) studies across the MIHR portfolio. An inventory of existing preventing sexual exploitation and abuse (PSEA) interventions and activities that exist in partner country was also started. A process of implementing the community action cycle to engage local communities and all leaders to improve gender, GBV, and sexual and reproductive health outcomes was started in South Sudan in PY1 and will be rolled out to communities in Magwi County early in PY2.

Population, Health, and Environment

For MIHR and population, health, and environment (PHE), PY1 was mostly about the transition of the Tanzania program from Evidence to Action (E2A) to MIHR. The USAID Mission in Tanzania requested that MIHR write a program description and begin to move into new geographic areas. Activities were mostly at the country level, with the core team providing technical support, including in writing the program description.

In PY1, little other activity from the core level was occurring related to PHE. In PY2, results from the Tanzania efforts will be summarized and disseminated across other MIHR activities, as relevant. MIHR also plans to engage cooperative agreement and external partners as relevant as programming moves forward. The MIHR PY2 Work Plan also noted other areas of exploratory MIHR programming through a PHE lens. MIHR plans to explore the potential of expanding the PHE integrated approach in an additional fragile setting in Francophone West Africa.

Community Health

COMMUNITY HEALTH GUIDANCE AND FRAMEWORK

MIHR prepared a community health strategy to outline how the project sees community health functioning as part of a larger health system, including its structure and services, and within the local community context. The strategy recommends strengthening (1) community participation; (2) community health governance; (3) quality of care and self-care; (4) social and gender norms and behavior change; and (5) improving resource allocation. The strategy is an internal guide in planning and implementing community health activities in MIHR partner countries. In PY1, the focus of the strategy and guidance was on the role(s) of CHWs and their interaction with the health system.

After preparing the strategy, MIHR did a thorough review of available tools to guide project involvement in strengthening community health in countries by building on existing platforms. WHO's "Community Health Worker Assessment and Improvement Matrix (CHW AIM)"[11] was a good fit to help assess the level of implementation of CHW programs and to identify implementation gaps. The tool was reviewed by MIHR

[11] See https://www.who.int/workforcealliance/knowledge/toolkit/54/en/.

partner countries, and efforts were made to incorporate the tool into the PY2 work plans of South Sudan, DRC, Mali, and Burkina Faso.

TECHNICAL ASSISTANCE AND GLOBAL LEARNING

In PY1, MIHR worked to provide cross-country technical assistance and advance global learning and technical leadership on community-based MNCH and FP/RH intervention adaptations that foster gender-equitable approaches for vulnerable urban contexts. To advance global learning on community health, MIHR participated in three forums: the community health CoP, the community health workers' impact coalition, and the health systems global community health workers technical working group. These groups enabled MIHR to learn from the global community and to share MIHR's experiences on community health in fragile contexts.

Guided by global learning and recommendations arising from analysis of local contexts, technical assistance was provided to South Sudan, Burkina Faso, Mali, DRC, Sudan, Tanzania, and Niger to enhance community health activities, especially by providing inputs to country-specific work plans and activity development processes. Recommendations made during the Integrating Community Health Conference 2021 (ICHC 2021) held in April also were considered, especially the integration of community health within primary health care as a solution to several challenges that community health workers face. These include payment, motivation and incentives, and support and supervision.

ENGAGE OTHER ENTITIES AND STAKEHOLDERS

MIHR worked to engage UNICEF, other MOMENTUM awards, and key stakeholders to provide technical assistance on UNICEF-led efforts to launch the development of guidelines on quality improvement through community-based primary health care. UNICEF has embarked on a multi-stakeholder process of preparing and vetting a list of core community health quality standards, including a technical guideline to support its implementation. MIHR offered support to UNICEF in guideline preparation. Once finalized, MIHR will review and discuss the product with partner country teams, and consider piloting it in one or two countries in PY2.

TECHNICAL ASSISTANCE TO PARTNER COUNTRIES

Technical assistance was provided to teams in South Sudan, Mali, the DRC, and Burkina Faso to help establish stronger community health systems by strengthening the engagement of community health workers and volunteers to increase access to community-based FP/RH and MNCH services. The latter is accomplished through regular communications and needs-based, remote support to country-based MIHR community health officers and project leadership teams.

In the last quarter of PY1, a virtual Peer Consultation session was organized for Mali, South Sudan, and the DRC to facilitate a cross-country learning exchange. The three countries presented lessons, best practices, and challenges. Motivation of CHWs, regular payments, defined service packages, standardized community health information systems, and integration within the primary health care system were major issues discussed that need particular attention. MIHR will address these issues in PY2 using the CHW AIM toolkit.

Field-funded Community Health Activities with Core Technical Support

Mali

- Two rounds of virtual learning exchange sessions with Madagascar and Ethiopia, focused on electronic community health information systems, payment and incentives for CHWs, and model family approaches, among others.

South Sudan

- 126 CHWs from 42 bomas (villages) trained in 14 facilities. Training focused on child health, safe motherhood, FP (including self-injection of DMPA-SC), and community health information systems.

DRC

- Rapid community assessment on the perceptions of community members and healthcare providers about the COVID-19 vaccine.
- 180 CHWs, also called *Recos,* were selected from Butembo city and Katwa province in North Kivu (both are Ebola Virus Disease hotspots) in collaboration with community leaders, to conduct community-based surveillance.
- Request for activity (RFA) was drafted to solicit proposals for sub-awards to local nongovernmental organizations (NGOs) for community health work. The NGOs will scale up community-based surveillance of targeted communicable diseases, expand basic community-based FP/RH, MNCH, nutrition, and WASH services, and address low vaccination coverage, among other actions.

FORMATIVE ASSESSMENT

A scope of work was prepared in PY1 to guide a community-level formative assessment of the quality of respectful, people-centered community-based models for FP/RH/MNCH services in South Sudan. A local firm, Dev-Com Consult Ltd., was selected to manage the data collection, analysis, and report writing, under the guidance of MIHR.

Health Resilience

MIHR used PY1 to refine frameworks and measurement and planning tools, and to understand contexts, which in turn resulted in the successful revision of the project theory of change (TOC), as well as consensus on Results Framework revisions, bringing forward resilience in fragile settings as the project's signature strategy.

GENERAL GUIDANCE ON RESILIENCE APPROACHES

MIHR initialized resilience efforts by organizing an internal technical working group. This group comprised technical leads and was led by the senior technical director and the monitoring, evaluation, research, and

learning (MERL) director. The group unpacked definitions of resilience at individual, household, community, and health system levels, gathered resources, and brainstormed on resilience framework and pathways for MIHR.

RESILIENCE MEASUREMENT TOOLS

MIHR selected and was working to adapt tools to measure health resilience at individual/household, community, health service delivery system, and health system levels, at both sub-national/national levels. At the individual/household level, MIHR integrated resilience assessment questions within KAP surveys, and planned to conduct a Recurrent Monitoring Survey (RMS). RMSs have primarily been used to assess livelihood resilience, so MIHR was reviewing these to adapt to health resilience. At the community level, MIHR adapted the Analysis of Resilience for Communities in Disaster (ARC-D) tool into the ARC-D Health tool, which was under internal review at the end of PY1.

At the health service delivery system level, MIHR follows a systems approach through implementing the resilience for social systems (R4S) tool, which has been used to analyze resilience of livelihood and market systems. R4S maps health service delivery system during both "calm" times and in times of crisis. At sub-national and national health systems levels, MIHR explored strategies to engage countries and local authorities and to support health systems strengthening through applying RED/REC approaches to all health planning and management practices, through training, mentorship, and supportive supervision.

INTEGRATING HEALTH RESILIENCE

To fully integrate health resilience within MIHR health programs, areas that will continue to be addressed throughout the project lifecycle include: review of the F2C tool; HFA tool with a resilience lens (that is, inclusion of specific questions related to exposure and vulnerability to shocks, preparedness to respond, continuity of operations, safety measures related to shocks, etc.); and close collaboration with the MERL team in identifying indicators related to health resilience (review of KAP surveys, support the discussion with REAL 2 on the implementation of RMS, etc.).

OTHER HEALTH RESILIENCE WORK

In South Sudan, an assessment of the Early Warning Response System was conducted in July-August 2021. This was complemented with the analysis of the District Health Information System (DHIS 2) to acquire an in-depth understanding of trends in health services coverage and health outcomes before, during, and aftershocks and stresses. Brown-bag sessions summarizing health resilience approaches on September 7 (in English) and September 8 (in French) 2021 were attended by technical teams of MIHR and other MOMENTUM implementing countries. In addition, MIHR technical team orientation was conducted on the adaptation of ARC-D and ARC-D Health as a measurement and planning tool of resilience in communities during September 14-17, 2021.

Working with the MIHR KM and Communications leads, the project's first MOMEMTUM brief, related to health resilience, was published on MIHR's first anniversary in May 2021. The program brief is noted in Appendix D.

Global Leadership

MIHR's Result 1, Activity 1.1 addresses global technical leadership. Along with related activities noted throughout the summaries above, an overall summary table of MIHR global leadership activities appears in Appendix F, which lists the range of involvement of MIHR staff across the spectrum of MNCH/FP/RH and related technical areas. Of particular note are the inroads that MIHR made regarding its participation in groups focused on fragile and conflict-affected settings, emergency preparedness, and resilience. In these groups, MIHR participation ranged from general involvement to substantive, technical contributions, to strategies and tools, to conceptual leadership. Below are highlights of key contributions that have the potential to influence strategies and decision-making about global health.

INTERNAL WORKING GROUP

The MIHR internal health resilience TWG worked to lay out the implications of the definition of health resilience for all the levels that the project intends to affect: individual, household, facility, community, and health systems. Largely from this work, a health resilience framework (including proposals for measurement) was developed and contributed to the MIHR TOC, that later informed results framework revisions. This understanding of health resilience and its implications for various technical areas has now begun to be disseminated through various forums. MIHR worked through the MOMENTUM-wide TWG on Health Resilience to help set implementation and measurement standards for health systems resilience interventions in fragile and conflict contexts.

RETHINKING THE MODEL

Building on E2A's work with the Method Choice Community of Practice, MIHR continued to refine a model for rethinking method choice. Instead of a method choice static definition as something that largely takes place in a facility setting, the model lays out an understanding of the concept as a series of influences and chain of decision-making, occurring from the individual up to structural and policy levels. The new Contraceptive and Method Choice Framework also highlights the importance of the reproduction intent of individual and couples, in addition to standard measurements of success in family planning. The new framework was just starting to be disseminated at the end of PY1; it has the potential to shift global thinking and acting on method choice expansion, particularly in fragile and conflict-affected settings.

TECHNICAL ASSISTANCE

MIHR worked closely with WHO's Department of Reproductive Health and Research and provided subject matter expertise during development of the WHO Academy e-learning course for pharmacists, "Counseling and prescribing of contraception in pharmacies." The course was designed to improve the quality of over-the-counter counseling and services for self-care contraceptive methods. This course is hosted on the WHO Academy mobile learning app. As noted in a prior section, in PY2, MIHR will use this course to strengthen the capacity of providers at pharmacies and drug stores to provide quality FP counseling and services, and document lessons learned in implementing this promising FP HIP, "Pharmacies and Drug Shops: expanding contraceptive choice and access in the private sector,"[12] into fragile settings.

[12] See https://www.familyplanning2020.org/resources/pharmacies-and-drug-shops-expanding-contraceptive-choice-and-access-private-sector.

In close collaboration with MCGL and USAID maternal and child health and nutrition (MCHN) teams, MIHR co-presented a MCHN course for USAID field teams. Specifically, MIHR developed the PowerPoint presentation, which compiled and synthesized the latest evidence in maternal health, including care around birth and management of complications, to strengthen the understanding of USAID field teams about emerging global technical guidance in maternal health.

In addition to these specific examples, MIHR continued to demonstrate leadership by adapting various tools, measures, and instruments for fragile settings. These materials will be available to a global audience and will move the field forward regarding work in fragile and conflict-affected settings. The MIHR tool tracker document is found in Appendix G.

Result Area 2: Capacity to Deliver Evidence-based, Quality Services

Result Area 2

Capacity of host-country institutions, local organizations, and providers to deliver evidence-based, quality MNCHN/FP/RH services/care improved, institutionalized, measured, documented, and responsive to population needs.

Local Engagement

Under MIHR reporting, local engagement activities are primarily described above under the Result 1 "Community Health" heading. Some community-oriented MEL activities are also noted below under Result 3.

Capacity Strengthening

In PY1, MIHR focused on developing and adapting strategies, approaches, guidelines, tools, and templates to be used for local organization and institution capacity strengthening for effective FP/RH/MNCH programming. The process included review of existing strategies, assessment tools, templates and other materials from both the field and successful USAID projects in order to best adapt materials for the fragile settings where MIHR works.

The project drafted the MIHR Capacity Strengthening Strategy, which outlines MIHR capacity strengthening guiding principles, implementation approaches and pathways, and a measurement framework. The project also developed the MIHR Organizational Capacity Assessment tool as the primary instrument to measure local partners (adapted from MCGL's Integrated Technical and Organizational Capacity Assessment [ITOCA] tool) and the MIHR Capacity Assessment Guide to apply in local partner capacity strengthening initiatives.

At USAID's request, the project also completed work on the Organizational Performance Assessment tool (utilizing Pact's Organizational Performance Index [OPI] tool). Organizations receiving NPI funding are subject to this assessment. While the original OPI tool covers four areas (effectiveness, efficiency, relevance, and sustainability), MIHR has been involved with Pact to add a fifth organizational performance indicator,

resilience. Adapting and enhancing tools to incorporate resilience and gender dimensions are key in the fragile settings where MIHR works.

MIHR also drafted an internal guide on mainstreaming capacity building in MNCH/FP/RH technical areas to support the project in integrating capacity strengthening into scoping, assessments, tools development, work planning, and implementation of FP/RH/MNCH activities. The guide, which was developed and shared internally during Q2, is aimed at sensitizing the MIHR technical team on the importance of mainstream capacity strengthening in their MNCH/FP/RH service delivery and health systems strengthening for the purpose of sustaining performance beyond the project.

MIHR has also completed developing a draft grants management capacity strengthening strategy, which is expected to be piloted in PY2. The strategy has been incorporated into the larger MIHR capacity strengthening strategy, and will be used to provide the principles and practices to be applied during grants management capacity strengthening efforts with local partners.

Social Accountability

In PY1, an MIHR Social Accountability Strategy was drafted. When finalized in PY2 Q1, the strategy will serve as an internal, guiding document for social accountability approaches in MIHR partner countries in collaboration with country teams and local partners. The strategy includes criteria for choosing social accountability mechanisms to adapt in MIHR partner countries, as well as illustrative measures for monitoring, learning, evaluating, and adapting social accountability approaches during implementation. These mechanisms include, for example, the Community Score Cards (CSC), Partnership Defined Quality (PDQ), and Citizen Report Cards (CRC). In addition to the social accountability strategy, the technical team developed a corresponding theory of change to illustrate how empowering communities, services providers, and other duty bearers develop a mutually beneficial engagement loop could lead to improved quality of FP/RH/MNCH services, as well as good governance in service provision.

In the last quarter of PY1, the MIHR social accountability working group shared the strategy with MIHR leadership. Final revisions will be made on the penultimate draft in early PY2, and an internal Learning Break is planned in early PY2 to orient the entire MIHR team on the rationale for, and goals and objectives of, the social accountability processes.

Some countries (e.g., South Sudan) have already initiated the planning and implementation of social accountability interventions. Other countries (e.g., Mali, Burkina Faso, Sudan) chose an appropriate social accountability intervention based on the criteria laid out in the strategy.

All MIHR partner countries included social accountability activities in their work plans. The criteria laid forth in the Social Accountability in Fragile Settings Strategy will help define the most appropriate and feasible social accountability mechanism to use in each country, in collaboration with other stakeholders and based on any lessons already learned.

MIHR was invited to be a member of the expert working group to develop an “enabling environment” HIP for family planning focused on social accountability. MIHR contributed to the theory of change and provided substantial input into iterative drafts. It is expected that the final draft will be circulated for comment in Q1 or Q2 of PY2.

New Partnership Initiative

During its first year, MIHR received approval to implement activities under the USAID-funded New Partnerships Initiative (NPI) addendum to the PY1 work plan. MIHR was in the process of obtaining Mission concurrence for each of the three countries (Burkina Faso, Mali, and Niger) included in the addendum for NPI funds. By the end of PY1, planning for mission concurrence was progressing, with MIHR anticipating achieving concurrence and beginning implementation in Q1 of PY2. NPI activities were also included in the Niger work plan, which was submitted early in Q4 of PY1.[13] During PY1, MIHR provided the USAID AOR team with ongoing NPI progress updates. MIHR anticipates implementation of NPI activities will ramp up in PY2, once all required approvals are obtained.

At the end of PY1, Mali and Burkina Faso were drafting expressions of interest in readiness to launch partnerships, as soon as respective Mission concurrences for NPI activities were received.

NPI funds will be used to ensure continuity of care and bolster the capacity of health facilities and health systems. MIHR will work within existing community structures to implement activities through subaward to local, national, and/or regional organizations. The focus will be on new and underutilized partners, and efforts to strengthen their organizational and technical capacities for sustained improvements in FP/RH outcomes.

Government Commitment to Health

This topic is outside of MIHR's immediate realm of engagement.

Result Area 3: Adaptive Learning and Use of Evidence

Result Area 3

Adaptive learning and use of evidence in MNCHN/FP/RH programming through sustained host-country technical leadership increased. MOMENTUM will also utilize USAID's catalytic, global leadership role to advance and amplify local technical leadership from the local to the global level, as noted in Result Area 1.

Intermediate Result 3.1 is "Increased appropriate and timely availability and use of data for decision-making in MNCH/FP/RH policy and programs at global, regional, and sub-national country levels." To meet this, MIHR worked to establish systems to collect and manage data needed by the project. As data are available, MIHR works with core and country staff, partners, and counterparts to improve the use of these data for learning and adaptive management (i.e., planning and decision-making).

[13] Approval of the Niger work plan was received after PY1, but prior to initial submission of this report.

During PY1, MIHR worked to build systems to ensure the availability of relevant data learning and adaptive management, such as for planning, decision-making, and course corrections. The backbone of this was the Monitoring, Evaluation, Research, and Learning (MERL) and Knowledge Management (KM) Plan. This MERL-KM Plan lays out how MIHR monitors the project's performance and achievements, and also includes the learning agenda.

MERL Country Support

Most of the data required for project monitoring come from country buy-in (field support) activities. Each country buy-in also is required to develop its own monitoring, evaluation, and learning (MEL) plan, which is part of their work plan. The indicators included in a country buy-in's performance monitoring plan (PMP) within their MEL plan are linked as closely as possible to the core PMP set of indicators, in order to roll the data up from the countries to core. However, core indicators used in a country are only those that pertain to the program description for that country. For example, if MIHR's work in "Country X" is only FP/RH, then MNCH indicators are not included in their PMP. Additionally, Country X's work plan may include other activities and related indicators that are not included in the core PMP.

As these field support activities came on board, the core MERL team supported them to collect, manage, and analyze needed data. The field data starting point was service data from each country's health management information system (HMIS), which requires strengthening data quality. HMIS review guidance was drafted and under review in PY1; it will be added as a module to a MEL Handbook. This guidance will be used by the country teams to map the processes employed to record, collect, and transmit data into their HMISs. This review also includes data quality assessments (DQAs). This mapping will help MIHR identify the points to intervene to strengthen the HMISs.

In addition to strengthening the HMIS process to improve data, MIHR also worked with country teams in South Sudan and Mali to conduct a health facility assessment (HFA). The master HFA data collection instrument was developed by the core MERL team. The country teams pulled modules from the master HFA that were aligned with their respective program descriptions and work plans. A rapid HFA was also conducted in DRC as part of the scoping process needed to develop their first work plan. Portions were repeated in facilities affected by the 2021 volcano, but this was done at the field level, not core.

During PY1, field-based MERL staff worked to strengthen capacity both within their MERL teams and with their local MEL colleagues/counterparts. The MIHR core team drafted guidance for MEL supportive supervision. The intent of this supportive supervision guidance was to provide recommendations to field MEL teams on how to strengthen capacity for data recording, data collection, data management, data analysis, data use, and provision of oversight of data systems. This MEL Supportive Supervision guidance will be finalized during PY2, and added as a module to a MEL handbook.

The core MERL team provided technical assistance to the country MEL teams on a wide range of monitoring, research, and learning activities for each country, as needed.

Measurement, Learning, and Adaptive Management

Adaptive management is "an intentional approach to making decisions and adjustments in response to new information and changes in context" (ADS 201.6). MIHR has designed MERL and KM activities and processes to promote continual learning that provides needed evidence to inform the adaptive management process.

Data and data outputs (e.g., tables, charts, and other data visualization) must be accessible for use and application for planning, decision-making, and course pivoting and correction. As this is essential to learning and adaptive management, MIHR worked in PY1 on developing a project-wide data system to manage and analyze routine data, and to improve efficiency and effective use of data at country and core levels. MIHR developed a contract with Dimagi for CommCare mobile device data collection apps needed by country teams. A contract was also created with BAO to develop and support a data management system to create interoperability across MIHR datasets and countries, and to provide staff access to data and outputs. (Access to the system by MIHR partners will be considered once it is up and running.) The BAO-supported MIHR data system will be developed in PY2, beginning with service data from country HMISs, HFAs, and other routine and readily available datasets. The data system will be available to all MIHR staff through a common dashboard; this will improve the efficiency of reporting processes, provide democratization of data, and increase data use for ongoing learning and adaptive management.

To monitor MIHR's work, achievements, and management processes, at least quarterly and as issues arise, the MIHR Senior Management Team (SMT) reviews data, knowledge sharing, reports, and other relevant documents, as well as information obtained experientially and through trusted sources. As issues and challenges are identified, MIHR identifies actions to address these issues (adaptation). The SMT and the Leadership Team routinely review progress made against these issues and challenges.

Learning questions and a learning agenda were developed in PY1, and were included in the MERL-KM Plan.

Knowledge Management

MIHR's KM activities work to share and promote the use of evidence-based information, and strengthen programmatic approaches across all intermediate results by:

- Fostering a culture that is supportive of documentation, knowledge sharing, and learning.
- Improving collaboration and sharing among MIHR staff members, the MOMENTUM suite, and USAID.
- Contributing to the learning agenda through documentation and knowledge sharing activities.
- Promoting voices from the field along with other forms of expertise.
- Focusing on and responding to the knowledge needs of different audiences.

Several specific activities were completed in PY1; some of these are ongoing through the life of the project:

DEVELOP KM PLAN AS PART OF MERL PLAN

In PY1 Q2, the Knowledge Management Plan was completed and submitted along with the MERL Plan to USAID for review and eventual approval.

DEVELOP KM PLATFORM IN COORDINATION WITH MKA

MIHR provided significant contributions and input during the development of the MOMENTUM HUB and the public website. MIHR also developed and launched an internal project intranet, called MIHR-I, that brings together tools and resources specific to MIHR and links to other MOMENTUM platforms. To ensure staff understand the differences between these platforms, a page on MIHR-I explains what belongs on each and where staff can go to get different types of information.

PEER-TO-PEER KNOWLEDGE EXCHANGE

In developing guidelines for peer-to-peer knowledge exchange, three types of approaches were prepared and launched in PY1 to support staff to share with each other. Two of these are specifically designed to enable exchange between country programs.

1. *Learning Breaks* are designed to share relevant, technical information with staff based on identified needs. During PY1, MIHR held six Learning Breaks, with a seventh taking place at the beginning of PY2:
    - Humanitarian 101
    - Maternal-Newborn Health in Fragile Settings
    - Digital Health Principles and Practice
    - RED-REC
    - Population, Health, and Environment (PHE)
    - Safety and Security
2. *Peer Consultations* bring together two or three country programs to explore a technical area in more detail and provide advice and recommendations to each other based on experiences in different countries. The first Peer Consultation was held in August 2021, and brought together staff from DRC, Mali, and South Sudan to discuss community health strategies and approaches. A second consultation on immunization was slated to take place in October 2021.
3. *Tea Talks* are mini communities of practice for MIHR staff in country programs to meet, network, and share experiences and knowledge with colleagues from other countries. The first group was launched during PY1 with two meetings among senior MEL advisors. A chief of party (COP) forum was organized during PY1, with the first meeting to take place in early PY2.

CREATE KM TEMPLATES AND GUIDELINES IN COORDINATION WITH MKA

Through the KM and Strategic Communications working groups, MIHR provided input during PY1 on MOMENTUM-wide templates and guidelines, adapted MKA generated tools, and developed award-specific tools and guidelines, including:

- **MOMENTUM-wide**
    - MOMENTUM country maps
    - MOMENTUM Knowledge Management Plan
    - MKA annual work plans
    - Adaptive Learning Guide: A Pathway to Stronger Collaboration, Learning, and Adapting
    - MOMENTUM Data Visualization Guide (drafted)
- **MIHR**
    - MIHR Document Planning Process
    - MIHR Publication Planning Form (drafted)
    - MIHR Reporting and Formatting Guidelines
    - MIHR Word templates (adapted from MKA templates)
    - Guidance for developing a MOMENTUM blog
    - Guidance for organizing a Peer Consultation
    - Template (and guidance) for country documentation and dissemination plans
    - Knowledge management and communications focal points (adapted from MKA tool)

- Internal and USAID review processes (drafted)

Other KM Activities

Partnership with Knowledge SUCCESS: During the project year, MIHR developed a partnership with USAID's Knowledge SUCCESS project to identify opportunities for collaboration. During Q4, MIHR developed "20 Essential Resources for Family Planning and Reproductive Health in Fragile Settings" that will be launched through Knowledge SUCCESS in PY2 Q1. Opportunities for collaboration during the next project year were also discussed, and plans were underway for podcasts to be jointly produced during PY2.

Bi-Weekly Knowledge Updates: Every two weeks, an internal Knowledge Update is shared via email with staff to give highlights of new MIHR resources, MOMENTUM resources, and other resources of interest. The email also includes upcoming events of interest to MIHR staff.

Webinars and Events: MIHR staff have been panelists and presenters at cross-MOMENTUM events, including the MOMENTUM Share Fair and Virtual Learning Exchanges. A public webinar was held on September 23, 2021, to mark World Contraception Day. A summary of knowledge sharing events, both internal and external, is available upon request.

Status summary of sub-activities in PY1 work plan:

- Develop KM Plan as part of MERL Plan: Completed
- Develop KM Platform in coordination with MKA: Completed
- Develop guidelines for peer-to-peer knowledge exchange: Completed
- Create KM templates and guidelines in coordination with MKA: Completed and ongoing
- Implement KM activities per KM Plan: Completed and ongoing

Additional, related information can be found in Appendix D, Knowledge Dissemination, and Appendix E, Strategic Communication.

Innovation

As MIHR works in health and development in fragile settings at the H-D nexus, the project is innovating on an ongoing basis to adapt standard interventions to these settings, as noted throughout this report. As these adapted approaches are introduced MIHR plans to use routine monitoring data to evaluate outcomes and performance. This will allow MIHR to evaluate these adapted approaches over time and across sites and countries.

MIHR incorporates health resilience throughout the project, requiring MIHR to define health resilience and apply metrics to monitor health resilience. MIHR had initially developed a health resilience definition, but then adopted the subsequent and similar USAID/Global Health definition of health resilience. This allows MIHR to use a common definition across USAID-funded health projects. However, as there were no existing metrics specific to health resilience, MIHR developed relevant indicators for the project's PMP.

In South Sudan, MIHR is interested in evaluating the project's interventions to improve demand for FP/RH/MNCH, self-care, and individuals' knowledge and practices. Initially, a household KAP survey was planned; however, the Liverpool School of Tropical Medicine (LSTM) conducted a National Household Survey,

utilizing a lot quality assurance sampling (LQAS) methodology in 2020. This LSTM survey produced results only down to the county level, but MIHR works at all levels within a country, so was interested in drilling down to a facility catchment and/or community level. As MIHR proposed a very similar household KAP survey in their supported sites, MIHR held meetings with LSTM in which it was suggested that MIHR could conduct a continuous KAP in project sites, using the LSTM National Household Survey county data as baseline, and to determine in supported sites what markers/questions fell below a determined threshold. This innovative approach would be done continually throughout the life of the project, and findings would be used for ongoing learning and applied to adaptive management. During PY1, MIHR developed a work plan, in consultation with LSTM, for this continuous KAP. This innovative continuous KAP and process for learning and adaptive management will be reviewed, along with the data. If as successful as hoped, MIHR will roll this out to other field-based projects, as appropriate.

Evaluation and Research

MIHR supports and implements new, adapted, and innovative approaches to FP/RH/MNCH and health resilience; therefore, it is important to track and evaluate their effectiveness. Work in fragile settings necessitates that standard interventions be adapted, and that these adaptations be evaluated. However, there is not a body of evidence regarding health resilience and how to implement development activities in the H-D nexus. Research and evaluations are thus critical for effective planning and implementing health programs while strengthening health resilience capacities.

In MIHR's first year, evaluation and research priorities needed to be set, and the project had very limited core-funded research activities. MIHR conducted a landscape analysis of the H-D nexus, with an emphasis from the development perspective. This was implemented by MIHR's resource partner Johns Hopkins University (JHU) Center for Humanitarian Health (CHH). JHU CHH conducted a briefing with USAID on the analysis, which MIHR submitted to USAID. Also, using core funding in PY1, MIHR developed a draft protocol for a Private Sector Assessment in Mali, which will be implemented in PY2.

MIHR was instructed to do fragility analytics and crisis sensitivity monitoring in every partner country. Complexity appraisal was also requested. For USAID guidance on these, MIHR noticed there were overlapping and linked characteristics embedded in each. Therefore, MIHR MERL core staff developed the Fragility, Crisis Sensitivity, and Complexity (F2C) Assessment. This begins with a desk review of existing reports and local media, then key informant interviews on the effects and coping mechanisms related to the identified shocks and stresses. The effort culminates in a workshop to develop recommendations for MIHR and to appraise the crisis sensitivity and complexity of each recommendation. The F2C protocol was shared with South Sudan and Mali country teams (the Mali team translated it into French). Both South Sudan and Mali recruited a local research consultant to implement F2C, using field funding in PY2.

In PY1, an evaluation and research agenda was developed in line with the MIHR Learning Agenda (included in the MERL-KM Plan). These research and evaluation priorities were included in the PY2 work plan submitted, and include a Mali Private Sector Assessment, H-D nexus case studies, a Recurrent Monitoring Survey (RMS), multi-country F2C review, MAMI review, and evaluations as part of the NPI innovation grants. Additionally, as more data are gathered from partner country buy-ins, Brigham Young University, another MIHR resource partner, will do secondary data analyses, allowing MIHR to pull data across datasets and countries.

Digital Health

Digital applications can improve the collection, transmission, and use of information and data. Digital applications can be web-based and/or accessed through mobile devices. MIHR digital applications support technical interventions with messaging, reminders, job aids, e-learning, etc.; support KM through knowledge exchanges and dissemination; and contribute to data collection, data management, and data analysis for MERL activities.

During PY1, MIHR actively participated in the cross-MOMENTUM Digital Health thematic working group, including presenting at the MOMENTUM Share Fair at a session on digital health. Most of PY1 focused on liaising with MIHR core and country staff to socialize digital health and determine needs. Information gathered was used in a Digital Health Plan draft, and to plan next steps. There is a great desire by MIHR staff to develop digital applications, particularly for use by partner country teams.

Core staff provided technical assistance to the South Sudan local resource partner conducting data collection for the Social Norms Assessment, utilizing tablets to collect and store data and record interviews, making data management and analysis more efficient. Lessons learned will be disseminated going forward to other partner countries and activities. In PY2, the HFA mentioned earlier in this section will be digitized, to be used by the South Sudan and Mali country teams.

To ensure the best possible outcomes for outside support, MIHR developed a requirements document for digital MERL needs. RFPs were issued, applicants reviewed, and digital partners selected. To support MIHR for digital data collecting, CommCare/Dimagi was selected. For the MERL system, BAO was selected.

Result Area 4: Cross-sectoral Collaborations and Innovative Partnerships

Result Area 4

Cross-sectoral collaboration and innovative partnerships between MNCHN/FP/RH and non-MNCHN/FP/RH organizations increased.

Partnerships

Effective human resources for health (HRH) and strategies for augmenting the capacity of health care workers is critical for effective FP/RH/MNCH care and service delivery in fragile and low resource settings. In PY1, MIHR undertook activities to explore opportunities for expanding training of existing health workers through partnerships and networking with existing training facilities, with the ultimate goal of increasing quality of care and reduction in morbidity and mortality. The activity was designed to augment and sustain the capacity of health workers to deliver essential health care services in remote and hard-to-reach areas. MIHR conducted a mapping exercise of health care institutions in two countries (South Sudan and DRC) to identify potential partnerships, and to implement capacity strengthening activities in PY2.

Building upon the platform of the MIHR award consortium's existing networks of educational institutions and partners, MIHR identified the priority training needs of MIHR-supported health care workers, and subsequently mapped relevant and available international, regional, national, and sub-national public and

private educational institutions, in order to strengthen the pipeline of quality health care workers and managers in fragile settings.

In PY2, MIHR will continue the mapping exercise and expand it to other MIHR-supported countries. Once the mapping is complete, MIHR will engage training institutions to expand access to their content and training programs, and collaborate to update tools and materials. MIHR will work with local training institutions to adapt digital e-learning content for frontline health workers.

Learning and Adapting

CLA Approaches and Use of Knowledge

Collaboration

MIHR participates in cross-MOMENTUM working groups, such as the Monitoring, Evaluation/Innovation and Learning (ME/IL), KM, and Strategic Communications working groups, as well as the Digital Health thematic working group (previously Distance Learning working group). MIHR staff also participate in cross-MOMENTUM thematic groups on technical issues. MIHR also collaborated with MPHD for input on the development of the Mali Private Sector Assessment, with MSSFPO on task shifting, and with M-RITE and MCGL on the zero-dose strategy, among other efforts.

In PY1, MIHR collaborated with other USAID-funded projects, such as Knowledge SUCCESS with the development of "20 Essential Resources for Family Planning and Reproductive Health in Fragile Settings" (see the FP/RH section under Result 1 above), which was expected to be posted early in PY2. MIHR also met monthly with REAL 2 to discuss measurement of health resilience. MIHR also collaborated with Breakthough ACTION in several countries, with coordination at the core level.

Learning

MIHR has integrated learning into the project culture. PY1 focused on defining the project's learning questions and agenda (see MERL-KM Plan). MIHR also worked to learn from others' applicable experiences and knowledge by attending webinars, sharing relevant articles, and participating in global working groups. MIHR's KM Lead coordinates Learning Breaks, which are internal webinars where MIHR staff present information on approaches and best practices applicable to MIHR programming. Learning Breaks occur regularly (on average, monthly), and have been conducted on humanitarian assistance; the latest information in, for example, MNH, RED/REC, digital health, PHE, and security rules and regulations; and MAKLab.

Adaptive Management

MIHR held routine meetings IN PY1 to review and discuss project status and to address issues as they arose. These were to continue in PY2. The Leadership Team meets weekly; the Senior Management Team meets biweekly, and other MIHR teams meet routinely. These meetings often go beyond management issues, and are used for problem solving and adaptive management. As project data become more available in PY2, these meetings will include a review of these data to identify both what is working and any areas for improvement.

Lessons Learned and Challenges

Lessons Learned

Lesson 1: A Systematic Approach to "Health Resilience" Requires Shifting Mindsets, Followed by Capacity Building

The MIHR team actively worked on developing the meaning and content of health resilience during PY1. When the project launched, there was little programmatic work on health resilience, including indicators of health resilience. Most resilience work focused on food security and livelihood. This required MIHR to adapt existing definitions, tools, and indicators to focus on health resilience. To integrate health resilience into FP/RH/MNCH and other MIHR work, a process of internal dissemination and socialization of health resilience was first needed. Then, since the concept was fairly new, staff needed time to internalize it, determine how "health resilience" was related to their own technical specialties, and how it could be implemented in programming.

A corollary lesson is that, just as the concept of health resilience was relatively new to core staff, it was also new to MIHR country-level staff, partner governments, technical partners, and Missions with whom MIHR works. To accelerate this shift in mindset–both at core and country levels–a concerted and extended capacity building effort is needed so that MIHR staff can champion a health resilience approach, analyze strategic issues, document efforts, and support country-level stakeholders and better support countries to move forward with their health resilience programming. This integration and programming of health resilience is an ongoing process that will continue and expand throughout the life of the project.

Lesson 2: The COVID-19 Pandemic Enabled Us to Learn How Much We Can Do Remotely

"Necessity is the mother of invention." In MIHR's case, the COVID-19 pandemic was the driving force to explore the contours and limits of conducting online project assessments and design, management, technical assistance, monitoring, and research and evaluation. It helped that the entire global community was affected, and all were forced to respond to the same crisis and adjust accordingly, and were similarly motivated.

MIHR learned, for example, that it is possible to develop collaborative work teams with high morale through regular meetings (using video when possible) of the entire team and, more often, working subgroups. Exercises that normally would have been done in person—such as the country scoping process to develop a new work plan—could be conducted effectively and efficiently using core partner organizations to identify and arrange key informant interviews with national and regional stakeholders. Good relationships have been developed between the country teams and core staff through this process. Regularly scheduled and well-planned meetings have been key to growing a sense of confidence and accountability among all MIHR staff members.

Learning from the remote scoping was organized and disseminated globally through a technical brief posted to the MOMENTUM website in July 2021.[14]

[14] See the brief on the MOMENTUM website at https://usaidmomentum.org/resource/recommendations-for-starting-programs-remotely-lessons-learned-from-momentum-integrated-health-resilience/.

Lesson 3: MIHR has Benefitted from Expanded Contact with the USAID AOR and Extended Technical Team

The level of contact between USAID and MIHR is a new experience for some staff. We have learned, however, that this level of engagement is optimal for the project. It ensures not only that MIHR remains responsive to our donor and the various country contexts in which we work, but also safeguards that technical work is grounded in deeper, cross-MOMENTUM, and state-of-the-art conversations and evidence. We have very much appreciated the more informal exchanges between our technical staff and the USAID technical team(s), which allows staff the freedom to check their impressions and ideas with USAID. Similarly, the monthly meetings between MIHR and USAID on MERL issues has helped with information exchange and in setting MIHR MERL priorities. This relationship has also made us aware of how MIHR's country contexts may be different from the other MOMENTUM awards, and the need to discuss when cross-MOMENTUM priorities may require different thinking for fragile and conflict-affected settings.

Challenges

Challenge 1: COVID-19 Forced a Re-thinking of Project Start-Up Procedures and Unavoidable Delays

Conducting scoping exercises for work plan development, strategic planning, hiring, on-boarding, supervision, and providing the ongoing technical backstopping that country staff need had to be rethought using online technologies. While we have learned from necessity about how to be effective at a distance, there was clearly a learning curve and concomitant delays. It is important to remember that the entirety of this project—thus far—has been carried out online. MIHR has been using adaptive management to ensure that activity implementation progresses. Lessons learned will be documented and shared regionally and globally to advance the field.

Challenge 2: Limitations Placed on Travel Due to COVID-19 have Lengthened our Learning Curve Regarding Fragile and Conflict-Affected Settings

Not all MIHR staff have deep experience in specific fragile and conflict-affected settings (FCAS) or in all partner countries. Enabling technical staff to travel to MIHR partner countries to learn first-hand and up close about the contextual realities of providing facility- and community-based services in these environments would have done much to shorten the learning curve about our specific FCAS. In PY2, with the knowledge gained through virtual efforts, and with travel restrictions somewhat eased, interventions, work plans, and priorities will become increasingly focused on fewer and more critical areas, thus increasing our responsiveness.

Challenge 3: Coordination Among MOMENTUM Awards Requires Time and Effort to Harmonize.

Challenges in coordinating efforts across six projects that started at different times and with different staffing levels and somewhat different foci are not unexpected, especially when projects are supposed to harmonize and speak with one voice. For example, strategic communication can play a great role in a project's success by effectively disseminating its messages and magnifying its achievements for the global community. However, efforts to streamline messaging across projects has not always been seamless. For example, MOMENTUM blogs, after internal review, have to pass another three layers of review (MKA, USAID Comms, MIHR AOR team). This presents a challenge when trying to finalize a blog tied to a particular global "day" or event on the calendar This particular challenge is recognized and being addressed by MKA. It also took MKA over a year into their award to produce written blog guidance. In another example, MIHR produced staff

reporting guidelines several months before MKA announced, without prior notification, that MOMENTUM-wide guidelines had been produced. Had MIHR received earlier notification, staff could have worked closely together to avoid duplication. Again, these challenges are not wholly unanticipated, but they have caused issues in contributing to the larger effort.

Harmonizing PMP indicators across all the MOMENTUM projects has also been challenging. As MIHR started later than MKA, we anticipated cross-MOMENTUM indicators would have been developed, but only Result 1 indicators had been drafted. Result 1 indicators were updated throughout most of PY1. During this time, MIHR needed to develop a project PMP with indicators for all four results, and this was prior to MKA finalizing Result 1 indicators, and drafting indicators for Results 2, 3, and 4. Additionally, every country PMP required country-specific indicators that MIHR tried to align with the core PMP indicators. Now that there is a full list of cross-MOMENTUM indicators (all four Results), MIHR is re-reviewing project indicators against the cross-MOMENTUM indicators and will move forward.

Way Forward

MIHR has prepared the groundwork for partnerships, tools, and guidance for capacity strengthening activities focused on FP/RH/MNCH and health resilience in fragile settings; their adaptation, strengthening, field testing, and roll out will continue. As MIHR transitions into PY2, core activities will build on ongoing TA and support for country work and actions, such as quality of care assessment and monitoring tools, health facility readiness assessments, digital health applications, and monitoring, evaluation, and learning systems, to help better inform FP/RH/MNCH activities at both core and partner country levels.

MIHR's initial priorities have evolved as the project's technical mandate and the mandates of the other MOMENTUM projects have taken shape. In PY1, MIHR articulated the following priorities, which continue into PY2:

1. Mainstream resilience for health
2. Differentiate technical approaches for scale up of high impact interventions and high impact practices, depending on the fragility typology of each setting
3. Improve quality of care at all service delivery points, including at the community level, through support groups to, for example, improve nutrition practices such as breastfeeding
4. Strengthen community health systems for service delivery, equity, and accountability for health
5. Increase equitable access to life-saving interventions across the continuum of care
6. Strengthen the capacity of local partners
7. Integrate service delivery
8. Foster and actively support innovation to provide lessons, models, and metrics for service delivery in fragile settings

MIHR will streamline **health resilience** programming in countries and ensure that country teams have the orientation, resources, and tools they need to measure, monitor, understand, and use resilience metrics for adaptive management.

MIHR has increased its emphasis on **community health systems** because of the critical role that communities and community members play in health resilience, especially when formal health services are disrupted and/or are chronically weak or absent. MIHR will promote self-care and evidence-based caregiving in the home by increasing access to DMPA-SC and emergency contraception; address bottlenecks to the advance distribution of misoprostol for postpartum hemorrhage prevention in South Sudan; introduce gender transformative and synchronized programming to promote couple-connectedness and household-level health resilience; promote immediate and exclusive breastfeeding, and community lactation support (especially in areas where accessing facility-based services is not feasible); and encourage kangaroo mother care (KMC) initiation or post-KMC discharge follow up at the community level (as funding permits), responsive care-giving, and other preventive measures that women and families can provide for themselves.

MIHR's approaches will also help to bring life-saving health services closer to clients in their homes by engaging community leaders and strengthening the skills and support systems in place for community health workers. MAMI and nurturing care packages will also mobilize community health workers and community leaders to promote appropriate and responsive infant and young child feeding and care.

MIHR promotes **integrated FP/RH/MNCH service delivery** at point of care to enhance resilience at individual, household, and community levels. This includes integrated, people-centered FP/RH/MNCH services that are youth- and gender-sensitive at facility and community levels; the addition of maternal mental health and psychosocial support services to antenatal care, postnatal care, and other FP/RH/MNCH services; and integrated SBC programming.

MIHR will intensify its work to integrate, institutionalize, and improve the quality of community- and facility-based FP/RH/MNCH care in fragile settings by introducing whole facility integration of FP and other MNCH services; building youth- and gender-responsive integrated service delivery systems; working with the President's Malaria Initiative in MIHR partner countries to update and institutionalize iCCM; expanding RED/REC to manage a package of integrated FP/RH/MNCH services, including community outreach; and adding gender-based violence screening and referrals to MNCH services in health facilities and during MNCH campaigns.

The **quality of FP/RH and MNCH care** in fragile settings varies by setting and circumstance. Both the clinical quality of care and the client's experience of care influence care seeking and the effectiveness of available FP/RH/MNCH services. MIHR will continue playing an influential role at the global level with communities of practice and working groups that focus on expanding service availability and quality. MIHR will also introduce:

- WHO MNCH QoC standards and quality improvement guidance for fragile settings.
- Tools and strategies to improve the clinical and non-clinical skills/practices of healthcare providers.
- Cross-training, team problem solving, provider bias awareness training, and improved workforce culture.
- Gender transformative community engagement and social accountability approaches to promote inclusion, identify barriers to service use and provision, and jointly generate, implement, and track the results of any solutions.

To increase access to quality FP/RH/MNCH services and **strengthen health resilience capacities at subnational levels**, government health managers must be able to mobilize the available human, financial, and material resources and effectively communicate with health staff, local government, civil society, and communities. MIHR will focus on subnational health systems capacity strengthening and resilience, and will house the expanded and integrated RED/REC approach.

Another **area of focus is youth**. This emerging priority has been identified organically for both core and country levels. At core and through country assessments/scoping exercises, MIHR recognized that all seven partner countries held overwhelmingly youthful populations. For example, the under-14 proportion of each partner country's population is in the 40 to 50 percent range. At the country level, MIHR field teams recognized the epidemiological reality of this population. Indicators such as early child marriage, adolescent pregnancy, contraceptive prevalence, and the proportion of out-of-school youth paint a dire portrait of disproportionate need. MIHR partner countries are ill prepared to take advantage of the potential demographic dividend to propel national development. In response to this broad recognition across MIHR, staff were engaged in a three-part learning series to better understand youth issues in partner countries, hear directly from young people about their situations and needs, and engage in an MIHR strategic planning process to determine the role that young people will play in the project moving forward. A potential conclusion of this exercise will be that instead of thinking about youth as a "special population" or an add-on, young people will become central to MIHR design, implementation, management, and MERL processes.

Collaborating Across the MOMENTUM Suite

Examples of collaboration with other MOMENTUM awards are described in various summaries throughout this report. Note that aspects of collaboration are also described just above under the "CLA Approaches and Use of Knowledge: Collaboration" section.

Initial indicator data were not available at the end of PY1, and were added in the second report draft. MIHR indicators for the MERL Plan (AMELP) use the MOMENTUM MEL Framework indicators and PIRS where they are the same; MIHR was in the process of double checking this by cross-walking MIHR and cross-MOMENTUM indicators. Once this review is completed, MIHR will add any missing, such as relevant cross-MOMENTUM indicators on coordination and collaboration.

The following tables list collaborations and coordination efforts between MIHR and other MOMENTUM projects (Table 1), and with other health and resilience projects (Table 2). These collaborations enhance MIHR's work, but also allow MIHR to participate in global discussions and leadership.

Table 1. MIHR Collaborations and Coordination with Other MOMENTUM Projects

Collaborating/Coordinating Project	Country	Topic	Description
MPHD	Mali	Private Sector Assessment	Consulted MPHD's expertise (in Bamako and DC) for design of the protocol and data collection instruments for MIHR's Private Sector Health Assessment. Continuing to coordinate to ensure data collection instruments are aligned with the baseline

			assessments MPHD is planning in other areas of Mali. The MIHR Mali Team also participated in MPHD's co-creation workshop in Bamako from March 2-3.
MKA Knowledge Management Working Group	GLOBAL	KM Working Group	Ongoing collaboration through working group meetings and regular contact via email. Examples include sharing resources, providing input on MKA work plans and strategies, providing input into MKA activities (e.g., the MOMENTUM Share Fair).
MKA Strategic Communications Working Group	GLOBAL	SC Working Group	Ongoing collaboration through working group meetings and contact via email. Examples include contributing to monthly social media toolkits, adding to the HUB photo bank, addressing blog needs and the MOMENTUM editorial calendar, and providing input on MKA communications plans and activities.
MKA, MSSFPO, MCGL	GLOBAL	Youth	MIHR led the development a youth-oriented blog among the respective project youth leads, which was published on International Youth Day, August 12, to promote MOMENTUM's approach and contributions toward advancing youth health and elevating youth voices.
All MOMENTUM Gender Leads	GLOBAL	Gender	Collaborating on development of a gender brief. The gender brief will provide an overview of how MOMENTUM is focusing on gender from the outset of its activities and within program areas where gender has often been overlooked.
All MOMENTUM Youth Leads	GLOBAL	Youth	Consultation and sharing resources on youth statements. Continual discussions on meaningful youth engagement.
All MOMENTUM SBC Leads	GLOBAL	SBC	The group shares updates and information on their respective SBC activities, and outcomes. It helps socialize and cross-fertilize SBC-related technical and programmatic issues and developments, and share resources and tools to inform MOMENTUM's work more broadly.
MKA	GLOBAL	ME/IL Working Group	Ongoing work to define and refine the cross-MOMENTUM indicators.
Child Health Task Force and MKA	GLOBAL	Child Health	Provide feedback to WHO on child health quality of care indicators.
MSSFPO	GLOBAL	Task Sharing	Co-hosts of the Task-Sharing TWG.

MCGL	GLOBAL	Postpartum Hemorrhage	Participation in the postpartum hemorrhage community of practice.

Table 2. MIHR Collaboration and Coordination with Other, non-MOMENTUM Projects

Collaborating/Coordinating Project	Country	Topic	Description
Country Health Information Systems and Data Use (CHISU)	Burkina Faso	HMIS & data use	Working with CHISU in Burkina Faso to align HMIS and data use strengthening activities, and assessment plans, and to create a data quality improvement plan with the Ministry of Health (MOH).
Advancing Nutrition	Burkina Faso	Nutrition	Working with Advancing Nutrition in Burkina Faso to develop South West nutritional profile with the MOH.
Knowledge SUCCESS	GLOBAL	FP	Development of "20 Essential Resources for FP/RH in Fragile Settings" to be hosted on their website. Final product to be completed and available during PY2 Q1.
Kènèya Nièta/Household and Community Health (HCH) Activity	Mali	Community, IYCF, & SBC	MIHR was integrated into existing monthly meetings between the USAID projects Kènèya Nieta and Keneya Sinsi Walé. These meetings focus on defining possible areas of synergy between the projects, and sharing experiences across the three projects in managing the challenges and constraints encountered, especially in non-permissive areas. MIHR staff are also helping to identify consultants in community case management, infant and young child feeding (IYCF), and SBC.
Keneya Sinsi Walé/HSS, Governance, & Financing Activity	Mali	HSS	
Breakthrough ACTION	Mali	SBC & COVID-19	MIHR consulted with Breakthrough ACTION at the national level on their COVID-19 communication tools, which were disseminated in Gao.
Breakthrough ACTION	GLOBAL	SBC & Youth	MIHR consulted with Breakthrough ACTION to discuss tools (e.g., Empathways) that will be adapted in several MIHR countries related to youth-friendly services in fragile settings.
Breakthrough RESEARCH	GLOBAL	Respectful care	MIHR consulted with Breakthrough RESEARCH to discuss tools related to respectful newborn and maternal care that may be adapted in several MIHR countries.
Infant Feeding in Emergencies core group and MAMI Global Network	GLOBAL	MAMI	MIHR staff were working to both stay abreast of new developments in IYCF in emergencies and MAMI, and to keep global colleagues updated on MIHR's nutrition activities, especially those related to MAMI.

One Health interest group, CORE Group	GLOBAL	One Health	MIHR staff organized and chaired a plenary session on One Health at the CORE Group annual practitioners' workshop.
CORE Group	GLOBAL	Conference	MIHR staff helped organize a CORE Group conference in January 2021.
CORE Group	GLOBAL	Humanitarian-Development Assistant	An MIHR staff member serve as co-chair on the CORE Group working group on humanitarian assistance.
Resilience Evaluation, Analysis and Learning (REAL) 2	Global	Resilience	MIHR meets monthly with REAL 2 to discuss health resilience measurement.

Science and Research

Manuscripts

As this is the first year of MIHR operation, no staff manuscripts produced wholly through MIHR funding were published in the scholarly literature. However, staff co-authored pieces that were produced in large part prior to MIHR launch. In other cases, manuscripts were submitted but not yet accepted in PY1. Several of these manuscripts are listed below.

Table 3. List of MIHR Staff-Authored Manuscripts

Tech Area	Article Title	Journal	Link	Status/ Date Published	MIHR funding (Yes/No)
Child Health	*Understanding factors influencing care seeking for sick children in Ebonyi and Kogi States, Nigeria*	*BMC Public Health*	https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-020-08536-5	November 2021	No (funded by MCSP)
MNCAH	*A global research prioritization exercise on COVID-19 for maternal, newborn, child, and adolescent health*	*Journal of Global Health*	N/A	Accepted for publication	Yes
SBC	*Social Norms Atlas: Understanding global social norms and related concepts*	*Social Norms Learning Collaborative*	https://irh.org/wp-content/uploads/2021/05/Social-Norms-Atlas.pdf	May 2021 (grey literature)	Yes
FP/RH	*Promoting Scale-Up Across a Global Project Platform: Lessons from the Evidence to Action Project.*	*Global Implementation Research and Applications*	https://doi.org/10.1007/s43477-021-00013-4	18 May 2021	No
FP/RH	*Strengthening Health Systems in Humanitarian Settings: Multi-Stakeholder Insights on Contraception and Postabortion Care Programs in the Democratic Republic of the Congo and Somalia*	*Frontiers in Global Women's Health*	10.3389/fgwh.2021.671058	30 August 2021	No
FP/RH	*Immediate postpartum family planning: a comparison across six humanitarian country contexts*	*Frontiers in Global Women's Health*	https://doi.org/10.3389/fgwh.2021.613338	06 April 2021	No

Tech Area	Article Title	Journal	Link	Status/ Date Published	MIHR funding (Yes/No)
MNH	*Lessons learned from helping babies survive in humanitarian settings*	*Pediatrics*	https://doi.org/10.1542/peds.2020-016915L	October 2020	No
Nutrition	*Infant and young child feeding practices in Tanzania: the impact of mass media and interpersonal communication*	*Current Developments in Nutrition*	https://academic.oup.com/cdn/article/5/Supplement_2/670/6293214	2021	No
Nutrition	*Tanzanian men's engagement in household chores is associated with improved antenatal care seeking and maternal health*	*BMC Pregnancy and Childbirth*	https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-021-04147-z	2021	No
Nutrition	*Effect of a national nutrition communications campaign on stunting awareness and promotion of exclusive breastfeeding behavior among rural Indonesian mothers*	*Journal of Maternal and Child Health*	Not yet available	In press	No
Nutrition	*Health facility-based counselling and community outreach are associated with maternal dietary practices in a cross-sectional study from Tanzania*	*BMC Nutrition*	https://bmcnutr.biomedcentral.com/articles/10.1186/s40795-021-00447-x	2021	No
Nutrition	*Engaging fathers to improve complementary feeding practices is acceptable and feasible for families in the Lake Zone, Tanzania*	*Maternal and Child Nutrition*	https://pubmed.ncbi.nlm.nih.gov/34241956/	2021	No
WASH	*Association between WASH-related behaviors and knowledge with childhood diarrhea in Tanzania*	*International Journal of Environmental Research and Public Health*	https://pubmed.ncbi.nlm.nih.gov/33924817/	2021	No

Conference Abstracts

As MIHR operations were till gearing up through most of PY1, and to some extent because of conferences being deferred by COVID-19, there were limited opportunities to submit abstracts. Of those abstracts submitted, one was accepted.

Date	Conference	Title	Presenter	Type
4/27/2021	Global Health Science and Practice Technical Exchange	*Integrated Health Resilience: Building Better, Building Stronger*	Mesrak Nadew	Presentation

Other Science and Research Presentations and Meetings

NA

Required Reporting

Human Subjects Protection

For all primary data collection that includes interactions with a respondent and/or an on-site person providing access to needed information, MIHR includes a consent process, which notes the purpose of the data collection, the risk and benefits to the respondents and community, the right to refuse to answer any question, and the right to refuse participation in the data collection process at any time without consequence. Only adults can provide their informed consent. If approved by an Institutional Reviewed Board (IRB), minors will be allowed to provide informed assent. If data collection occurs when data are abstracted from existing documents with unique identifiers, data can only be abstracted without this identifying information.

An informed consent statement included in all data collection interactions must contain:

- Introduction of facilitator/note-taker
- Purpose of the evaluation/assessment
- Purpose of interview/discussion/survey
- Statement that all information provided is confidential and information provided will not be connected to the individual
- Right to refuse to answer questions or participate in the interview/discussion/survey
- Request consent prior to initiating data collection

MIHR requested an IRB review through JSI's IRB on F2C, for which it was given an "Exempt Determination - not human subjects research." Although not a core activity, MIHR also received IRB approval through JSI on the South Sudan Social Norms Assessment.

Environmental Compliance

MIHR developed a detailed Environmental Mitigation and Monitoring Plan (EMMP) near the start of the project, based on findings and recommendations in the USAID Initial Environmental Examination (IEE) provided to IMA in Attachment D of the Cooperative Agreement. MIHR interpreted the identified conditions and mitigation measures into specific, implementable, and verifiable actions. The MIHR EMMP is intended to allow IMA World Health and its partners to reduce or eliminate potential negative environmental impacts, through careful monitoring and management of waste generated during the project or from a particular activity, from any adverse health or environmental factors. It presents the environmental considerations that must and are be considered in the design, implementation, and assessment of project activities; defines mitigation measures, monitoring indicators and reporting frequency; and identifies knowledgeable parties responsible for each specific action. All activities are designed to manage and monitor potential risks and adhere to the IEE assessment included in the Cooperative Agreement.

Annually, MIHR will prepare an Environmental Mitigation and Monitoring Report (EMMR), to be submitted to the MIHR AOR and the USAID Environmental Compliance Database, summarizing the effectiveness of

mitigation measures, issues encountered, resolutions, and lessons learned. As appropriate, attachments such as site photos, verification of local inspections, and product warranties will also be included.

During PY1, supplemental EMMPs also were developed for all MIHR partner countries and were submitted to respective USAID Mission colleagues for review and approval.

Other USAID Policy Compliance

General

IMA World Health, as the MIHR prime partner, is accountable for ensuring that all agreement partners spend project funds appropriately, efficiently, and in compliance with USAID rules and regulations governing the project.

During PY2's initial months, the project team developed various internal systems and tools for effective project management and compliance implementation designed to clarify various desk procedures for MIHR staff, and to improve speed and efficiency in submitting and processing contractual requests and project documents and deliverables. The project compliance team worked on a Grants/Sub-awards Manual, designed to guide the team on management of sub-awards and grants under the project, consistent with USAID regulations. The manual is built to be used by all MIHR partners awarding sub-awards and grants. The team has also developed various other tools and templates including, but not limited to, RFAs, selection documentation, sub-agreement/grant templates, and pre-award due diligence forms/templates.

Subrecipient Monitoring

During the reporting period, IMA signed sub-agreements with the other five MIHR partners and accordingly filed Federal Funding Accountability and Transparency Act (FFATA) reports on the FFATA Sub-award Reporting System (FSRS).

As approved by the MIHR AOR during PY1, the following three sub-recipients joined MIHR:

- **Dev-Com Consult Ltd**, a South Sudan-based Non-Governmental Entity identified through an open competition, joined MIHR to help with the social norms assessment in the country.
- **Johns Hopkins University**, on behalf of its Center for Humanitarian Health within the Bloomberg School of Public Health, joined to provide technical assistance on the H-D nexus and to develop a related review paper.
- **Liverpool School of Tropical Medicine (LSTM)** was engaged to provide technical assistance to MIHR in South Sudan to recurrently use the lot quality assurance sampling (LQAS) method for a KAP survey on adaptive management of SBC and health services in designated MIHR-supported sites in South Sudan.

The sub-recipients were onboarded through a facilitated coaching/onboarding meeting designed to clarify MIHR team roles and responsibilities and the project governing rules and regulations.

The MIHR compliance team continually worked with project partners and sub-recipients to provide guidance on specific questions, and to help ensure compliance with donor/client requirements.

Family Planning Statutory and Policy Compliance

During PY1, a Family Planning Statutory and Policy Compliance strategy/plan was developed and received clearance from the AOR team at USAID, with just a few minor recommendations for revisions for MIHR to consider. MIHR was advised that the revised plan did not require formal USAID approval; however, a copy of the finalized plan shall be submitted to the AOR team for their records. Based on USAID guidance, the project started working on various monitoring and reporting tools to be submitted for AOR team feedback and approval once drafts are developed. These tools were being processed for finalization, and shall be submitted to USAID early in PY2.

As a mandatory step in the onboarding process, any individual newly joining the project, including full- and part-time staff, completes the required certificate-based training for U.S. Abortion and FP Legislative and Policy Requirements. The certificates of completion were filed and available upon request.

Appendix A – Indicator Table

Revised version, submitted 15 February 2022

Indicator Table[15]							
Indicator Number	**Indicator* (bold common MOMENTUM Framework indicators)**	**Country**	**Baseline or Previous Year**	**Project Year 1**			**Notes**
				Target	**Result Achieved**	**Percent Achieved[16]**	
Result 1: Scaled-up and sustained access to and equitable use of evidence-based, quality MNCHN/FP/RH information, services/care, and interventions in public and private health sectors							
Maternal Newborn and Child Health							
1.1	Estimated potential beneficiary population for maternal, newborn, and child survival program: number of live births. (HL.6-1) [X-M]	Burkina Faso	N/A	No Target	7,839		Population Estimation. Does not require baseline, target or percent achieved
		South Sudan[17]	N/A	No Target	8,202		
		Democratic Republic of the Congo	N/A	No Target	22,462		
		Mali	N/A	No Target	11,816		
		Tanzania	N/A	No Target	3,666		
		Niger	Country Not Yet Reporting				
		Sudan	Country Not Yet Reporting				
1.2	Number/percent of women with institutional delivery in MIHR-supported facilities (HL.6.2-2) [X-M]	Burkina Faso	TBD	TBD	1,765 / 90.0%		
		South Sudan	TBD	TBD	2,898[18]		
		Democratic Republic of the Congo	TBD	TBD	4,074 /72.5%		
		Mali	TBD	TBD	1,859 / 62.9%		
		Tanzania	In PY1, Tanzania did not have MNCH funding. In PY2, it does have MNCH funding.				
		Niger	Country Not Yet Reporting				

[15] Catchment area populations are provided by the national Ministry of Health. Burkina Faso provided age disaggregated catchment population, but not estimations for live births or pregnancy. All other population estimations utilize demographic multipliers from the U.S. Census Bureau's International Database.

[16] Percent achieved is calculated as achievements towards annual targets. Targets will be set in PY2, as they are approved by USAID.

[17] Does not include hospitals that MIHR supports, as hospitals cover much larger population and serves secondary and tertiary needs.

[18] South Sudan catchment populations are being finalized. It is expected that they will report fully in Q2 of PY2.

		Sudan	Country Not Yet Reporting				
1.3	Number/percent of women giving birth who received uterotonics in the third stage of labor (or immediately after birth) through MIHR-supported programs (HL.6.2.1) [X-M]	Burkina Faso	No data on uterotonic use in national HMIS				
		South Sudan	TBD	TBD	2,620 / 90.4%		
		Democratic Republic of the Congo	TBD	TBD	4,066 / 99.7%		
		Mali	No data on uterotonic use in national HMIS				
		Tanzania	In PY1, Tanzania did not have MNCH funding. In PY2, it does have MNCH funding.				
		Niger	Country Not Yet Reporting				
		Sudan	Country Not Yet Reporting				
1.4	Institutional maternal mortality ratio in MIHR-supported facilities (per 100,000) [X-M]	Burkina Faso	TBD	TBD	0		
		South Sudan	Data not currently unavailable. Core is working with country staff to identify data source.				
		Democratic Republic of the Congo	TBD	TBD	24.5		
		Mali	TBD	TBD	107.5		
		Tanzania	In PY1, Tanzania did not have MNCH funding. In PY2, it does have MNCH funding.				
		Niger	Country Not Yet Reporting				
		Sudan	Country Not Yet Reporting				
1.5	Institutional newborn mortality rate in MIHR-supported facilities (per 1000) [X-M]	Burkina Faso	Data not currently unavailable. Core is working with country staff to identify data source.				
		South Sudan	TBD	TBD	5.4		
		Democratic Republic of the Congo	TBD	TBD	5.4		
		Mali	TBD	TBD	2.5		
		Tanzania	In PY1, Tanzania did not have MNCH funding. In PY2, it does have MNCH funding.				
		Niger	Country Not Yet Reporting				
		Sudan	Country Not Yet Reporting				
1.6	Number/percent of newborns who received postnatal care within two days of childbirth in MIHR-supported programs (HL.6.3-63) [X-M]	Burkina Faso	Country HMIS does not directly align with indicator. Indicators under review to determine if there is a suitable match or proxy.				
		South Sudan	TBD	TBD	851 / 29.4%		
		Democratic Republic of the Congo	TBD	TBD	4,068 / 99.8%		

		Mali	TBD	TBD	839 / 45.1%		
		Tanzania	In PY1, Tanzania did not have MNCH funding. In PY2, it does have MNCH funding.				
		Niger	Country Not Yet Reporting				
		Sudan	Country Not Yet Reporting				
1.7	Average of the service gaps between: a) ANC1 and ANC4; and b) DPT1 and DPT3, in MIHR-supported districts (HL-4) [19]	Burkina Faso	TBD	TBD	22.5%		
		South Sudan	To calculate this indicator, the underlying catchment population is needed. South Sudan catchment populations are being finalized. It is expected that they will report in PY2.				
		Democratic Republic of the Congo	TBD	TBD	1.6%		
		Mali	TBD	TBD	56.1%		
		Tanzania	In PY1, Tanzania did not have MNCH funding. In PY2, it does have MNCH funding.				
		Niger	Country Not Yet Reporting				
		Sudan	Country Not Yet Reporting				
1.7A	Dropout between first dose (DTP1) and third dose (DTP3) of DTP-containing vaccines in MIHR-supported areas [X-M]	Burkina Faso[20]	TBD	TBD	10.6%		
		South Sudan	To calculate this indicator, the underlying catchment population is needed. South Sudan catchment populations are being finalized. It is expected that they will report in PY2.				
		Democratic Republic of the Congo	TBD	TBD	1.3%		
		Mali[21]	TBD	TBD	17.8%		
		Tanzania	In PY1, Tanzania did not have MNCH funding. In PY2, it does have MNCH funding.				
		Niger	Country Not Yet Reporting				
		Sudan	Country Not Yet Reporting				
1.7B	Service gap between ANC1 and ANC4, in USAID-supported districts [X-M]	Burkina Faso	TBD	TBD	34.4%		
		South Sudan	To calculate this indicator, the underlying catchment population is needed. South Sudan catchment populations are being finalized. It is expected that they will report in PY2.				
		Democratic Republic of the Congo	TBD	TBD	1.9%		
		Mali	TBD	TBD	77.7%		
		Tanzania	In PY1, Tanzania did not have MNCH funding. In PY2, it does have MNCH funding.				
		Niger	Country Not Yet Reporting				

[19] Data for service gap analysis (both ANC and DPT) is under review to check data quality and accuracy.
[20] Burkina Faso records DPT1 to DPT3 among children 0 – 11 months.
[21] Mali records DPT1 to DPT3 among children 0 – 11 months.

		Sudan	Country Not Yet Reporting				
1.8	Number of surviving infants who received 1st dose of measles-containing vaccine (MCV1) in MIHR-supported sites [X-M]	Burkina Faso	TBD	TBD	2,226		
		South Sudan	TBD	TBD	3,152		
		Democratic Republic of the Congo	TBD	TBD	5,672		
		Mali	TBD	TBD	2,877		
		Tanzania	In PY1, Tanzania did not have MNCH funding. In PY2, it does have MNCH funding.				
		Niger	Country Not Yet Reporting				
		Sudan	Country Not Yet Reporting				
1.9	Number of cases of child diarrhea treated in MIHR-assisted programs (HL.6.6-1) [X-M]	Burkina Faso	TBD	TBD	2,306		
		South Sudan	TBD	TBD	3,663		
		Democratic Republic of the Congo	TBD	TBD	1,208		
		Mali[22]	TBD	TBD	1,288		
		Tanzania	In PY1, Tanzania did not have MNCH funding. In PY2, it does have MNCH funding.				
		Niger	Country Not Yet Reporting				
		Sudan	Country Not Yet Reporting				
1.10	Number of children 0-59 months with diagnosed pneumonia treated with antibiotics in MIHR-supported areas [X-M]	Burkina Faso[23]	TBD	TBD	9,435		
		South Sudan	TBD	TBD	1,850		
		Democratic Republic of the Congo	TBD	TBD	2,059		
		Mali[24]	TBD	TBD	1,074		
		Tanzania	In PY1, Tanzania did not have MNCH funding. In PY2, it does have MNCH funding.				
		Niger	Country Not Yet Reporting				
		Sudan	Country Not Yet Reporting				
1.11	Number of children under five (0-59 months) reached with	Burkina Faso	TBD	TBD	16,123		
		South Sudan	Indicator not in country PMP				

[22] Mali reports "Number of cases of diarrhea" It assumes treatment of diarrhea.
[23] Burkina Faso reports "Number of Children with Pneumonia". It assumes treatment of pneumonia.
[24] Mali reports "Number of Children with Pneumonia". It assumes treatment of pneumonia.

	nutrition-specific interventions through USG-supported nutrition activities (HL.9-1) [X-M]	Democratic Republic of the Congo	TBD	TBD	39,417		
		Mali	TBD	TBD	4,993		
		Tanzania					
		Niger	Country Not Yet Reporting				
		Sudan	Country Not Yet Reporting				
Family Planning							
1.12	Couple years of protection (CYP) in MIHR-supported programs (HL.7.1-1)	Burkina Faso	TBD	TBD	2,714		
		South Sudan	TBD	TBD	3,499		
		Democratic Republic of the Congo	Country team not yet reporting on this. It is under review with core team. It is expected to be included in Q1 for PY2.				
		Mali	TBD	TBD	1,973		
		Tanzania	TBD	101,030	49,654	49%	
		Niger	Country Not Yet Reporting				
		Sudan	Country Not Yet Reporting				
1.13	Percent of MIHR-assisted service delivery sites providing FP counseling and/or services (HL.7.1-2) [X-M]	Burkina Faso	TBD	TBD	100%		
		South Sudan	TBD	TBD	100%		
		Democratic Republic of the Congo	TBD	TBD	100%		
		Mali	TBD	TBD	100%		
		Tanzania	TBD	TBD	100%		
		Niger	Country Not Yet Reporting				
		Sudan	Country Not Yet Reporting				
1.14	Number of family planning client visits [X-M]	South Sudan	TBD	TBD	5,417		
		Democratic Republic of the Congo	TBD	TBD	7,245		
		Mali	TBD	TBD	2,725		
		Tanzania	Indicator not in country PMP				
		Niger	Country Not Yet Reporting				
		Sudan	Country Not Yet Reporting				
1.15	Number of MIHR-supported CHWs providing FP information,	Burkina Faso	TBD	TBD	80		
		South Sudan	TBD	TBD	0		

	referrals, and/or services during the year (HL.7.2-2)	Democratic Republic of the Congo	TBD	TBD	0		
		Mali	TBD	TBD	0		
		Tanzania	0	203	182	89%	
		Niger	Country Not Yet Reporting				
		Sudan	Country Not Yet Reporting				
1.15	Number/percent of MIHR-supported service delivery sites that provided a contraceptive method in the last 3 months [X-M]	Burkina Faso	TBD	TBD	20 / 100%		
		South Sudan	TBD	TBD	14 / 100%		
		Democratic Republic of the Congo	TBD	TBD	24/100%		
		Mali	TBD	TBD	22 / 100%		
		Tanzania	TBD	TBD	59/100%		
		Niger	Country Not Yet Reporting				
		Sudan	Country Not Yet Reporting				
Health Resilience [25]							
1.16	Percent change in service utilization before, during, and after shock and during stress	Analysis of service change before, during, and after shocks and stresses will be undertaken in PY2					
1.17	Number/percent of MIHR-supported outpatient health facilities that provide the essential range of FP/RH/MNCH services, comparing baseline readiness status to post-shock readiness.	Burkina Faso	HFA Data Not Yet Collected				
		South Sudan—Family Planning	100%	TBD	100%		
		South Sudan—Maternal & Newborn Health	100%	TBD	100%		
		South Sudan—Child Health	100%	TBD	100%		
		South Sudan—Nutrition	100%	TBD	100%		
		Democratic Republic of the Congo	HFA Data Not Yet Collected				

[25] Health resilience indicators are under review and revision will be submitted separately from this report.

		Mali—Family Planning	100%	TBD	100%		
		Mali—Maternal & Newborn Health	100%	TBD	100%		
		Mali—Child Health	100%	TBD	100%		
		Mali—Nutrition	100%	TBD	100%		
		Tanzania	HFA Data not Yet Collected				
		Niger	Country Not Yet Reporting				
		Sudan	Country Not Yet Reporting				
Result 2: Capacity of host-country institutions, local organizations, and providers to deliver evidence-based, quality MNCHN/FP/RH services/care improved, institutionalized, measured, documented, and responsive to population needs							
2.1	Number/percent of NGOs/CBOs/FBOs support by MIHR with improved average organizational capacity assessment (OCA) scores	MIHR has not yet begun organizational capacity assessments with its partner organizations.					
2.2	Number/percent of providers observed through supportive supervision or similar observations with improved average quality improvement scores.	QI activities have yet to begin, and their accompanying tools are still under development.					
2.3	Number of health care staff trained (BHA-H4)	Burkina Faso	0	TBD	0		
		South Sudan	0	TBD	40		
		Democratic Republic of the Congo	0	TBD	0		
		Mali	0	TBD	70		
		Tanzania	0	40	44	110%	
		Niger	Country Not Yet Reporting				
		Sudan	Country Not Yet Reporting				

2.4	Number/percent of facilities with an accountability action plan designed through a Community Scorecard approach or other similar social accountability indices	Social accountability activities in communities have yet to begin.					
2.5	Percent of provider/client interactions where clients were treated respectfully (respectful treatment) in MIHR-supported facilities	Tools for measuring respectful treatment still under development.					
Result 3: Adaptive learning and use of evidence in MNCHN/FP/RH programming through sustained USAID and host country technical leadership increased							
3.1	Number/percent of MIHR-supported health facilities and subnational health departments that utilize data for planning and decision-making	Data use activities and reporting set to begin in PY2.					
3.2	Percent completeness of HMIS reporting for health facilities and CHW services in MIHR-supported sites	To measure the completeness of the HMIS reporting within MIHR, MIHR first needs to finish its digital MERL system. This system is expected to be completed in June 2022.					
3.3	Number of south-to-south learning exchanges	Global	0	TBD	3		
Result 4: Cross-sectoral collaboration and innovative partnerships between MNCHN/FP/RH and non-MNCHN/FP/RH organizations increased (see Appendix E in the MEL Framework plus award-specific indicators)							
4.1	Local and global partnerships (# of Partnerships)	Global	0	TBD	24		
		South Sudan	0	TBD	0		
		Burkina Faso	0	TBD	3		
		Democratic Republic of the Congo	0	TBD	1		
		Mali	0	TBD	4		
		Tanzania	0	TBD	0		
		Niger	0	TBD	7		
		Sudan	Country Not Yet Reporting				
Cross-cutting Indicators (see Appendix I in the MEL Framework plus award-specific indicators)							

CC.1	Number/percent of women who report participation in decision-making related to seeking health care.	This information should come from household surveys and this data collection is set to begin in PY2.					
CC.2	Number of health facilities supported by MIHR [X-M]	South Sudan	0	TBD	20		
		Burkina Faso	0	TBD	14		
		Democratic Republic of the Congo	0	TBD	24		
		Mali	0	TBD	22		
		Tanzania	0	54	59	105%	
		Niger	Country Not Yet Reporting				
		Sudan	Country Not Yet Reporting				
Context Monitoring							
CM.1	Number of instances of stresses and shocks in MIHR-supported areas [X-M]	Context monitoring indicators are planned to start reporting in Q1 of PY2.					
CM.2	Changes in service use associated with shocks or stresses	This advanced analysis is expected to be undertaken in PY2.					
CM.3	EWARS or epidemiologic surveillance system, and in-country hazard and early warning systems (e.g., FEWSNet) to track disease outbreaks and other hazards/shock exists and are functional	Context monitoring indicators are planned to start reporting in Q1 of PY2.					
CM.4	Existence of emergency coordination system exists and is functional	Context monitoring indicators are planned to start reporting in Q1 of PY2.					

Appendix B – Country Summaries

Countries represented in this section include:

- Burkina Faso
- Democratic Republic of the Congo
- Mali
- Niger
- South Sudan
- Sudan
- Tanzania

Burkina Faso Summary

<table>
<tr><th colspan="3">Burkina Faso PY1 Summary and Results</th></tr>
<tr><td>  </td><td>Contextual Indicators

Regions: 3, Center East, Center West, South West

Districts: 6 total districts (3 in Center East, 2 in Center West, and 1 in South West)

Facilities/Communities: 30 health facilities and 60 villages</td><td>Population

Country: 21.5 million

Project-supported Regions: 4.1 million</td></tr>
<tr><td colspan="3">Technical Areas: Maternal Health, Newborn Health, Child Health, Voluntary Family Planning, Reproductive Health, Nutrition, Gender, Health Resilience, Capacity Building, Immunization, Community Health</td></tr>
<tr><td>Program Dates: February 2021 – December 2024

PY1 Budget: US$2,512,593 (FP/RH $1,447,451, MCH $485,287, Nutrition $579,855)

Cumulative Budget: US$2,512,593</td><td colspan="2">Strategic Objectives

Increased capacity of the MOH to sustainably plan and manage quality MNCH/FP/RH and nutrition services, including building resilience to health system shocks and stresses, by:

• Access to and use of evidence-based, quality MNCH/FP/RH and nutrition information, services, and interventions scaled-up and sustained
• Capacity of host country institutions, local organizations, and providers to deliver evidence-based, quality MNCH/FP/RH and nutrition services improved, institutionalized, measured, documented, and responsive to population needs
• Adaptive learning and use of evidence in MNCH/FP/RH and nutrition programming through sustained USAID and host country technical leadership increased

Key Accomplishment Highlights

• Established project offices in Ouagadougou and the Center East region and onboarded technical and operations staff for these two offices
• Coordinated with the Ministry of Health and the national and regional levels to introduce the project and get their buy-in and support for project interventions
• Participated in several workshops with the MOH and other partners to provide technical input, increase project visibility, and establish ongoing coordination</td></tr>
</table>

Burkina Faso

KEY ACCOMPLISHMENTS

During PY1, MIHR's work in Burkina Faso focused on setting the stage for successful implementation of the project through administrative start-up, initial information gathering, and consultation with the MOH and other implementing partners. In the first and second quarters of PY1, MIHR conducted an initial situational analysis/scoping exercise to determine the current situation and urgent needs of supported regions to inform development of strategies and key interventions. MIHR established project offices at the national and regional levels and recruited technical and administrative staff at both levels to ensure successful implementation and management of the project. MIHR also conducted several coordination meetings with the MOH at the national and regional levels and engaged with other implementing partners for coordination and joint planning.

START-UP ACTIVITIES

MIHR conducted start-up activities to ensure successful implementation of the project. MIHR established project presence in Ouagadougou at the Pathfinder/Burkina Faso main office and successfully recruited and onboarded 75 percent of the project staff based there. Recruitment was in process for two remaining positions and will be finalized in the first month of PY2. MIHR also began to conduct activities in the project's focus regions through a phased approach. In order to prepare for implementation at the regional level, MIHR contracted a security firm to conduct a security risk assessment (SRA) of the Center East and South West regions. The SRA documented the security situation in supported regions and determined the severity, likelihood, and potential impact of security risks. The SRA also recommended mitigation measures to ensure staff safety and ability to safely implement project activities. Following the SRA, MIHR established a project office in the Center East region and began onboarding staff for this office. MIHR was able to recruit and onboard 71 percent of the positions in the Center East region, and recruitment for the remaining two positions will be finalized in the first quarter of PY2. MIHR will establish project offices in South West and Center West in PY2. For the three regional offices, MIHR is coordinating with the Integrated Family Health Services (IFHS) project to ensure the office space needs meet needs for co-location within the three regions. MIHR also procured vehicles, office equipment, and supplies for the project. With USAID support, MIHR was able to recover the two vehicles that were transferred from E2A. These vehicles were overhauled and are now operational. Two new vehicles were also purchased, which will make it possible to cover the needs at the central level and in the three regions.

COORDINATION WITH THE MINISTRY OF HEALTH

In July 2021, MIHR met with the Director of Family Health to present the project in detail. During this meeting, discussions focused on the primary areas of intervention and establishing mechanisms for collaboration in preparation for implementation in the regions. On July 19, 2021, with the support of the Department of Family Health, MIHR—accompanied by USAID—met with the Minister of Health to present the project and the regions of intervention and advocate for the support of the Minister in the implementation of activities. After the initial meeting with the Director of Family Health and the audience with the Minister of Health, MIHR obtained the letter of introduction to the intervention regions signed by the Secretary General of the Ministry of Health. This made it possible to establish ties with the regional health directorates and to start the process of selecting health districts, health facilities, and villages for

project implementation. MIHR also coordinated with USAID and the MOH to disseminate the project's initial contributions toward CHW payments. MIHR agreed with USAID to contribute to the payment of 4,703 CHWs in the three regions. For the first round, MIHR supported the MOH with the payment of 6 months (January to June 2021). Going forward, MIHR will contribute up to 149,555,400 West Africa CFA francs (US$270,000). MIHR also coordinated closely with the MOH to determine the exact mechanism for the contribution of these payments and will continue to work closely with the MOH and the CHW payment vendor, Orange Burkina, for the distribution and tracking of these funds to CHWs.

PARTICIPATION IN WORKSHOPS WITH THE MINISTRY OF HEALTH AND OTHER IMPLEMENTING PARTNERS

During Q3 and Q4 of PY1, MIHR participated in a series of workshops held by either the Ministry of Health or other implementing partners. MIHR contributed to the following meetings:

- Global Health Supply Chain – Procurement Supply Management (GHSC-PSM) FY2 Work plan development workshop: July 14 - 16, 2021
- Workshop to develop the national strategic immunization plan 2021 - 2025 with the *Direction de la Prévention par la Vaccination* (DPV): July 21 to 31, 2021
- Collaboration Market for joint action planning with SCC: August 2 - 3, 2021
- IFHS Project FY2 Work plan development workshop with Jhpiego: August 17 - 18, 2021
- Training session followed by the adaptation of health information system (HIS) stage of continuum improvement (SOCI) tools with CHISU and MOH: August 23 – 28, 2021
- Workshop to develop the nutritional profile of the South West region with Advancing Nutrition: August 21-24, 2021
- Workshop to present/validate joint action plans with SCC: September 1-2, 2021
- Workshop to develop the M&E component of the national strategic immunization plan 2021-2025: October 4-9, 2021
- Workshop with the MOH and CHISU on SOCI tools: development of the data quality improvement plan: October 25-29, 2021
- Workshop to develop the operational plan of the national strategic immunization plan 2021-2025: November 2-5, 2021

Through participation in these workshops and meetings, MIHR was able to contribute expertise in the project's technical areas, increase visibility of the project, and establish relationships and coordination with MOH directorates as well as other implementing partners and projects.

INITIAL MONITORING, EVALUATION, RESEARCH, AND LEARNING (MERL) ACTIVITIES

During this project year, MIHR initiated some key MERL activities in Burkina Faso, including initial information gathering on the HMIS, refinement of the PMP indicators and data reporting systems, coordination with other partners in Burkina Faso on community health digitization, and planning for F2C. In terms of the HMIS, MIHR collected information on the available indicators in the Burkina Faso DHIS2 system to assess alignment with MIHR indicators. Additionally, the project collected information on the available disaggregates in the national HMIS which will feed into MIHR's proposed disaggregation for each indicator in its PMP. The project

also began reviewing data reporting templates and mechanisms with a view towards digitization, which will be finalized in PY2. Regarding community health digitization, MIHR participated in a partners' meeting on the community health digitization approach in Burkina Faso. The objective of this meeting was to organize the different partners to align their interventions. MIHR also began coordinating with Terre des Hommes to explore MIHR contributions to the Integrated e-Diagnostic Approach (IeDA) tool. Coordination on community health digitization will continue in PY2.

KEY CONTEXTUAL ISSUES AFFECTING ACTIVITIES

The ongoing COVID-19 pandemic created some challenges for the project, particularly in the initial scoping and planning phases. In example, under normal circumstances these activities would have involved travel and in-person coordination, but instead the project needed to shift to a virtual approach. With some adaptations, MIHR was able to effectively implement these activities remotely. Additionally, during the initial start-up phases of this project some key activities took longer than anticipated, including receiving work plan approvals and hiring and onboarding staff, which led to some delays in beginning implementation. However, the project is now well positioned to rapidly begin key activities on the ground in PY2.

WAY FORWARD

In PY2, MIHR will leverage the strong foundation set for the project in PY1 to ramp-up implementation on the ground, including initiation of activities in all three regions of intervention. In the first two quarters of the year, MIHR will establish the project offices in the South West and Center West regions and will finalize recruitment of all staff positions. To further prepare for implementation, the project will conduct F2C and use the findings from that assessment—as well as the SRA conducted in PY1—to develop a business continuity plan. The project will also conduct assessments and mapping activities to further guide project interventions, including a rapid baseline assessment of quality FP/RH/MNCH services at health facilities, a review of existing quality assurance/quality improvement tools and mechanisms, a targeted SBC rapid formative assessment, and a mapping of local partners and organizations for potential future partnership or coordination.

At the facility level, MIHR will work with health districts to set up quality improvement teams and support these teams to conduct continuous quality improvement in facilities and communities. MIHR will also ensure quality service provision through on-site clinical mentorship of providers and joint, supportive supervision. At the community level, MIHR will support CHWs (through payments, capacity building, mentorship, and supervision) to provide a range of FP/RH, MNCH, nutrition, and immunization interventions. MIHR will also work with different actors to reinforce community health governance and will adapt the community-level Sahel Women's Empowerment and Demographic Dividend (SWEDD) model to promote gender equity. MIHR will build on successful community-level interventions—such as the E2A FTP program and the approaches from the (re)solve project—and conduct SBC and health promotion activities to improve health outcomes and resilience at the community level. MIHR will also work with the MOH at multiple levels to implement the National Community Health Strategy. MIHR will support health system governance frameworks at regional and health district levels and provide capacity building at the central level. To build health resilience capacity of country institutions, MIHR will support the implementation of the "One Plan, One Budget, One Report" initiative and will build upon the MCSP RED/REC interventions in project areas, expanding these to include services beyond immunization. Last, MIHR will conduct activities to improve data quality and use in project-supported areas and will coordinate with the MOH and other implementing partners on community health digitization efforts.

Selected Performance Indicators for PY1
MIHR is still in the process of establishing targets in Burkina Faso and will report on performance indicators in subsequent reports.

Democratic Republic of the Congo Summary

<table>
<tr><th colspan="3">DRC PY1 Summary and Results</th></tr>
<tr><td>  </td><td>Contextual Indicators

10 Health Zones within North Kivu province, situated around Beni, Butembo, and Goma

Regions/Provinces/etc.: 1, North Kivu

Districts: 10 health zones

Facilities/Communities: 24 health facilities and 48 health areas (aires de santé)</td><td>Population

Country: 86.8 million

Project-supported Regions: 3.4 million</td></tr>
<tr><td colspan="3">Technical Areas: Maternal Health, Newborn Health, Child Health, Voluntary Family Planning, Reproductive Health, Nutrition, Tuberculosis, Gender, Health Resilience, Capacity Building, Immunization, Community Health</td></tr>
<tr><td>Program Dates: November 2020-December 2021

PY1 Budget: US$4,044,625 (FP/RH $1,019,084, MCH $2,521,083, Nutrition $249,744, TB $254,714)

Cumulative Budget: US$4,044,625</td><td colspan="2">Strategic Objectives
To support improved FP/RH/MNCH outcomes and strengthen health resilience capacities. MIHR will work with the MOH, partners, and key stakeholders to achieve the following objectives:

1. Availability of, access to, and use of quality, integrated MNCAH, nutrition, FP/RH, and tuberculosis services increased in targeted health zones
2. Capacity of provincial, zonal, and facility managers to plan and deliver priority primary health care services strengthened
3. Adaptive learning on transitioning from response to development and restoring MNCAH, nutrition, FP/RH, and tuberculosis services, and on strengthening health resilience capacities, documented, used, and shared

Key Accomplishment Highlights
• MIHR facilitated trainings for health care providers, in collaboration with the provincial MOH, in emergency obstetric and newborn care (EmONC), integrated management of acute malnutrition (IMAM), and prevention of sexual exploitation and abuse (PSEA) awareness
• Conducted rapid health facility assessments in all MIHR-supported health facilities, as well as a targeted, rapid HFA of facilities impacted by the May 24, 2021, volcanic eruption of Mt. Nyiragongo
• Responded to the February 2021 outbreak of Ebola Virus Disease to ensure continuity of and access to health services through community-based surveillance, supportive supervision and infection and prevention control interventions</td></tr>
</table>

	• Collaborated with USAID, M-RITE, DPS and implementing partners to roll-out COVID-19 vaccines in North Kivu

Democratic Republic of the Congo

KEY ACCOMPLISHMENTS

Following start-up activities in recruitment, selection, and assessment of 24 MIHR-supported health facilities and health areas, MIHR immediately began implementing activities to respond to the Ebola Virus Disease (EVD) outbreak in February 2021 to ensure continuity of and access to health care services. In close collaboration with the provincial MOH (DPS), MIHR provided training to 135 health care providers in EmONC, IMAM, and integrated management of newborn and childhood illnesses (IMNCI). MIHR also trained 723 CHWs and health care providers in PSEA awareness. To respond to the COVID-19 pandemic, MIHR also collaborated with the DPS, the Expanded Program on Immunization (EPI), and M-RITE to roll out the COVID-19 vaccine in select vaccine sites in North Kivu with implementation occurring in September 2021.

START UP ACTIVITIES

By mid-May 2021, MIHR had onboarded all key staff including the COP, Deputy COP, MNH Advisor, Child Health/Immunization Advisor, FP/RH Advisor, Community Health Strengthening Advisor, Sr. MEL Advisor, Nutrition/Tuberculosis Officer, Cluster Team Leads, and MIHR Technical Officers. Three offices were established: the main office in Goma and two satellite offices located in Beni and Butembo. During the start-up period, MIHR selected 24 health facilities in coordination with the DPS and the health zone offices (BCZ) followed by a rapid health facility assessment to determine gaps and needs of the facilities.

INTEGRATING EBOLA RESPONSE INTO REGULAR PROGRAMMING

Following a resurgence of EVD in northern North Kivu in early February 2021, MIHR shifted its focus to strengthening community surveillance and awareness while assuring quality, safety, and continuity of care/services in MIHR-supported health facilities in five EVD risk zones. Through infection prevention and control (IPC) at health facilities, supportive supervision, and community-based surveillance, MIHR responded to the enhanced need to improve overall health seeking and quality, equitable health service provision for MNCH, FP, nutrition, and tuberculosis while also supporting North Kivu in strengthening surveillance systems in the EVD outbreak context. MIHR supported 15 health facilities by providing protective IPC materials (disinfectants, cleaning gloves, soap), rubber boots, gowns, and gloves for cleaners, as well as gowns, visors, or goggles for health workers who could be in contact with symptomatic or high-risk patients. Additionally, 240 CHWs in risk areas conducted community-based surveillance and awareness through door-to-door visits to communicate disease prevention and continuing preventative visits for ANC, well-child and immunization, nutrition, FP, and other services, and with specific attention to EVD symptoms to ensure effective monitoring of at-risk areas. By the end of May, EVD was officially declared over. MIHR continued to provide EVD surveillance for 90 days, as recommended by the MOH.

TRAININGS

The HFAs identified specific challenges in training, especially inadequate monitoring of pregnancy and childbirth and weak capacity to manage obstetric and neonatal emergencies. In coordination with the DPS, MIHR prioritized EmONC training for health facility providers. By the end of PY1, MIHR had trained 72 healthcare care providers (35 male and 37 female), including nurses and midwives, from MIHR-supported facilities to provide basic EmONC services, per MOH guidelines. MIHR also trained 63 providers (31 male, 43 female) to strengthen their capacity management of severe acute malnutrition and medical complications. Not only were MIHR staff trained in PSEA awareness, but all 723 health facility providers and CHWs (375 male, 348 female) were also trained.

COVID-19 VACCINE ROLL-OUT

In April 2021, MIHR began collaborating with the MOH, EPI, M-RITE, USAID, and other stakeholders to assess the need for collaboration on the COVID-19 vaccine roll-out in North Kivu. By August 2021, MIHR submitted and received approval to provide support, which included integrating with and building upon existing activities. MIHR COVID-19 vaccine support included coordination with key stakeholders, risk communication and community engagement, community-based surveillance, training, and surveillance of adverse effects. MIHR collaborated with the EPI Coordination Unit to identify 11 vaccination sites to support in North Kivu and continued collaboration with M-RITE for guidance and to ensure close alignment of approaches. MIHR supported three sites in Goma and four each in the Butembo and Beni clusters where MIHR began the process to procure urgent supplies for IPC. By late PY1, MIHR had conducted a brief survey to understand vaccine uptake among health providers and community members in project-supported areas. MIHR also began preparations for the October 2021 partner coordination meeting being held to revisit and confirm vaccination site mapping, strategies, and other related COVID-19 vaccination rollout activities. MIHR also recruited a technical consultant at the Goma-level and three cluster-based consultants for Goma, Beni and Butembo.

KEY CONTEXTUAL ISSUES AFFECTING ACTIVITIES

MIHR faced multiple challenges relating to disease outbreaks (EVD, COVID-19, cholera, measles), a volcanic eruption in May, and armed conflict (state of siege and violent attacks by armed groups), all of which affected MIHR activities by preventing access to health services and to sites for trainings and supervision. In many cases, MIHR was able to pivot and address or work around these challenges. MIHR addressed challenges related to EVD, COVID-19, and other communicable diseases through its regular programming and collaboration with the DPS, implementing partners, and other stakeholders. During the volcanic eruption, Goma-based staff worked remotely until the office was safe to enter. Some activities were delayed as a result, but other activities, such as supportive supervision, were able to continue in the areas not affected by the eruption.

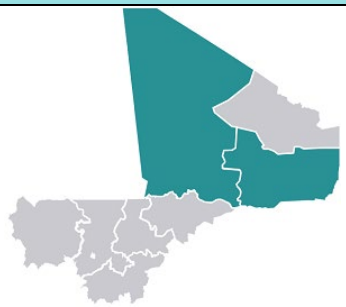
WAY FORWARD

MIHR will include a stronger focus on COVID-19 prevention and response and ensure the overall project platform is adaptable so MIHR can pivot in response to changes in the security situation or potential disease outbreaks. Due to some delays, MIHR will implement certain activities in PY2 that had been planned for PY1 but not completed. These include developing a PSEA compliance and monitoring plan, identifying one or

more local NGOs to implement community-based health activities (addressing low immunization, implementing gender and youth responsive SBC programming, and supporting local community health groups in leadership and accountability), and conducting MEL activities such as the F2C and KAP assessments. MIHR will also conduct new activities in PY2 such as supporting the health zone annual planning, mentoring to strengthen capacities of health care providers, and conducting the CHW Program Assessment and Improvement Matrix (AIM) tool.

Selected Performance Indicators for PY1
MIHR is still in the process of establishing targets in DRC and will report on performance indicators in subsequent reports.

Mali Summary

<table>
<tr><th colspan="3">Mali PY1 Summary and Results</th></tr>
<tr><td>  </td><td>Contextual Indicators

Regions/Provinces/etc.: 2, Gao and Timbuktu

Districts: 2, Gao and Timbuktu Districts

Facilities/Communities: 22</td><td>Population

Country: 17.6 million

Project-supported Regions: 1.3 million</td></tr>
<tr><td colspan="3">Technical Areas: Maternal Health, Newborn Health, Child Health, Voluntary Family Planning, Reproductive Health, Nutrition, Social and Behavior Change, Digital Health, Health Resilience, Capacity Building, Immunization, Community Health</td></tr>
<tr><td>Program Dates: November 2021 – February 2025

PY1 Budget: US$2,271,895 (FP/RH $643,425, MCH $1,125,884, Nutrition $502,585)

Cumulative Budget: US$2,271,895</td><td colspan="2">Strategic Objectives

Increase the resilience and preparedness of health systems in the north of Mali by:

1. Improved, equitable access to and use of MNCH, FP/RH, nutrition, immunization, and household WASH services (including via referrals to and provision of emergency care)
2. Increased accountability of district and other local governance structures to absorb, adapt to, and recover from health system shocks and stresses
3. Increased cross-sectoral collaboration to improve or prevent backsliding of health outcomes

Key Accomplishment Highlights

• Completed critical start-up activities, including identifying and opening of offices, recruiting and onboarding of key staff, and completing security risk assessment and implementing recommendations
• Held co-creation workshops to introduce MIHR to all stakeholders, get their buy-in and support for the project, and officially launch activities in each region
• Contracted a local research partner and completed the health facility readiness assessment
• Trained 69 data managers on DHIS2, held data entry and review workshops that brought timeliness and completeness of data to greater than or equal to 95 percent in both regions (on average)</td></tr>
</table>

Mali

KEY ACCOMPLISHMENTS

In PY1, MIHR's work focused on better understanding the gaps and challenges in Gao and Timbuktu, as well establishing a strong partnership with the local government and other stakeholders. MIHR worked to identify priorities in both regions through baseline assessments and co-creation meetings that included partners at the national, regional, and district levels. The project contextualized its strategies to the differing needs of the two districts and regions and began implementing activities, such as building the capacity of health workers in both regions to collect, analyze, and report primary data in the national District Health Information System 2 (DHIS2).

START-UP ACTIVITIES

In PY1, MIHR completed critical start up activities and began program implementation. MIHR took a phased approach to operations and staffing in Mali. During this reporting period, the project opened offices in Bamako and Gao and identified an office in Timbuktu (to open during PY2). At the start of the program, MIHR also engaged a security company to conduct a comprehensive security risk assessment (SRA) to gauge the current security situation in the country and determine MIHR's possible exposure to different security and safety threats. Each threat was assessed to determine the severity, the likelihood of it occurring, and the potential impact should it occur. The SRA included proposed security measures and procedures and evaluated their impact on project implementation. MIHR used these findings in the development of its Country Safety and Security Plan (CSSP) during PY1. MIHR faced some challenges in human resources management during the year, including staff retention (Security and Logistics Manager, MNCH Officer, MEL Officer) and finding qualified candidates (Resilience Advisor). By the end of the program year, 90 percent of planned staff in Bamako, Gao, and Timbuktu had been recruited and fully on-boarded. Additionally, a candidate for the Resilience Advisor had been identified and the team was working to fill the vacant Gao MEL Officer position.

REGIONAL CO-CREATION WORKSHOPS

In order to start activities in Gao and Timbuktu effectively, MIHR worked with the Regional Directorates and the districts to hold co-creation workshops. The workshops served to introduce MIHR to all stakeholders, get their buy-in and support for the project, and officially launch activities in each region. Overall, the workshops were very successful with a high-level of participation. At the end of the two days of work, all stakeholders shared a common understanding of MIHR's goals, strategies, and activities, as well as their roles and responsibilities, which were formalized through the signing of a commitment document. A mechanism was put in place for better coordination and collaboration between the project team and local authorities, and between the project team and humanitarian and development partners. At the CSCom (community health center) level, monthly partner meetings will be held to discuss challenges and solutions. At district and regional levels, quarterly and semi-annual meetings will also be held. MIHR also received valuable feedback on the PY1 work plan and potential activities for PY2. As a result of this meeting, MIHR now has a work plan that better addresses the needs and priorities of Gao and Timbuktu. Additionally, stakeholder testimonies from the meetings highlighted their appreciation for this participatory process and their investment in the project's success.

HEALTH FACILITY READINESS AND OTHER ASSESSMENTS

MIHR contracted a local research partner in Mali, CERIPS, to assist in completing key project baseline and other assessments. During PY1, MIHR and CERIPS completed the health facility readiness assessment (HFA) in 26 facilities in Gao and Timbuktu health districts (1 CSRéf, 10 CSComs, and 2 private clinics in each district). The facilities were assessed for readiness to provide FP/RH, MNCH, and nutrition services using MIHR's facility assessment tool. Preliminary findings were used during the PY2 work planning process and a dissemination meeting will be scheduled for early PY2. MIHR also worked on the protocol, tools, and other preparation aspects of the following assessments during PY1: health care worker (HCW) skills and knowledge baseline assessment; Fragility, Crisis Sensitivity, and Complexity (F2C) Assessment; and the core-funded private sector assessment.

DATA QUALITY AND USE

The Timbuktu and Gao regions faced recurring problems with internet connectivity. Very early on in project implementation, MIHR provided technical and financial support to ensure the timely availability of health data in both regions. A two-day monthly data entry workshop and one-day quarterly data quality review workshop were regularly held in both districts, along with training of data managers on DHIS2. Table A1 below outlines the various data quality activities in detail. With the support of MIHR, the timeliness and completeness of the data on average is now greater than or equal to 95 percent in both regions. These workshops were opportunities for continual capacity building of the technical directors and data managers in the use of DHIS2. Whenever necessary, improvement plans were developed for lower performing health center technical directors and followed up by the health districts.

Table A1. Data Quality Activities by Region

Activity	Gao	Timbuktu
Data Entry	7 workshops held 41 health areas included	4 workshops held 15 health areas included
Data Review	3 workshops held	1 workshop held
DHIS2 Training	1 training held 41 data managers included	1 training held 28 data managers included

KEY CONTEXTUAL ISSUES AFFECTING ACTIVITIES

MIHR faced various challenges during PY1 implementation in the northern regions of Gao and Timbuktu. In general, the cost of operating in these regions was much higher than expected due to many factors such as limited choice in vendors (i.e., office space, equipment), enhanced security service needs, high cost of in-country travel, and more frequent in-country travel than initially planned due to the extremely poor internet connection in the North. Internet connectivity was a major barrier to coordination and technical assistance for MIHR staff, both between MIHR Mali staff regionally and between MIHR Mali and headquarters technical

teams. The project also found it difficult to find and maintain qualified staff in its regional offices. Additionally, as a development partner operating in a space that has mainly been receiving humanitarian aid, MIHR struggled to address certain precedents put in place by humanitarian actors. For example, local government and other partners are accustomed to certain benefits for participating in workshops and other activities with humanitarian actors. Also, some humanitarian actors purchase flights home for their staff during holidays. These are benefits that MIHR cannot afford but staff who have worked in these environments are expecting.

MIHR temporarily addressed some of these challenges by delaying the opening of the regional office in Timbuktu and hiring short-term consultants in Bamako to provide technical assistance to regional teams. In the long term, MIHR will look to build the technical capacity of regional staff (for example, in resilience) and explore additional equipment needs, such as a very small aperture terminal (a satellite dish for voice and internet connectivity).

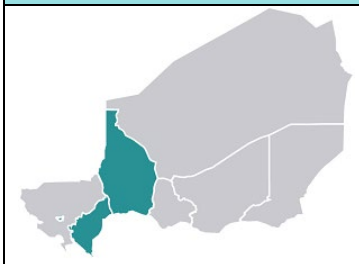
WAY FORWARD

In PY2, MIHR will build on its strong foundation with local stakeholders as it begins implementing MNCH/FP/RH service delivery and systems strengthening activities on a larger scale. The project will focus on improving preparedness and quality of health services. Activities will include clinical training, mentorship, creating quality improvement teams, introducing new strategies (such as pediatric death audits), collaborating with partners to improve functionality of CHWs, and supporting district outreach strategies. Another focus of MIHR's work in PY2 is on increasing health literacy and demand for services. Activities include mapping and adapting or developing new SBC messages and materials (if needed), piloting a Model Family Approach, and completing a values clarification exercises at the facility and community levels. MIHR also plans to engage multiple local NGOs during PY2. Some of these NGOs will focus on community-level resilience planning and others will utilize core NPI funds to implement community-level FP activities.

MIHR will continue its work on improving data quality and use in PY2. In addition to data entry and review workshops, MIHR will look into digital solutions that facilitate clinical decision-making and offer opportunities for continuing medical education for service providers. To support clinical decisions across the continuum and accelerate the pace of change by using real time data, MIHR will consider digital options to support the use of the Safe Childbirth Checklist, postnatal care checklists, and data collection as appropriate in the northern Mali context. MIHR will also explore supporting the expansion into Northern Mali (Gao and Timbuktu) of DHIS2's tracker and events capture functions for client follow-up and Mali's national DHIS2 electronic register system to enable client tracking for improved adherence to follow-up visits for MNCH/FP/RH, immunization, and nutrition services. MIHR will also complete key baseline assessments, such as the HCW skills assessment, F2C assessment, and core-funded private sector assessment. It will also work on additional MEL activities, such as targeted SBC and nutrition rapid formative research, the Community Score Card, and ARC-D Health.

Selected Performance Indicators for PY1
MIHR is in the process of establishing targets for its indicators in Mali and will provide updates on these in subsequent reports.

Niger Summary

<table>
<tr><th colspan="3">Niger PY1 Summary and Results</th></tr>
<tr><td>  </td><td>Contextual Indicators

Regions/Provinces/etc.: 2 Dosso and Tahoua

Districts: 2 districts per region

Facilities/Communities: To be determined</td><td>Population

Country: 25.3 million

Project-supported Regions:

Dosso: 2,634,733
Tahoua: 4,284,435</td></tr>
<tr><td colspan="3">Technical Areas: Maternal Health, Newborn Health, Child Health, Nutrition, Capacity Building, Community Health, Pharmaceutical Supply Chain, Voluntary Family Planning, Reproductive Health, Social and Behavior Change, Health Resilience.</td></tr>
<tr><td>Program Dates: June 2021 – March 2025

PY1 Budget: US$415,630 (FP/RH $200,216, MCH $143,012, Nutrition $72,402)

Cumulative Budget: $US5,812,532 (through September 2022)</td><td colspan="2">Strategic Objectives

Strengthen quality MNCH/FP/RH, and nutrition services and support for improved resilience by:

• Access to and use of evidence-based quality MNCH/FP/RH information, services, and interventions scaled-up and sustained.
• Capacity of host country institutions, local organizations, and providers to deliver evidence-based quality MNCH/FP/RH services improved, measured, institutionalized, documented, and responsive to population needs.
• Adaptive learning and use of evidence in MNCH/FP/RH programming through sustained host country technical leadership increased.
• Cross-sectoral collaboration and innovative partnerships between MNCH/FP/RH and non-MNCH/FP/RH local organizations increased.

Key Accomplishment Highlights
• Received approval of the PY1 work plan
• On-boarded the Chief of Party
• Conducted Security Risk Assessment for Niamey, Dosso, and Tahoua</td></tr>
</table>

Niger

KEY ACCOMPLISHMENTS

After receiving the program description in May 2021, MIHR began the scoping process and drafting the PY1 work plan and budget. Submission of the work plan took place in July, provisional approval was received from USAID at the end of August, and final approval was received, after a resubmission addressing USAID's comments, at the end of September. Following provisional approval, MIHR began recruitment for the COP as

well as the process for procurement of laptops to prepare for new staff. Additionally, a security risk assessment (SRA) was completed in August.

SCOPING AND WORK PLANNING

In June 2021, MIHR initiated scoping and work planning. Throughout scoping, MIHR consolidated policy documents, met with various stakeholders including government officials and staff from peer organizations, and reviewed existing reports and data to develop a comprehensive work plan for PY1. Stakeholders interviewed during the scoping phase included the national-level MOH; regional-level MOH officials in Dosso and Tahoua; and NGOs, including Pathfinder Niger, World Vision, PSI/IMPACT Malaria, Concern Worldwide, JSI/CHISU, and UNICEF. Findings from the scoping, as well as suggested implementation strategies, were shared with USAID to inform the development of the PY1 work plan, for which MIHR received provisional approval in September 2021.[26]

SECURITY RISK ASSESSMENT

MIHR conducted an SRA in the Niamey, Dosso, and Tahoua regions to inform activities, implementation strategies, and administrative processes of the project to ensure safe and effective project implementation that is responsive to the current security situation in our project areas. This assessment was conducted by a contracted firm—Other Solutions—and an internal security assessment report was finalized on August 10. On August 18, the lead consultant that led the rapid security assessment gave a presentation to MIHR staff on the main findings and key considerations for the project moving forward. These findings were applied as the project underwent operational start up.

START-UP ACTIVITIES

During the reporting period, MIHR engaged in several operational start-up activities. These included establishing an office in Niamey, procuring laptops, and coordinating handover of equipment, including motorcycles from IMA World Health's sister organization, Lutheran World Relief.

STAFF RECRUITMENT

By the end of Q4, MIHR had successfully recruited a COP and several administration staff, including finance and human resources. The project expedited recruitment for the remaining positions including finance and administration, technical, and program management staff.

KEY CONTEXTUAL ISSUES AFFECTING ACTIVITIES

MIHR Niger is still in the process of recruiting staff and the process has been lengthier than expected. For a few positions, shortlisted candidates were not successful in the interview process and the positions had to be re-posted for additional applicants.

[26] MIHR received full approval of the revised work plan and budget submission from USAID on October 28th, 2021, which is after the program year ended, but prior to submission of this report on 15 November 2021.

WAY FORWARD

MIHR Niger will continue to recruit staff to fill all vacant positions. As technical positions are filled, MIHR will undertake key start up activities including determining the districts where MIHR will work, finalizing indicators and targets, and conducting baseline assessments.

Selected Performance Indicators for PY1
MIHR is in the process of finalizing selected performance indicators and establishing targets in Niger and will provide updates on these in subsequent reports.

South Sudan Summary

<table>
<tr><th colspan="3">South Sudan PY1 Summary and Results</th></tr>
<tr><td>  </td><td>Contextual Indicators

Regions/Provinces/etc.: 5 states and 6 counties: Central Equatoria (Juba & Kajo Keji), Western Equatoria (Yambio), Eastern Equatoria (Magwi), Western Bahr El Ghazal (Wau), Jonglei (Bor)

Facilities/Communities: 14 facilities & 42 bomas</td><td>Population

Country: 11 million

Project-supported Regions: 6.7 million</td></tr>
<tr><td colspan="3">Technical Areas: Child Health, Maternal Health, Newborn Health, Community Health, Health Resilience, Gender, Voluntary Family Planning, Reproductive Health, Social and Behavior Change</td></tr>
<tr><td>Program Dates: August 2020 – May 2024

PY1 Budget: US$6,719,652 (FP/RH $5,352,839, MCH $1,366,813)

Cumulative Budget: $US6,719,652</td><td colspan="2">Strategic Objectives

Support improved FP/RH/MNCH outcomes and strengthen the USAID/South Sudan resilience platform. MIHR will work with the MOH, partners, and key stakeholders.

• Increase access to and quality of integrated FP/RH/MNCH care and services in public and private health sectors
• Increase demand for and utilization of quality FP/RH/MNCH interventions and care by individuals, families, and communities
• Enhance the resilience and inclusiveness of the health system in South Sudan with increased capacity to provide integrated client centered FP/RH/MNCH care and services

Key Accomplishment Highlights

• 100 percent of MIHR South Sudan staff were recruited and onboarded in both Juba and field-based locations.
• The Social Norms Assessment was completed with results validated and disseminated. The final report was completed in PY1 and is anticipated to be finalized in early PY2.
• MIHR took over service delivery from E2A in four facilities and provided integrated quality FP/RH/MNCH service delivery in a total of 14 facilities.</td></tr>
</table>

South Sudan

KEY ACCOMPLISHMENTS

In PY1, MIHR focused on building relationships with the MOH, raising awareness about the project, start-up activities, and implementing program activities. By the end of Q3, MIHR recruited all positions for both Juba and field-based positions, completed logistics and orientation to co-locate with Breakthrough ACTION (BA) staff, implemented facility-and community-based services and trainings, and commenced several studies and assessments, including a health facility assessment (HFA), routine data quality assessments, and a Social Norms Assessment.

ACCESS TO QUALITY INTEGRATED FP/RH/MNCH SERVICES AT FACILITY AND COMMUNITY-LEVEL

Following the conclusion of the E2A project in South Sudan, the four E2A facilities were transferred to MIHR support in January 2021. MIHR hired Country Project Officers for the six counties (Bor, Magwi, Wau, Juba, Kajo-Keji, and Yambio) where MIHR is active in health facilities, who are responsible for coordinating closely with the county health departments and the Health Pooled Fund implementing partner in activities, reporting, and supervision. MIHR also hired a dedicated FP Provider and MNCH Officer in each MIHR-supported health facility to improve the quality of and access to integrated FP/RH/MNCH services. MIHR supported 127 boma health workers (BHW), who were selected within their communities to improve demand and utilization of FP/RH/MNCH services. The MIHR-supported BHWs were selected in communities where the Government of South Sudan's Boma Health Initiative was not active.

MIHR updated FP training modules, used standardized checklists to identify areas of improvement, and conducted onsite mentorship, routine skills assessments, technical support, guidance, and coaching through in-person and remote support to the Dedicated FP Providers and MNCH Officers. Quality Improvement Teams were formed at nine facilities, which will focus on sustainability of quality improvement efforts at facilities while integrating community members' viewpoints to ensure lasting change.

ASSESSMENTS

MIHR successfully completed the Social Norms Assessment in Y1. The assessment used vignettes, allowing participants to share and identify social norms in their communities around FP, early marriage, menstruation, seeking care, and gender-based violence. The study was conducted in Bor, Leer, Budi, Wau, and Yambio, and participants included men and women ages 15-49, both married and unmarried; key influencers; and primary health care workers. After data collection was finalized, results were shared with a group of South Sudanese key influencers to validate findings, and a final report was drafted and is expected to be finalized in early PY2. The draft was shared with the MOH and BA, who will use the findings and recommendations to further refine their innovation team's work.

In addition to the Social Norms Assessment, three other assessments were completed. Routine Data Quality Assessments (RDQAs) were conducted in 12 of the 14 MIHR-supported facilities. MIHR assessed several indicators and developed an improvement plan for each facility to monitor changes after the completion of the RDQA. A health facility assessment (HFA) was conducted in four counties (Wau, Yambio, Magwi, and Juba) to understand health facility service availability, readiness, and data use. The HFA will provide baseline

data to guide program planning and implementation in the MIHR areas of intervention. A health resilience assessment was completed by a consultant as well, which focused on understanding the challenges to the health system in South Sudan and generated recommendations on how to improve resilience of the health system.

TRAININGS

MIHR mapped, identified, and engaged key stakeholders, including influential community leaders, religious leaders, women, youth, and adolescent leaders, to spearhead community-based SBC and gender interventions on gender-based violence, community-based gender-sensitive dialogues, and social accountability. All mapping reports were shared with BA for contextual purposes to help in tailoring their approaches. Save the Children, a subcontractor to BA, is implementing Partnership Defined Quality (PDQ–social accountability) and Community Action Cycles (CAC), as is MIHR. The respective teams coordinated sites so as not to overlap, and began documented lessons learned. When the first round of PDQ/CAC is complete, lessons learned will be compared in order to enhance and improve the activity for scale up. MIHR will invite BA to the CAC training in January 2022, as well as co-facilitate the first co-creation workshop in Juba in early 2022 with BA. The BA mini-innovation work is planned to be incorporated at that workshop.

Additional trainings conducted by MIHR in PY1 included a DHIS2 refresher training in Magwi, Wau, and Yambio to emphasize data entry, use, and quality; training on quality improvement (QI) methods for quality improvement teams at nine MIHR-supported facilities; and a training of trainers' session for MIHR staff to review the ARC-D Health tool, which will be used to conduct community-based health risk and resilience assessment.

KEY CONTEXTUAL ISSUES AFFECTING ACTIVITIES

MIHR faced several security-related challenges in South Sudan in PY1, including an uptick of violence against medical facility staff. In Q2, an MIHR-health facility received threats against its dedicated provider and other health workers because a client’s husband did not approve of his wife receiving services and an FP method without his consent. MIHR country leadership engaged government structures and other stakeholders, which ultimately led to a peaceful resolution of the issue and ensured resumption of activities with the health facility. MIHR engages with senior government officials to keep them apprised of project activities and implementation to ensure their support if a similar situation arises. MIHR determined appropriate adaptations at the facility-level, including maintaining a detailed understanding of relevant FP/RH national policies, with copies on hand at health facilities to assist in addressing concerns from beneficiaries.

On a more positive note, MIHR and BA staff, who share office space, held bi-weekly meetings, and the MIHR SBC Lead initiated introductory calls and ongoing email exchanges with BA/HQ to foster partnership and synergy. MIHR attended BA’s SBC workshop and co-creation workshop on male engagement, and BA attended MIHR’s training on Partnership Defined Quality. MIHR shared the social norms assessment draft with the MOH and BA. BA is using the data to inform their mini-innovation work. MIHR and BA have a data sharing agreement in place as well.

WAY FORWARD

In PY2, MIHR plans to continue: strengthening quality FP/RH/MNCH service delivery and expanding to additional counties, communities, and facilities; focusing on engagement with the private sector; and continuing to improve the data quality of existing MOH systems.

To provide more clients with quality integrated FP/RH/MNCH services, MIHR plans to expand and operate within up to an additional 10 health facilities across eight counties in five states. Additional counties proposed are Budi in Eastern Equatoria and Jur River in Western Bahr El Ghazal. In all supported health facilities, MIHR anticipates collaborating closely with state and county governments to prioritize sites and bomas and will co-design joint objectives, approaches, and interventions to improve quality of FP/RH/MNCH services. QI will be a major focus of activities throughout PY2, and MIHR will utilize the Partnership Defined Quality and Partnership Defined Quality – Youth models to integrate community feedback into QI teams. Provider behavior change (PBC) will also be a key component of coaching and mentoring within the health facilities where MIHR is present. MIHR was working with BA in PY1 to adapt the programmatic PBC tools that were being finalized in Q2 from BA's Provider Ecosystem conceptual model; this will continue into PY2.

MIHR will also map local health systems (including private providers) and work closely with the USAID funded Sustaining Health Outcomes through the Private Sector (SHOPS+) in PY2 to inform engagement with the private sector. By connecting private sector partners and professional associations in Juba and other areas, MIHR hopes to explore mutually beneficial partnerships (i.e., providing training, coaching, or mentoring), with private sector partners, in turn, reporting and adopting formal Government of South Sudan protocols and providing FP services and commodities free of charge. MIHR will continue discussions begun in PY1 on how the private sector can access FP commodities supplied under the national public health system.

As MIHR's monitoring, evaluation, and learning (MEL) framework prioritizes efforts to strengthen existing MOH systems (DHIS2) for data collection, reporting, and learning, MIHR will continue to focus efforts to improve reporting rates, data quality, and data use/sharing by health facility teams and county health departments. In PY2, MIHR will provide MEL training and technical assistance to MIHR MEL staff, MOH M&E counterparts, and BHWs/health care workers; provide equipment to increase prompt data collection and transmission; and continue to apply RDQA and other improvement strategies.

Selected Performance Indicators for PY1
MIHR is still in the process of establishing targets in South Sudan and will report on performance indicators in subsequent reports

Sudan Summary

<table>
<tr><th colspan="3">Sudan PY1 Summary and Results</th></tr>
<tr><td>  </td><td>Contextual Indicators

Regions/Provinces/etc.: 1, South Kordofan

Districts: Three (3) localities: Kadogli, Alliri, and Abujebaha

Facilities/Communities: Three rural hospitals and four to six referring PHC centers per hospital/locality. Catchment communities of these health facilities (rural hospitals and PHC centers) cover the total catchment population (964,477 persons)</td><td>Population

Country: 42 million

Project-supported Areas: 964,477</td></tr>
<tr><td colspan="3">Technical Areas: Maternal Health, Newborn Health, Child Health, Pharmaceutical Supply Chain Management, Community Health, Immunization, Social and Behavior Change, WASH, Gender</td></tr>
<tr><td>Program Dates: March 2021 – January 2022

PY1 Budget: US$387,474 (MCH $258,316, WASH $129,158)

Cumulative Budget: $US2,478,000 (through September 2022)</td><td colspan="2">Strategic Objectives

To increase the capacity of Sudan’s institutions to sustainably plan and manage quality MNCH and WASH services

• Improve access to and use of evidence-based, quality MNCH and WASH services
• Strengthen the capacity of host country institutions at locality and state level to deliver quality MNCH and WASH services
• Adaptive learning and use of evidence in MNCH and WASH programming

Key Accomplishment Highlights

• Finalized and received approval for PY1 work plan and initiated start-up activities
• Introduced MIHR to all key stakeholders in South Kordofan, including MOH and all humanitarian actors
• Agreed on the selection process of primary healthcare centers (PHCs) that will refer to the three MIHR-supported rural hospitals
• Reviewed the latest Maternal Death Surveillance and Response (MDSR) reports and made key technical recommendations
• Participated in the revision and finalization of the Strategic Work Plan and Policy for Health Recovery and Reform in Sudan</td></tr>
</table>

Sudan

KEY ACCOMPLISHMENTS

AVAILABILITY, QUALITY, AND UTILIZATION OF AN ESSENTIAL PACKAGE OF MNCH AND WASH SERVICES IN SUDAN

MIHR has introduced the project to humanitarian actors and United Nations (UN) agencies currently operating in Sudan. The humanitarian community, particularly those who have active programs in South Kordofan (SK), were briefed during health and WASH cluster meetings, as well as through bilateral discussions. MIHR will coordinate with UNICEF and WHO, who were assessing MNCH and WASH services by harmonizing assessment activities and aligning assessment tools to help inform MNCH policy, services, and outreach in SK. Some humanitarian actors, for example International Rescue Committee (IRC), Corus International, and International Medical Corps (IMC) were planning to expand their health and WASH programs in SK to address the increasing needs of newly displaced communities. MIHR will also collaborate with these actors in PY2 to ensure they are well informed about the project and to enable the humanitarian response to also be sequenced, layered, and integrated with MIHR planned activities. MIHR continued to coordinate with all humanitarian actors, the Ministry of Health Emergency Department, and UN agencies to prepare the health system to efficiently and effectively respond to any health emergencies.

IMPROVED SERVICE READINESS

The MIHR team discussed and agreed with the State Ministry of Health (SMOH) on the selection process of primary healthcare center (PHC) facilities that will refer to the three MIHR-supported rural hospitals. The SMOH and MIHR team planned joint field visits to complete the selection process of these PHC facilities. Additionally, MIHR will also carry out rapid needs assessments at these health facilities to further inform the MIHR program. Lastly, a project technical agreement was drafted and discussed with both state-level MOH and the Humanitarian Aid Commission (HAC) and was expected to be approved in November 2021. The agreement will subsequently be shared with federal-level MOH and HAC.

INCREASED EFFECTIVENESS TO SUSTAINABLY PLAN AND MANAGE QUALITY SERVICES

MIHR worked closely with state and federal MOH offices as well as with the State Water Corporation in developing and updating their work plans, policies, and strategies. MIHR also participated in reviewing sessions of the Sudan National Health Recovery and Reform strategic work plan and policies. In addition, MIHR reviewed and analyzed the results of the national gender statistics assessment in Sudan with the SMOH and WHO, and worked with policymakers at the national level, providing technical support through participation in technical discussions and sharing of experiences and resources related to MNCH and WASH programming. In SK, MIHR reviewed the state's strategic health work plan with the SMOH. The review findings will inform the MIHR implementation at three levels:

- At the federal level, MIHR will provide technical support to the MOH to ensure the gender inclusion policy is incorporated into all health strategies and work plans, particularly for MCH and related community activities.

- At the state level, MIHR will assess the barriers and accessibility of women and girls to MCH and WASH services.
- At the community level, the results will guide the implementation of community outreach and engagement, ensuring that women are well represented and can participate in MCH, WASH, and social and behavioral change activities without hindrance.

AVAILABILITY AND USE OF DATA FOR DECISION-MAKING

MIHR worked with both the MCH monitoring and evaluation and District Health Information System (DHIS2) teams to review the latest maternal death surveillance and response (MDSR) reports and made key technical recommendations, including recommendations on how to improve the quality of data collection in SK. Additionally, MIHR discussed and agreed with the SMOH in SK on preparatory steps to support a robust health information system at select localities, which included bolstering information management within health facilities and to support locality focal points in data collection and compilation from the health facilities.

KEY CONTEXTUAL ISSUES AFFECTING ACTIVITIES

For most of its independent history, Sudan has experienced internal conflicts, and humanitarian needs continue to grow. The underlying conditions driving poverty and insecurity persist across the southern regions and Darfur. New conflicts are emerging, and inter-communal conflict is a recurring pattern that negatively impacts the population. The continuing economic crisis, exacerbated by COVID-19, high inflation, and erosion of purchasing power has resulted in high levels of food insecurity, and severely curtailed livelihoods. The ability of households to meet basic needs and access basic services, including food, has been severely affected. A decline in the economy is disrupting health services, including medicines, with only 15 percent of essential drugs available in the country.

During the preparation of this report after PY1, a state of emergency was declared in Sudan as the Sudanese transitional government was overthrown with the arrest of almost all civilian government officials. All internet and cell phone networks were subsequently blocked. This resulted in disruption of public services at almost all federal and state ministries and its related departments and offices. However, the MOH Emergency Department, at both federal and state level, continued activities without interruption. Supported by the international humanitarian community, the Emergency Department continued the provision of health services at all health facilities. Health facilities were seeing an increased number of trauma cases as a result of the violence. The country continued to face supply chain challenges, and health facilities were facing shortages of life-saving drugs and supplies.

The security situation throughout the country was volatile and worsening daily due to economic hardship and political instability. This subsequently makes future implementation of MIHR uncertain, including USAID's direction on program funding and implementation in Sudan.

WAY FORWARD

In PY2, MIHR will improve the availability, quality, and utilization of an essential package of MNCH and WASH services in Sudan through layering, sequencing, and integrating health activities with existing humanitarian response and other sectoral investments. At the state level, MIHR will work closely with the SMOH and the

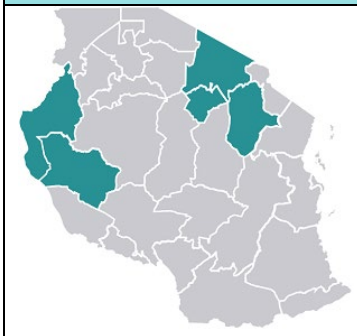
State Water Corporation to plan, implement, and monitor MNCH and WASH strategies in close coordination with humanitarian and development actors to ensure complementarity, build resilience, and promote sustainability. In addition, MIHR will work closely with the MOH and other government entities, including the Ministry of Water Resources, Irrigation, and Electricity and water corporations at federal, state, and locality levels, to strengthen staff capacity and leadership to implement processes and policies to improve MNCH, EmONC, and WASH services, promote optimal WASH behaviors, increase demand for services, and improve the reliability and sustainability of WASH systems in health facilities and communities.

At the community level, MIHR will focus on strengthening danger sign recognition and referrals during pregnancy, the postpartum period, and postpartum care (including integrated counseling) for mothers and newborns to support timely care seeking and adoption of healthy behaviors. Given the substantial share of home deliveries in supported areas, MIHR will also target strengthening the capacity of village midwives to provide safe deliveries at home. Barriers and underlying norms that inhibit MNCH care seeking and healthy WASH practices will be addressed through SBC activities at individual, household, and community levels.

Note after the close of PY1: The security and operating conditions in Sudan remain volatile since the coup of October 25, 2021. Uncertainties related to engagement with the Sudanese government structures continue pending USAID's ongoing guidance, and may affect what the project is able to achieve in the coming program year.

Selected Performance Indicators for PY1
MIHR Sudan was finalizing the project work-plan and will subsequently determine targets per indicator to measure project performance. At the end of PY1, targets had not been determined.

Tanzania Summary

<table>
<tr><th colspan="3">Tanzania PY1 Summary and Results</th></tr>
<tr><td>  </td><td>Contextual Indicators

Regions: 4, Kigoma, Katavi, Manyara, Arusha

Districts: 6 total districts (1 in Kigoma, 1 in Katavi, 3 in Manyara, 1 in Arusha)

Facilities/Communities: 56 facilities, 87 villages</td><td>Population

Country: 58.1 million

Project-supported Regions: 6.2 million</td></tr>
<tr><td colspan="3">Technical Areas: Maternal Heath, Newborn Health, Child Health, Voluntary Family Planning, Reproductive Health, Community Health, Health Resilience, Population, Health and Environment</td></tr>
<tr><td>Program Dates: March 2021 – May 2025

PY1 Budget: US$724,091 (FP/RH $566,321.65, MCH $157,769.57)

Cumulative Budget: US$724,091</td><td colspan="2">Strategic Objectives

Improve the health and resilience of individuals, households, and communities, and their sustainable natural resources, within the project intervention areas.

• Result 1: Access to and use of evidence-based, integrated quality Population, Health, and Environment (PHE) (MNCH/FP/RH) information, services, and interventions sustained
• Result 2: Strengthened capacity of government, health, and community system to deliver integrated quality PHE (MNCH/FP/RH) services
• Result 3: Increased adaptive learning and use of evidence in PHE (MNCH/FP/RH) programming through sustained local technical leadership
• Result 4: Increased cross-sectoral collaboration and innovative partnerships

Key Accomplishment Highlights

• Provided 42,021 clients with voluntary contraceptive methods through facility-based providers, CHWs, and mobile outreach, achieving 49,654 couple years of protection
• Trained 44 CHWs and 13 CHWs on maternal, newborn, and child health and health promotion, with the aim of expanding the role of CHWs to provide MNCH counseling and support
• Established 1,643 new model households/bomas to promote positive PHE behaviors at the household level</td></tr>
</table>

Tanzania

KEY ACCOMPLISHMENTS

In March 2021, MIHR began operating in Tanzania through a short-term transition period (March-May 2021) that continued some of the key activities previously implemented under the Evidence to Action (E2A) project. Planning for the 5-year MIHR program in Tanzania also got underway through the co-development of a project description with USAID. Key activities that were sustained during this period included: support to health facilities for the provision of high-quality FP services; mobile FP outreaches; home visits and service provision through CHWs; establishment, support to, and monitoring of model households/bomas to promote positive PHE behaviors; and support to Community Conservation Microfinance Groups (CCMGs). MIHR also developed and implemented a June-September work plan, with a revised results framework to align with the global MOMENTUM framework, that included the same key activities and some new intervention approaches, including the introduction of some MNCH activities and services.

Between March and September 2021, the project recorded several results. At the facility level, MIHR provided 14,771 clients with various modern FP methods of their choice. To support these health facilities and improve the quality of FP services provided, MIHR conducted joint supportive supervision visits in the project facilities with the local government authorities (LGAs). During these visits, improvements in infection prevention and control (IPC) standards, including the use of incinerators and placenta pits, and improvements in provision of services, were noted. At the community level, through CHWs, MIHR reached a total of 26,823 community members with integrated FP/RH and environmental conservation information and services. Of the total of counseled clients, 23,154 clients received voluntary FP services from CHWs. Additionally, the project supported training of 44 CHWs on MNCH. This was the first step in expanding the CHW role to include broader MNCH services in project-supported areas. Through FP mobile outreaches, MIHR reached 4,995 clients with voluntary FP counseling, education, and services. During PY1, MIHR also recruited 1,643 model households/bomas in the Northern Tanzania Rangelands (NTR) and Greater Mahale Ecosystem (GME) landscapes. Lastly, the project conducted an exploratory visit for the proposed new area of the Ruaha-Rungwa Ecosystem landscape. This activity has given the project staff a good understanding of the landscape, including an understanding of the partners present and possible areas of coordination.

PROVISION OF FP COUNSELING AND SERVICE THROUGH FACILITY-BASED PROVIDERS, CHWS, AND FP MOBILE OUTREACHES

MIHR supported 56 public health facilities (including 33 in the NTR and 23 in the GME) to improve the quality of FP and other reproductive and primary health care services in the project areas. All health facilities provided a full range of voluntary modern contraceptive methods to women, young persons, and men. Between March and September 2021, a total of 14,771 clients were provided with a contraceptive method of their choice through the project-support facilities. Of these clients, 70 percent were first-time FP users. The most frequently selected methods included injectables (38 percent of clients), implants (33 percent), contraceptive pills (13 percent), and condoms (12 percent). MIHR also worked with 182 CHWs (72 of whom are also trained PHE Champions) to provide integrated PHE messages and voluntary FP counseling and services in all 87 supported villages. The project reached a total of 26,823 community members with integrated FP/RH and environmental conservation information and services. Out of the total counseled clients, 23,154 clients received voluntary FP services from CHWs; 5,146 clients opted for pills and 18,008 chose condoms. In addition to providing pills and condoms, CHWs referred 3,669 clients to health facilities

for FP methods—such as injectables, long-acting methods, and permanent methods—and other health services, including antenatal care, HIV testing, and STI screening. Of the clients referred, 70 percent completed their referrals. MIHR also conducted FP outreach in the two project landscapes, which integrated FP with other health services, such as cervical cancer screening and child immunizations, to provide clients in hard-to-reach areas with access to a broad range of FP methods, including long-acting methods. In PY1, MIHR conducted 158 integrated FP outreach events in coordination with the Council Health Management Teams (CHMTs). Through these outreach events, a total of 4,995 clients were provided with a contraceptive method of their choice. Of the clients that received an FP method through these outreaches, 62 percent opted for an implant, 16 percent selected an IUCD, and 9 percent opted for injectables. Over half of the mobile outreach clients (51 percent) were youth under the age of 25.

INITIATION OF MNCH COMPONENT

In July 2021, MIHR began implementing an MNCH component to the project after receiving additional MCH funds from USAID. One key approach to integrating MNCH and FP in project-supported areas was to expand the role of CHWs to incorporate MNCH counseling and services. In preparation for this expanded role of CHWs in both the NTR and GME, the project started laying a foundation for MNCH activities. During the final quarter of PY1, a total of 44 CHWs and 13 CHW supervisors in the GME were trained on health promotion and MNCH, including identifying pregnant women within first 3 months of pregnancy and counseling them for early antenatal visits, identifying danger signs during pregnancy, provision of youth friendly services, provision of FP counseling and services, and basic nutrition skills and knowledge. After the training, the CHWs started activity implementation by reaching out to women with MNCH information and services, including providing referrals for 468 women to the health facilities for antenatal care. The training on MNCH was completed a few days before the end of PY1. CHWs were following up with the referred women to encourage completion of the referral at a health facility.

INTEGRATED PHE INITIATIVES

MIHR conducted a number of activities to promote positive PHE behaviors at the community level, including sensitization by CHWs and PHE Champions; establishment of, support to, and monitoring of model households/bomas; initiation of PHE school clubs; and engagement with Community Conservation Microfinance Groups (CCMGs). CHWs and PHE Champions conducted sensitization activities on FP and environmental conservation with a variety of different community groups, including in- and out-of-school youth, CCMGs, village environmental committees, women's groups, community members through the village assembly/meeting, and members of village councils. Through these efforts, CHWs and PHE Champions reached a total of 21,307 community members between March-September 2021 with information on FP/RH and environmental conservation. PHE Champions also recruited 1,643 new households/bomas into the model household initiative and continued to follow up with and provide information to 2,669 existing model households/bomas that were established through the E2A project. The purpose of the model household approach is to promote positive PHE behaviors at the household level. The households are assessed on 21 indicators—including indicators related to clean water, hygiene practices, sustainable gardening, girls' education, and attitudes towards family planning—with the goal of moving up into higher "classes" of model households based on their adoption of these positive behaviors. During PY1, MIHR also identified 20 schools (10 in the NTR and 10 in the GME) for the establishment of PHE School Clubs. The purpose of these clubs is to reach the younger generation with information on the linkages between their health and the health of the environment. The clubs will use a curriculum developed by the Jane Goodall Institute and can include

activities such as creating tree nurseries to grow seedlings to distribute throughout the community and establishing kitchen gardens to teach youth how to grow nutritious fruits and vegetables. Lastly, to improve access to financial resources and income generating activities for individuals and households, the project worked with the government through the District Community Development Officers to conduct supportive supervision for Community Conservation Microfinance Groups and other environment-friendly livelihood and income generating activities. In PY1, MIHR provided supportive supervision, connections to community health insurance, and guidance on the government CCMG registration process to 166 CCMGs.

KEY MERL ACTIVITIES

During PY1, MIHR conducted a number of key MERL activities, including the development of a CHW and Model Household mobile application, incorporation of data review into supportive supervision visits, and the development of case studies documenting results and lessons learned from key approaches implemented under E2A. For the development of the mobile application, MIHR worked closely with a consultant to develop a revised application to be used by CHWs and PHE Champions to guide FP/PHE home visits and visits to model households, and to collect data on these activities. During PY1, MIHR adopted software developed for a Landscape Conversation in Western Tanzania activity, including a mobile application, completed configuring the server, completed developing all forms, and the general make-up of the system. During PY1, the project also incorporated data reviews into supportive supervision activities at project-supported health facilities.

Overall, the goal of incorporating data review into supportive supervision is to catch and correct data entry errors. During this reporting period, the data review team consisted of one Regional Health Management Team (RHMT), which oversaw the activity supported by the Council Health Management Teams (CHMTs) and project staff. The team reviewed and verified the health facility and CHW data. During the review process, the team cross-checked the data reported in DHIS2 compared with data in the source tools stored at the facility. No serious data issues were observed, except for small data discrepancies caused by human/data entry errors. All these were corrected immediately at the specific health facilities. Lastly, during PY1, the project conducted three case studies focusing on three key project interventions from the E2A project, including first-time parents (FTP) interventions, model households/bomas, and CCMGs. The purpose of these case studies is to learn from the experiences of the E2A project and apply this learning to ongoing MIHR project activities. Two case studies were completed and submitted to USAID for review, and the project was finalizing the third case study, which focuses on the CCMGs—specifically looking at the role of the CCMGs in increasing women and girls' income and decision-making at household and community levels.

KEY CONTEXTUAL ISSUES AFFECTING ACTIVITIES

MIHR Tanzania experienced a few challenges during this initial project year. The first related to increasing CHW responsibilities—through the addition of MNCH activities/services—while their allowances remained the same. The project anticipated this, and to address it, MIHR was conducting ongoing advocacy with the local government authorities to review CHW allowances and calibrate this with the work expected of them. The project also noticed that some NTR facilities were not implementing new MOH guidelines on infection prevention and control. To address this, MIHR was working with facilities to distribute the new guidelines and ensure their implementation. Lastly, CHWs, PHE Champions, and CCMG trainers had difficulty in reaching all community platforms in their catchment areas due to how many there are, and the varying times when they meet. To address this, the project was working with community resource persons and community groups to bundle meetings together to reach community members more efficiently.

WAY FORWARD

During PY2, MIHR will continue to implement and build upon the above approaches to ensure that project-supported communities have access to high-quality FP/RH and MNCH services, are well educated on PHE, have access to sustainable livelihood activities, and ultimately have increased resilience to respond to shocks and stresses caused by climate change or other sources. During PY2, MIHR will continue to provide clinical mentorship and coaching to facility-based providers through supportive supervision visits to ensure the availability of quality services. MIHR will also continue to conduct integrated FP mobile outreach and provide counseling and services at the community level through CHWs and PHE Champions. Additionally, MIHR will initiate another phase of first-time parents' activities, including the integration of additional MNCH topics and the incorporation of an adapted couple connectedness module, in order to meet the needs of this unique subset of youth and increase their resilience at a pivotal stage in their lives. MIHR will also continue to expand new programmatic approaches, including through the training of CHWs on MNCH and health promotion and training on postpartum family planning at health facilities. MIHR will continue to engage with RHMTs and CHMTs to explore opportunities for further integration of technical approaches and introduction of best practices at project-supported facilities and communities.

MIHR will continue to work with CHWs and PHE Champions to conduct house-to-house, community, and village education and awareness to promote adoption of positive PHE behaviors and to enroll households/bomas into the model household initiative. MIHR will continue to support CCMGs, including establishing linkages to Universal Health Coverage and capacity building for income generation. The PHE School Club initiative will continue through teacher/administrator training, convening of groups, and ongoing supervision and support. MIHR will conduct several MERL activities, including ongoing data review and DQAs, the implementation of the F2C Assessment, the finalization of the CHW and model household/boma mobile applications, and annual model boma and CCMG assessments. Lastly, MIHR will continue to build the capacity of local actors to promote sustainability, and will continue exploring opportunities for transition into the Ruaha-Rungwa Ecosystem through engagement with potential partners, information gathering, and a learning visit with the NTR landscape.

Selected Performance Indicators for PY1		
Indicator #	**Indicator**	**Achievement (target)**
Indicator 1.1.4	Number of people accepting modern FP services	42,021 (no target set)
Indicator 1.1.5	Couple years of protection (CYP) generated through FP services supported by the project	49,654 (no target set)
Indicator 1.1.14	Number of new model households/bomas recruited	1,643 (146% achievement)
Indicator 1.1.15	Number of existing model households/bomas revisited	2,669 (95% achievement)

Appendix C – Success Stories

Improving the Quality, Equity, and Coverage of MNCHN/FP/RH Services

Julia Poni, a wheelchair-bound mother of five in South Sudan living on limited resources, has been grappling with the challenges of unplanned pregnancies for years. These pregnancies have often been detrimental to her health, and she married into a community with negative attitudes toward the use of modern family planning. Julia, 31, bravely broke what is considered a cultural taboo and made the unpopular decision within her community to access voluntary family planning services at a USAID-supported health facility in Gurei, a suburb of Juba, the capital.

MOMENTUM Integrated Health Resilience's work in South Sudan, following on the efforts of a prior USAID-funded project, Evidence to Action (E2A), began in 2020 to increase access to and quality of integrated FP/RH/MNCH care in both the public and private health sectors. MOMENTUM works in a dozen health facilities with the South Sudan Ministry of Health, other implementing partners like UNICEF, and key stakeholders to achieve these ends. MOMENTUM also works to increase the demand for and utilization of equitable, quality FP/RH/MNCH care by individuals, families, and communities. In addition, there is a focus on enhancing the resilience and inclusiveness of the health system in South Sudan. This includes mothers like Julia, who was raised in a society of social exclusion, especially for persons of her circumstances.

The family planning method gives Julia's body time to recover from the frequent childbirths, and allows her some time to work informally or ask for support from others at the local market to provide for her children.

"I have seen a lot of benefits from using an FP method. My health has greatly improved. I am able to provide good clothes for my children, and when they return from school, they find good food to eat. When they fall sick, I am able to provide medication for them."

Julia expresses satisfaction with the way she is treated and respected at the health facility. She is also appealing for the continuation of such services for women and to make the health facility more accessible to other persons with disabilities.

In just one quarter of 2021, over 10,000 clients received voluntary informed choice counseling, and nearly 5,000 clients chose a family planning method across the 12 health facilities.

MIHR also identified 27 trained community health workers who were mentored by MIHR's MNCH officers and dedicated FP providers. As MIHR continues to build its coverage for the South Sudan program, more stakeholders will receive quality, integrated services.

Having endured several challenges, Julia expressed optimism for herself and her children. Health support provided through USAID has allowed her to make appropriate and meaningful family planning and related choices for a more positive future.

Advancing Sustainable Development

Early in 2021, MOMENTUM Integrated Health Resilience was asked by the Gao district health office in Northern Mali to help develop and validate its operational plan. The project focused on data quality, identifying issues such as incomplete routine immunization data and inconsistencies in antenatal and delivery data.

In May 2021, MOMENTUM convened a diverse and inclusive stakeholder group in Gao, including international organizations, civil society, health associations, and Ministry of Health representatives, to review and use the data in the process of creating a joint project work plan. The joint ownership of the work plan, including defined roles and responsibilities and coordination mechanisms between the project and local authorities, contributes to a more resilient health system that can address protracted MNCH and other health problems in Gao.

“Usually (donor) projects are created, set up in Bamako, and are brought to us. Often, they are not adapted to the context in the field, and this causes many issues during implementation…This project is adapted to our reality and our needs...I am committed to making this project a real success.”

Abdramane Alpha Maïga, *Secretary General of the Gao Regional Federation of Community Health Associations, Mali*

“I have worked with several partners who support health activities in the region, and it is only with MIHR that I participated in a workshop to co-create project activities. This approach is unique and vitally important to me as it involves implementing actors at all levels in the design, planning, and even implementation of the project. We don't see this every day. It is especially important for us that key, local development actors be really involved with partners to achieve the expected results. It is much easier for us if we are involved from the project’s start. The co-creation was planned and executed from end to end with our participation. We included the priorities and concerns that we have at the regional, district, and community levels within the activities. I can now assure the project’s implementation success, because it is now our project, and we will be accountable for the results. We are confident that this co-creation approach will help this project to effectively meet our needs. I urge other partners to draw inspiration from this approach in order to facilitate ownership of the various programs and projects.”

Dr. Isaac Kodio, *Health Activity Planning Lead, Gao Regional Directorate of Health*

Learning and Adapting Across Contexts to Achieve Health Objectives

In 2020, MIHR launched its first country program in South Sudan. Due to the ongoing COVID-19 pandemic, the entire start-up process had to be supported remotely. Since it was the first country program for MIHR, and it had to be done remotely, the team undertook a series of after-action reviews to identify lessons learned and successes. These were then applied to the scoping and start-up in other MIHR countries as they came on board.

For the after-action reviews in September 2020, core team members came together for two separate meetings (operations and technical/MERL), facilitated by the Knowledge Management Lead, to address 1) communication with partners; 2) identification of the lead partner; 3) the scoping exercise; and 4) engagement with USAD. Within each category, the discussion focused on what was supposed to happen, what actually happened, and any ideas for strengthening the process going forward. Recommendations were developed based on the discussions and later presented by the KM Lead and Country Support Lead to the Senior Management Team for further discussion and action.

The Senior Management Team and the Country Support Team adopted several of the recommendations, including: running operational scoping concurrently with technical scoping rather than afterward; identifying a technical point of contact in the country; regular coordination with Corus/IMA counterparts; and greater clarity on outcomes and outputs.

Additional recommendations were published on the MOMENTUM website in a program brief: "Recommendations for Effectively Starting Programs Remotely: Lessons Learned from Momentum Integrated Health Resilience," as noted elsewhere in these appendices. While MIHR has always had Collaborating, Learning, and Adapting (CLA) planned as integral to project activities, the COVID-19 pandemic provided a clear and dramatic opportunity to act on and reflect the benefits of CLA.

Amplifying Country and Global Leadership

The CORE Group[27] convenes global health professionals to share knowledge, evidence, and best practices, and helps to advance dialogue at both country and global levels. Several MIHR staff hold key committee positions with the group to help amplify and improve our work.

For example, MIHR Country Support Lead Sarah Kellogg noted how the team she helps to co-chair, the Humanitarian-Development Global Health Task Force, organized three webinars in 2021. These webinars focused on work in the humanitarian-development nexus, navigating COVID-19, developing organization capacity, managing responses to shocks, and different implementation models.

"One thing that makes organizing our webinars so exciting is that they facilitate further introductions to other professionals we might not otherwise have the opportunity to work with," said Kellogg. "They are a way to engage all of us while bringing together various points of view that we normally don't get to hear."

She noted that the committee work is also a way to engage with peers to discuss integral topics and how these relate to what we are all trying to accomplish, while also serving to highlight MIHR's work.

[27] Visit https://coregroup.org/ for information and details.

MIHR SBC Lead Kamden Hoffmann, co-chair of the Systems for Health Working Group, said that one of the group's three workstreams that she leads is focused solely on social accountability, which is one of MIHR's guiding principles. MIHR can further global thought leadership and evidence generated through country level activities through its involvement in this workstream with other global actors.

MIHR Senior Technical Advisor for MERL, Nancy Stroupe, co-chair of the M&E Working Group, noted that a major focus for the coming year is on data equity and inclusive monitoring and evaluation. This is an important topic for donors and implementing partners, and working group participation allows MIHR to both learn about and share ideas and best practices for ensuring that MERL is an inclusive and equitable endeavor.

MIHR Nutrition/WASH Lead Kirk Dearden has been helping the CORE Group begin organization-wide work on One Health, a topic of increasing importance for donors, implementing organizations, academicians, and others, especially in light of the COVID-19 pandemic. A major objective of the One Health Interest Group is to build a strong network of individuals committed to addressing the intersection of human, animal, and environmental health.

MIHR anticipates that staff will continue engaging with the CORE Group, IAWG, and many other collaborative, USAID-priority global efforts as the project moves forward.

MIHR is also working to build youth leadership at community levels. These community youth leaders today can emerge as tomorrow's country and global leaders.

Hellen Ayenyo is a 24-year-old South Sudanese student and youth leader at a Seventh Day Adventist church in Eastern Equatoria State. She sees herself as an advocate for change and a voice for the voiceless in her community.

"My future will be full of advocacy for change and helping the needy," she said. "In terms of leadership, I want to ensure that I help reduce [the number of] girls and boys dropping out of school, and spearhead promoting community empowerment on family planning, maternal and child health, and gender-based violence issues."

Her involvement with MOMENTUM started when project staff visited her church to meet youth leaders. She sees MOMENTUM as a conduit to help her community outreach and advocacy. For example, in a radio talk show that MOMENTUM helped organize, she called into the show and contributed to a discussion on voluntary family planning, and thus felt that her voice was heard.

With MOMENTUM support, Hellen believes she can overcome challenges such as lack of access to reproductive health services, as current social norms stigmatize youth who use such services. She also hopes her work through MOMENTUM will help to offset negative social pressures coming from some peer groups, which can be addressed through activities with youth groups, health clubs, and faith-based programs.

Appendix D – Knowledge Dissemination

Reports, Briefs, and Fact Sheets

Title	Publication Date
MOMENTUM Integrated Health Resilience Fact Sheet	January 2021
Building Resilience in Health: The MOMENTUM Integrated Health Resilience Approach	May 2021
Commitment to Immunizing Zero-Dose Children	June 2021
Recommendations for Starting Programs Remotely: Lessons from MOMENTUM Integrated Health Resilience	July 2021

Webinars and Seminars

Date	Title	Audience
11/17/2020	Humanitarian 101: The Other Side of the Nexus	MIHR
2/5/2021	Latest in Maternal and Newborn Health in Fragile Settings	MIHR
3/11/2021	Digital Health: Principles and Practice	MIHR
4/1/2021	MOMENTUM Virtual Learning Exchange: Country Co-creation Processes	MOMENTUM, USAID
4/8/2021	RED/REC Learning Break	MIHR
5/4/2021	Socializing the Gender Strategy	MIHR Core Staff
6/10/2021	Population, Health, and Environment Learning Break	MIHR
7/19/2021	MOMENTUM Share Fair • All Things Zero-Dose and Equity • Implementation in the Humanitarian-Development Nexus: Ebola & MIHR in DRC • Digital Health 101: MOMENTUM Approaches • Collaborating in the Humanitarian-Development Nexus • Does Growth Monitoring and Promotion Work? A Search for Better Alternatives • Implementing an Integrated Population, Health, and Environment Program in Western and Northern Tanzania to Build Resilience of Individuals, Households, and Communities • Health Resilience-Build Back Better and Forward • Pitchfest	MOMENTUM, USAID
8/17/2021	Learning Break: Security Rules and Regulations	MIHR
8/31/2021	Community Health Peer Consultation	MIHR
9/7/2021	Health Resilience Workshop (En)	MOMENTUM country staff
9/8/2021	Health Resilience Workshop (Fr)	MOMENTUM country staff

Date	Title	Audience
9/23/2021	Strengthening Health Resilience to Improve Voluntary Family Planning in Fragile Settings (World Contraception Day Webinar)	Public
9/29/2021	Humanitarian-Development Nexus Webinar with JHU	USAID

Training

NA

Other Technical Dissemination

NA

Appendix E – Strategic Communication

At the start of calendar year 2021, MIHR staff began discussing ideas for initial blogs and social media. As program activities were in large part just getting underway in just a few countries, the themes of these products were mostly about approaches for future work. At the close of PY1, MIHR had led the production of three blogs and participated in another, held a live Twitter event with MCGL and MKA, and contributed to monthly toolkits, various tweets, and other social media. Several other products were in the works as PY2 got underway.

Blogs

"Celebrating Mothers as Protectors of Health."
Mother's Day, May 6, 2021. In recognition of Mother's Day, this blog highlights how mothers are the front line of family health care, and notes how MOMENTUM helps support them. https://usaidmomentum.org/celebrating-mothers-as-protectors-of-health/

"Breaking Down Barriers to Health Equity Through Community Engagement."
Health equity, June 11, 2021. How MOMENTUM works with country partners to address health equity, even in fragile and marginalized settings. https://usaidmomentum.org/breaking-down-barriers-to-health-equity-through-community-engagement/

"MOMENTUM's Efforts to Strengthen Youth Health Care and Leadership."
World Youth Day, August 10, 2021. A look at four specific actions MOMENTUM is taking that help to develop youth leadership and builds on the evidence and learning generated by USAID's YouthPower projects. The blog includes a youth leader profile. Prepared in collaboration with MCGL and MSSFPO. https://usaidmomentum.org/strengthening-youth-health-care-and-leadership/

In addition, MIHR staff contributed to a blog coproduced with partners IMA and JSI; the blog appeared on both organizations' websites for World Population Day in July 2021: https://imaworldhealth.org/blog/2021/world-population-day-one-family-at-a-time

MIHR also coordinated with JSI to produce a profile blog with reflections from the MIHR Immunization Lead for World Immunization Week, on April 30, 2021: https://www.jsi.com/reflections-on-world-immunization-week-20-years-of-experience-from-across-the-globe/

A blog draft related to project activities in Tanzania was submitted to MKA for review, but was instead modified into a series of social media posts by MKA during World Water Week in August 2021.

Press Releases

NA

Videos

NA

Photographs

A limited number of photographs of MIHR activities were contributed by several staff and are used internally by MIHR, as they limited in range and quality. All MIHR staff have been provide with guidelines for taking quality photos.

High-quality photos provided through a professional photographer have been placed on the MOMENTUM Hub. Captions accompany all photos. Consent forms for all photos are kept on file on MIHR computer servers. These photographs (n=17) are from June 2021 in Gurei Primary Health Care Clinic, a facility supported by MIHR near Juba, South Sudan. Photos show beneficiaries, some of their children, and health workers discussing FP methods and related information.

https://km.usaidmomentum.org/toolbox/photo-galleries/mihr-south-sudan-photos

Appendix F – Global Leadership Table

Technical Focus/Area	Name and Brief Description of Group/TWG/CoP	MIHR's Role	PY1 Achievements
Resilience/ Humanitarian-Development Nexus	**MOMENTUM-wide TWG on Health Resilience.** This group is expected to be the global thought leader in setting implementation and measurement approaches for health systems resilience interventions in fragile and conflict contexts.	**Lead**	MIHR began working on health resilience by initially organizing an internal technical working group (TWG). This group constituted technical leads and was led by the senior technical director and the monitoring, evaluation, research, and learning (MERL) director. The group unpacked the definitions of resilience at individual, household, communities, and health systems levels. The group also gathered resources (e.g., academic and grey literature) and brainstormed on a health resilience framework and pathways for MIHR. . A health resilience framework (including proposal for measurement) was developed, and was used to contribute to the MIHR TOC that later informed the revision of the results framework.
Family Planning and Reproductive Health (FP/RH)	**Inter-agency Working Group on Reproductive Health in Crises (IAWG) Voluntary Contraception workstreams on QoC and localization.** MIHR participates in the Voluntary Contraception Sub-Working Group; it is an opportunity for bidirectional knowledge sharing on lessons learned in fragile contexts and for contributions to evidence-based technical guidance, standards, and tools; to identify gaps in research and service; and generate new evidence for advocacy to policymakers, managers, and practitioners.	**Co-lead**	Contributed to preparations and hosting of the *Self-Care Everywhere: Innovative approaches to achieving sexual and reproductive health and rights in humanitarian and fragile settings* panel session, during the Self-Care Trailblazers Group Learning and Discovery Series, through the IAWG Voluntary Contraception Sub-Working Group.
	IAWG Sub-working Group on supply chain management in humanitarian settings. MIHR participates in monthly meetings to contribute to and draw upon the network and learning across working group members, including humanitarian NGOs, UN organizations, and universities.	**Member**	Contributed to the Women's Rights Commission (WRC) key informant interview on COVID-19 and FP in fragile settings and panel discussion during dissemination of the findings and recommendations from the assessment. The report was published by IAWG as *Shaping the New COVID-19 Reality: Creating Evidence-based Solutions to Sustain FP in Humanitarian Settings and Across the Nexus*.

Technical Focus/Area	Name and Brief Description of Group/TWG/CoP	MIHR's Role	PY1 Achievements
	IAWG Voluntary Contraception Sub-working Group: ICFP2022 subcommittee. As a strategic inflection point for the FP/RH community worldwide, ICFP2022 provides an opportunity to disseminate knowledge, celebrate successes, and identify next steps in moving FP/RH priorities to the center of development and achieve universal access to FP services and contraception. MIHR's participation in the conference is an important platform for FP and contraception in fragile settings, as is learning from others about approaches that the project can adapt to achieve its mandate of expanding access to FP in these settings.	**Contributor**	Contributed to preparations for and hosting a panel session on FP in humanitarian settings during the *ICFP2021 Not Without FP* forum: *Emergency preparedness to ensure continued access to contraception in a crisis*. Three countries shared their experience on how various shocks and stresses affect access to FP/RH care. Vanuatu shared experience on the challenges of a hurricane and COVID-19; DRC discussed its experience on the 11th Ebola Virus Disease outbreak during the ongoing COVID-19 pandemic; and Yemen discussed experience with human conflict and COVID-19. MIHR has used these three country experiences to inform programming in partner countries.
	Task-sharing Technical Working Group (with MSSFPO). USAID asked MIHR to co-host the Task-sharing TWG with MSSFPO to bring together stakeholders in FP/RH to take forward task-sharing as one of the approaches to expand universal access to FP/RH care. MIHR's contribution will bring perspectives and lessons learned from fragile settings, where task-sharing is critically important due to the severe shortage of human resources for health.	**Co-host**	Contributed to a review of the draft terms of reference that define the areas of focus of this iteration of the TWG, membership, how the TWG will transact business, and priority activities.
	Contraceptive and Method Choice Community of Practice. Hosted by MCGL to share collective learning and technical advances and updates for FP and contraception.	**Contributor**	Contributed to discussions in the Method Choice Community of Practice Technical Advisory Group and the development of the framework to transition to the Contraceptive and Method Choice CoP.
	Contraceptive-Induced Menstrual Changes (CIMC) Technical Consultation	**Contributor**	Contributed to the CIMC technical consultation that discussed the effect of menstrual changes on the uptake and/or continuation of contraceptive methods, and identified the how to frame conversations on CIMC as part of counseling for the initiation and continuation of modern contraceptive methods. Reviewed a report of that technical consultation, expected to be published as the *Global Call to Action: Addressing Contraceptive-Induced Menstrual Changes in Research, Product Development, Policies and Programs*.

Technical Focus/Area	Name and Brief Description of Group/TWG/CoP	MIHR's Role	PY1 Achievements
	WHO Department of Human Reproduction and Research. Contributions on the use of FP data adaptation kits and global FP/RH technical guidance.	**Contributor**	Provided subject matter expertise to WHO's Department of Reproductive Health and Research during development of the WHO Academy e-learning course for pharmacists, "Counseling and prescribing of contraception in pharmacies." This course is hosted on the WHO Academy mobile learning app. In PY2, MIHR will use this course to strengthen the capacity of providers at pharmacies and drug stores, and document lessons learned.
	FP2030 technical discussions and support to countries making FP2030 commitments.	**Contributor**	Participated in the *FP2020: Celebrating Progress, Transforming for the Future*, and the *FP2030 CSO engagement* meetings to gain deeper understanding of the process of making commitments by countries. MIHR is creating opportunities to provide technical support to strengthen country commitments on emergency preparedness and response in PY2.
	Hormonal IUD Access Group. A global consortium of governments, donors, manufacturers, procurement agencies, researchers, and service delivery organizations collaborating to expand access to the levonorgestrel (LNg) IUD (a hormonal IUD) in LMICs.	**Contributor**	MIHR participates in monthly meetings convened by this group to discuss opportunities for scaling up the hormonal IUD. Lessons learned through this forum may be helpful in considering expanding access to the method in one MIHR partner country from PY3 onwards.
Maternal, newborn, and child health, and QoC	**MOMENTUM-wide QoC thematic WG.** The MOMENTUM Quality of Care thematic group serves as a centralized forum where representatives from across the suite can come together to coordinate on their respective activities, indicators, and outcomes related to QoC. Members include all QoC focal point and members from of all projects across the MOMENTUM suite of awards. The thematic working group coordinates and integrates QoC efforts by leveraging experiences and resources, and coordinating interventions at the global and field levels. It will enhance the learning on implementing best practices to strengthen adaptive, absorptive, and transformative capacities of health systems to improve quality, client-	**Lead**	MIHR initiated and is currently leading the MOMENTUM-wide QoC thematic working group, to coordinate and integrate QoC efforts across the MOMENTUM suite of awards by leveraging experiences and resources and coordinating interventions at the global and field levels.

Technical Focus/Area	Name and Brief Description of Group/TWG/CoP	MIHR's Role	PY1 Achievements
	centeredness, and continuity of essential FP/RH/MNCH services in countries that may be fragile at subnational levels (or may become fragile in the future).		
	Child Health Task Force. Steering Committee member and member of subgroups, including institutionalizing iCCM; Child Health in Emergencies and Humanitarian Settings; Implementation Science; Monitoring and Evaluation; Newborn and Child Health Commodities; Nutrition and Child Health; Private Sector Engagement; Quality of Care; and Re-imagining the Package of Care for Children. The Child Health Task Force currently comprises more than 1,900 individuals based in 80 countries from over 300 organizations, including government agencies, NGOs, multi- and bi-lateral donor organizations, and academic institutions, as well as individual consultants. The task force organizes frequent webinars and produces white papers and guidance on various topics. As a member of different subgroups, MIHR participates in multi-agency dialogue around quality of care indicators for newborn and child health, child health in the private sector, Nurturing Care Framework, and other topics of interest. The task force is an ideal platform for the exchange of ideas and to share lessons learned and best practices, as well as new standards and recommendations with the global child health community.	**Steering Committee**	In PY1, MIHR staff moderated a bi-lingual technical webinar, organized by the Child Health Task Force, WHO QoC Network for MNCH, and UNICEF on delivering quality essential maternal, newborn, and child health services during COVID-19. This has enhanced shared learning on strategies to address service continuity of essential IMNCI and iCCM services in LMICs.

Technical Focus/Area	Name and Brief Description of Group/TWG/CoP	MIHR's Role	PY1 Achievements
	IAWG sub-working group on MNH. The sub-working group is a dedicated group of IAWG members who advocate and provide technical guidance for evidence-based MNH programming for crisis-affected populations. Its members include donors and implementing agencies supporting the development or humanitarian programs in fragile, conflict-affected settings, and is co-led by Jhpiego and the International Rescue Committee (IRC). This group is an ideal platform to share experiences and lessons learned, and translate global best practices on improving MNH in fragile settings into field-supported programs.	**Member & Contributor Leading specific deliverables**	MIHR joined and became active in the IAWG subgroup on MNH, where MIHR is contributing to the Respectful Maternity Care (RMC) task team to identify promising practices and missed opportunities for RMC, to develop an RMC brief in humanitarian settings, and support the development and adaptation of a maternal mental health and psychosocial support (MMHPSS) toolkit, with a "caring for the carers" component that includes provider self-care considerations.
	ENAP in Emergencies/Humanitarian Settings (ENAP-E). Operating under the umbrella of the ENAP WG, the ENAP-E working group is a platform to support operationalization of the ENAP and other global strategy and technical guidance in fragile and humanitarian settings. Its members include USAID, UNICEF, Save the Children, and other donor and implementing agencies, including humanitarian actors.	**Member & Contributor**	MIHR joined and is an active member of the ENAP in Emergencies/Humanitarian Settings (ENAP-E) WG. In PY2, MIHR will contribute to the development of guidance/checklists on emergency preparedness and response plans for MNH in different types of shocks and emergencies, and support operationalization of the global newborn technical guidance tailored to fragile, conflict-affected settings. This group will be used as a platform to share experiences and lessons learned, and translate global best practices on improving newborn care in fragile settings into field-supported programs.

Technical Focus/Area	Name and Brief Description of Group/TWG/CoP	MIHR's Role	PY1 Achievements
	Global MAMI Network Implementation Group. The group provides MAMI Global Network members implementing MAMI and related research with an informal and confidential platform for problem solving and learning; information and resource sharing; and discussing programmatic and technical issues. In addition to MIHR, the implementation group includes the Emergency Nutrition Network, Save the Children, International Medical Corps, World Vision, Doctors without Borders, Action Against Hunger, and others. MIHR participation in the MAMI Global Network will benefit the network itself and inform future implementation of the Care Pathway. In PY2, MIHR will share lessons learned from the testing of Care Pathway version 3.0 in two countries.	**Member & Contributor**	Developed concept note on adaptation of MAMI Care Pathway tools, which was reviewed by USAID. A scope of work for the international MAMI consultant was modified, based on feedback from USAID. Both documents were shared with the MAMI Global Network. Subsequently, a highly qualified MAMI consultant (Hedwig Deconinck) was hired.
	Implementation and Monitoring TWGs of Global MNCH QoC Network at WHO. The group serves as a technical resource partner to embed strategies and solutions that address the unique challenges of MNCH QoC in fragile settings. The group provides technical inputs on the guidance documents and support implementation of QoC standards and WHO's compendium of resources on QoC in fragile and conflict-affected settings. Shares experiences on improving and measuring QoC and experience of care in fragile settings, support operationalization of WHO QoC standards for MNCH, and field test pediatric QoC indicators.	**Member & Contributor**	In PY1, MIHR was an active participant of this working group.
	Maternal Health Global RMC Council To utilize resources and share experiences on measuring and improving experience of maternal, newborn, and childcare in fragile contexts.	**Contributor**	Joined monitoring and implementation TWGs of the Global RMC Council
	Postpartum Hemorrhage Community of Practice (PPH CoP) To share resources and experiences on prevention and	**Co-Chair**	MIHR has co-chaired is and actively participated in the PPH Community of Practice Annual Meeting (Sept 15-16, 2021). MIHR is incorporating emerging evidence and lessons learnt in field programming,

Technical Focus/Area	Name and Brief Description of Group/TWG/CoP	MIHR's Role	PY1 Achievements
	management of PPH in fragile contexts; present bottleneck analysis of misoprostol use for prevention of PPH in low birth attendance settings.		particularly the barriers of using misoprostol for PPH prevention at the community level (and its advanced distribution) in the settings where skilled birth attendance is limited (a planned PY2 activity in South Sudan) and is promoting PPH prevention, early detection, and treatment bundle to reduce preventable maternal morbidity and mortality from PPH.
	Reproductive Health Supply Coalition (RHSC), Maternal Health Supplies Caucus. To coordinate efforts to bring up maternal health supply-related challenges from fragile settings, and share resources and experiences to address the bottlenecks undermining commodity security across health systems, utilizing coalition experiences, resources, and tools.	**Member**	Ongoing participation.
	Ending Preventable Maternal Mortality (EPMM) group. To provide technical inputs on EPMM milestone targets feasible in fragile settings, and to increase the visibility of fragile contexts into global technical directions, guidance, and best practices, to reduce preventable maternal mortality.	**Member**	Participated in EPMM consultation on coverage milestones.
	WHO's Small and Sick Newborn indicator group. To contribute to the indicator prioritization methodology from the lens of fragile contexts and embed priority indicators in MIHR's SSNC programming.	**Member**	Ongoing participation.
	WHO Life Course Quality of Care Measurement Coordination Working Group (LCQM-CWG). To embed the fragility context into technical discussions to harmonize/standardize frameworks and methodology for developing, testing, and implementing QoC indicators across the life course. To collaborate with MoNITOR, CHAT, GAMA, and "Aging" TAGs to share challenges and best practices on the generation, collection, and use of data to support QI at different levels across the life course in fragile contexts.	**Member**	Ongoing participation.

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	Ad hoc TWGs or consultations (MOMENTUM Maternal Mental Health Consultation, WHO ad hoc consultations, Every Breath Counts, SPA QoC indicator revisions, EPMM consultation, etc.)		Ongoing participation.
	MCGL and USAID MHCN	**Collaborator**	MIHR collaborated closely with MCGL to develop a social media toolkit, including key messages and a blog, for World Prematurity Day. In close collaboration with MCGL and the USAID MCHN team, MIHR is co-presenting the MCHN course for USAID field teams. Specifically, MIHR has developed the PPT presentation, which compiles and synthesizes the latest evidence in maternal health, including care around birth and management of complications, to strengthen the understanding of USAID field teams about the emerging global technical guidance in maternal health.
Immunization	**IA2030 TWG Outbreaks & Emergencies (SP5 subgroup).** MIHR participates in this coordination mechanism on immunization and outbreaks in fragile settings and the humanitarian-development nexus. Other members are UNICEF, WHO, IFRC, IVAC, and MSF focal points in humanitarian areas. SP5 is developing zero-dose guidelines and a theory of change, while also monitoring COVID-19 vaccine roll out, identifying actions to improve surveillance, maintaining immunization and other primary health care services, engaging communities of partners in COVID-19 vaccination, and sharing and disseminating guidelines, including Sphere guidance and CCC.	**Contributor**	Although MIHR was introduced as a new USAID project, MIHR team members were able to bring the project's perspective and voice to relevant meetings and consultations because of their prior involvement in these groups. MIHR partner JSI's well-known work on routine immunization in post-conflict and other fragile settings over the past 30 years also helped to position MIHR as the trusted partner it is becoming in the global space. MIHR also participated in initial discussions with the IA2030 SP5 working group on its own zero-dose theory of change for reaching zero-dose and under-immunized infants, their families, and communities with immunization and other FP/RH and MNCH services. This IA2030 theory of change and zero-dose operational guidance will be completed in PY2 with MIHR technical support, and be widely disseminated through global immunization partners.

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Nutrition	**Emergency Nutrition Network (ENN) Core Group Subcommittee A: Gaps and Challenges.** Established in 1995 to respond to concerns and gaps related to infant feeding during emergencies, ENN is a global collaboration of agencies and individuals committed to the protection, promotion, and support of IYCF in emergencies by strengthening learning, guidance and policies, planning, and capacity in IYCF in emergencies. Sub-committee A is responsible for assessing gaps in core group activities, identifying and incorporating solutions into the overall work plan, and monitoring progress.	**Co-lead**	Involvement in the ENN gives MIHR a seat at the table with respect to IYCF in emergencies. MIHR contributes to ongoing strategic planning, follow-up, reporting, and recruitment of new members.
	CORE Group's One Health interest group. This group develops annual meetings and practitioners' workshops and helps set the agenda for CORE Group's work. In PY2, MIHR will attend and co-lead regular One Health interest group meetings, work with the group on proposed products (e.g., a central location for WASH resources), and provide technical input into future international NGO directions in nutrition and SBC.	**Co-lead**	Led the CORE Group's One Health activities, including informational sessions at the CORE Group's annual conference, a webinar for Earth Day, and a journal club. MIHR staff also co-planned the CORE Group Practitioners' Conference.
	Infant Feeding in Emergencies (IFE) core group	**Participant**	Through monthly conferences with the IFE core group, MIHR identified activities and developed a work plan to establish and strengthen communities of practice and to improve nutrition in fragile settings.
Community Health Systems	**UNICEF working group to develop QoC/QI guidance for community-based primary health care.** MIHR will contribute to UNICEF-led efforts to develop and promote use of QoC/QI guidance in fragile contexts.	**Contributor**	As activity progresses, MIHR may be able to field test the guidance in one country; the process has not yet begun, and progress depends on UNICEF's plan.
	Community Health Community of Practice (CH CoP). MIHR participates actively in the CoP, sharing lessons from MIHR-supported partner countries and serving as the primary source of information and a thought leader on community health in fragile settings.	**Contributor**	MIHR joined the Community Health CoP in PY1 and uses the platform as a resource center for accessing tools, and technical documents. In PY2, MIHR will share at least one technical brief on community health in fragile contexts that is based on experience from MIHR-supported countries. MIHR's participation helps to focus the CoP's attention on fragile contexts, and the adaptation of generic tools and guidelines for these contexts.

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	Community Health Workers (CHWs) Thematic Working Group (TWG) of Health Systems Global. The CHW TWG brings together academics, policymakers, program implementers, funders, students, CHWs, and other national and international stakeholders.	**Contributor**	MIHR shares lessons and experiences to learn from and contribute to the global dialogue. Considering the limited global experience on community health in fragile contexts, MIHR expects to make a significant contribution to this group's work. In PY1, MIHR attended a webinar organized by the CHW TWG that focused on CHW in fragile and conflict affected settings. Technical documents that were shared by the TWG have been reviewed and used as inputs to the work of MIHR.
Gender	**USAID Interagency Gender Working Group (IGWG).** The group shares gender-related technical and programmatic issues.	**Contributor**	MIHR participates in the IGWG that brings together all MOMENTUM gender representatives from across the suite to coordinate respective gender activities, indicators, and outcomes. The group was in the process of developing a gender brief that draws from each awards' gender strategy/approaches. The team finalized the review of the performance indicator reference sheets for four cross-cutting gender indicators to be used across the suites.
	Inter-agency Gender Working Groups' Male Engagement Task Force (METF) Among its myriad activities, the Task Force considers shifting social and gender norms, and has recently put together an infographic on male engagement in nurturing care. MIHR will review and make inputs with the fragile settings lens.	**Contributor**	MIHR participates in the IGWG's METF for information, advocacy, knowledge exchange, and networking on engaging men and boys in health promotion and gender equality.
Youth	**IAWG sub-working group on Adolescent Sexual and Reproductive Health (ASRH) in Humanitarian Settings.** The IAWG sub-working group on ASRH in Humanitarian Settings sets priorities and objectives for ASRH. The IAWG completed the review of the Adolescent and Sexual Reproductive Health Toolkit 2020 edition, has translated it into Arabic, Spanish, and French, and uploaded it to the IAWG's website. IAWG has also developed TORs to engage young people as co-chairs of the group.	**Contributor**	Working with the IAWG on ASRH, a plan was developed to have young people selected into co-chair positions on the IAWG ASRH group, and two young people, one from India and another from South Sudan, are co-chairing the IAWG monthly meetings as they receive mentorship from the SWG selected members on leadership for ASRH. A process to disseminate the IAWG ASRH toolkit in humanitarian settings was also developed.

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	HCDExchange Community of Practice. MIHR has recently joined the HCDExchange CoP, a youth-led regional network of individuals and organizations who work to design evidence-based, youth-centered sexual and reproductive health interventions. MIHR will engage in sharing and receiving ideas from peers and experts in the human-centered design (HCD) and ASRH fields. The details of the team can be found at https://hcdexchange.org/community/.	**Member**	MIHR has initiated a relationship with the HCDExchange community of practice that offers young ASRH practitioners and advocates human-centered design workshop learning opportunities. MIHR will build linkages with country Youth Action Teams and the HCDExchange COP for further engagement and learning.
Social and Behavior Change	**SBC CoP for Service Delivery.** MIHR contributes to this CoP, led by Breakthrough ACTION, as a technical subject matter expert and co-author of peer reviewed and grey literature. MIHR works to ensure that resilience and fragility are captured within provider behavior, and to bring focus to the community's role in the health system; this CoP has traditionally focused on only the facility.	**Contributor**	Contributed to the design and revisions of the Provider Behavior Ecosystem, led by Breakthrough ACTION. Contributed to prototyping of diagnostic and programmatic tool linked to the Provider Behavior Ecosystem and contributed substantially to a PBC journal commentary and the Breakthrough RESEARCH SBC in Emergencies journal article. MIHR also presented on the role of SBC in improving the uptake of modern contraception at the SBC for Service Delivery Community of Practice. MIHR will continue participating in the CoP activities for experiential learning and sharing. In PY2, the group will finalize the Provider Behavior Ecosystem diagnostic and programmatic tool.
	MOMENTUM-wide SBC Thematic Group. Managed by MKA, staff from across the suite with specific SBC technical interests come together to exchange ideas, information, and resources in an easy "light lift" way. The MIHR SBC Lead is heading the group, which is discussing adaptive management strategies across the projects through the MOMENTUN HUB.	**Lead/Member Contributor**	MIHR led the Thematic Working Group for Q3, posted key materials for SBC group use, and initiated discussions around COVID-19 pictorial materials for vaccine uptake, based on requests from field teams.
	CORE Group Systems for Health (S4H) Working Group	**Co-Lead**	Co-led quarterly meetings, expanded social accountability workstream members, and discussed a social accountability repository with CORE group to consolidate key materials, among other activities. Planned for upcoming semi-annual CORE Group meeting to take place in October 2021.

Technical Focus/Area	Name and Brief Description of Group/TWG/CoP	MIHR's Role	PY1 Achievements
	Social Norms Atlas Learning Collaborative	**Contributor**	Contributed to the development of the Social Norms Atlas that was launched May 2021, and shared widely with MIHR staff.
	Community of Practice on MeasURing Social Accountability (MURAL). Members include UNDP, UNFPA, UNICEF, WHO, and the World Bank. MIHR plays the role of a technical subject matter expert and provides feedback on key documents.	**Contributor**	Provided technical input/feedback to the draft reporting checklist for social accountability practitioners, to be published and distributed in Year 2. In PY2, the group will adapt a reporting checklist for social accountability practitioners in MIHR countries. MIHR participates with MURAL because the tools it develops will help to improve social accountability approaches within MIHR and continue to build the evidence base globally.
	MIHR Social Accountability Working Group		In Q4, the MIHR social accountability working group finalized the Social Accountability in Fragile Settings Strategy and shared the strategy with MIHR leadership. Final revisions will be made on the penultimate version in PY2, and a learning break is planned in early PY2 for MIHR core and field staff, to ensure the team understands the rationale for, and goals and objectives of, social accountability processes.
	Expert Working Group for HIPs.		MIHR was invited to be a member of the expert working group to develop an enabling environment High Impact Practice (HIP) for Family Planning focused on Social Accountability. MIHR provided input to theory of change, provided substantial input into iterative drafts, and it is expected that the final draft will be made public for comment in Q1/2 of PY2.
Local Organization Capacity Building	**MOMENTUM-wide Capacity Building Technical Consultation Group.** This is an ad hoc group consisting of MOMENTUM's capacity technical leads. The objective is to discuss and contribute to the development of MOMENTUM-wide capacity building frameworks and tools.	**Contributor**	MIHR actively participated in PY1 discussions. In PY2, the group expects to finalize the development of a cross-MOMENTUM measurement framework for organization development, and a cross-MOMENTUM MEL framework, whose development was spearheaded by MKA in PY1. MIHR's involvement will contribute to the development of more accurate frameworks and tools for building capacity of local organizations and measuring organizational capacity and performance.

Technical Focus/Area	Name and Brief Description of Group/TWG/CoP	MIHR's Role	PY1 Achievements
	The Health Systems in Fragile and Conflict-Affected Settings Thematic Working Group (TWG-FCAS). This group draws upon the breadth of experience of key actors in health in fragile and conflict-affected settings and promotes research, policy, and advocacy actions to contribute to the development and implementation of responsive and context-specific health systems.	**Follower**	MIHR follows this group to identify opportunities with other members, like UNICEF and WHO.
	Reproductive Health Supplies Coalition.	**Member**	MIHR participates in the group to help collectively develop and implement strategic solutions that have a lasting impact on commodity security. This includes collecting new evidence and integrating updated learning to ensure continuous access to SRH supplies for women, girls, and other marginalized groups, who need them before, during, and after crises to build resilient supply chains.

Appendix G – MIHR Tools and Product Tracker

IR	Activity #	Deliverable	Status	Target Audience	Start Date	Com-pletion Date	FY21 Q4 Implementation Status	Dissemination Plan (for tools that are not internal; where will they be housed? What is the long term use?	End of PY1 Update
RESULT 1: ACCESS TO AND USE OF EVIDENCE BASED, QUALITY MNCH/FP/RH INFORMATION, SERVICES, AND INTERVENTIONS SCALED UP AND SUSTAINED									
1.2	1.1.b	MNCH/FP/RH Best Practices list	Field Use	Government/MOH leadership (policymakers, program planners and implementers) at national and subnational levels; health care providers; professional organizations; international and local NGOs; development partners; academic institutions	FY21 Q2	FY25 Q1	Ongoing	This is an internal list that will be maintained on an ongoing basis	For FP/RH, discussions have been ongoing with country teams to incorporate the WHO guidance on *Providing Family Planning Services During an Epidemic*, to maintain continuity of FP/RH care as an essential service during the COVID-19 pandemic. MIHR co-facilitated a learning course for USAID MCHN field offices on latest global technical guidance on maternal health, including providing and maintaining essential MNH services in the context of COVID-19.
1.2	1.2	Basic Assessment Toolkit (discontinued; now a compendium of multiple instruments and each instrument will be tracked separately)	Testing/ adaptation/ lessons learned	International and local NGOs; humanitarian and development partners; academic institutions	FY20 Q4	FY22 Q2	Ongoing	MIHR-I; MOMENTUM Hub per each tool/instrument as appropriate as MIHR moves forward	MIHR no longer refers to a "basic assessment toolkit." As we evolved during PY1, we have a list of data collection instruments that will be used in many MIHR-supported countries. This list of data collection instruments include: i) F2C Assessment; ii) ARC-D for Health; iii) Health Facility Readiness Assessment (HFA); iv) Organizational Capacity Assessment tool (OCA); v) Organizational Performance Index (OPI); vi) QoC toolkit (under development). MIHR also maintains an index of KAP questionnaires for use by country buy-in projects.
1.3	1.3.1a and 1.3.2a	Technical guidance for providing quality FP/RH care in fragile settings	Adaptation	Government/MOH leadership (policymakers, program planners and implementers) at national and subnational levels; health care providers; professional organizations; international and local NGOs; development partners; academic institutions	FY21 Q2	FY22 Q2	Ongoing	In-country dissemination to MOH and partners; cross-country learning forums; MIHR-I and MOMENTUM Hub	MIHR will develop guidance after the QoC assessment results analysis. Revision is ongoing to identify key elements of QoC that are most applicable in fragile settings.
1.3	1.3.1c	SBC in Fragile Settings Roadmap program brief	Develop-ment/Draft-ing	MIHR core staff, country project teams, NGO/CBOs, local partners staff, and donors who will be involved or have interest in SBC	FY21 Q3/4	FY22 Q1	Ongoing	Country teams, MIHR-I & MOMENTUM Hub	MIHR works in countries where stresses already exist and shocks are likely imminent. This roadmap will provide key considerations focused on MIHR's resilience capacities that promote proactive responses for SBC during shocks and stresses to prevent disruption in demand and care seeking, rather than reactive responses to these crises. The outline draft was developed in Q3/4 and will be finalized in Q1 PY2.

IR	Activity #	Deliverable	Status	Target Audience	Start Date	Com-pletion Date	FY21 Q4 Implementation Status	Dissemination Plan (for tools that are not internal; where will they be housed? What is the long term use?	End of PY1 Update
1.3	1.3.1c	Provider Behavior Diagnostic tool	Adaptation	MIHR core staff, country project teams, CBO/NGOs, local partners staff, and donors who will be involved or have interest in MIHR provider behavior change assessments and interventions	FY20 Q4	PY2	Being revised/ updated	N/A: this is an internal tool	Low fidelity testing took place in Q3, medium/high fidelity testing delayed by BA, expected in PY2.
1.3	1.3.1c	Provider Behavior programmatic tool	Adaptation	MIHR core staff, country project teams, CBO/NGOs, local partners staff, and donors who will be involved or have interest in MIHR provider behavior change assessments and interventions	FY20 Q4	PY2	Being revised/ updated	N/A: this is an internal tool	Low fidelity testing took place in Q3, medium/high fidelity testing delayed by BA, expected in PY2.
1.3	1.3.1c	Provider Behavior youth focused programmatic activity	Adaptation	MIHR core staff, country project teams, CBO/NGOs, local partners staff, and donors who will be involved or have interest in MIHR provider behavior change interventions and activities	FY21 Q2	PY2	Being revised/ updated	N/A: this is an internal tool	BA pre-tested and piloted in Cote D' Ivoire and Togo. The tools are ready for adaptation and piloting in MIHR countries. Conversations are ongoing regarding next steps for PY2. Adaptation of the tool has been incorporated in the PY2 work plans for Mali and Niger.
1.3	1.3.2b and 1.3.3b	Adapted MAMI Toolkit	Testing/ adaptation/ lessons learned	Governments (policymakers, program planners and implementers), INGO and CSO staff, donors, academicians	FY21 Q2	PY2	Ongoing	A report on lessons learned regarding adaptation of the toolkit to South Sudan and one French-speaking West African country will be shared with Governments (policymakers, program planners and implementers), INGO and CSO staff, donors, and academicians as well as the MAMI Global Network, the Emergency Nutrition Network, and multilateral organizations. Similarly, final, adapted tools will be shared with the same audiences. We anticipate sharing our experiences through webinars and MAMI Global Network meetings.	MIHR will share results from the pilot, including an assessment of the feasibility of expanding MAMI in fragile settings, to inform potential adaptation and expansion of the MAMI approach in PY2 and beyond. International consultant was hired and is coordinating activities with MIHR's South Sudan team.

IR	Activity #	Deliverable	Status	Target Audience	Start Date	Com-pletion Date	FY21 Q4 Implementation Status	Dissemination Plan (for tools that are not internal; where will they be housed? What is the long term use?	End of PY1 Update
1.3	1.3.2b	Nurturing Care in Humanitarian Settings framework	Testing/ adaptation/ lessons learned	Governments (policymakers, program planners and implementers), INGO and CSO staff, donors, academicians, MIHR project staff	FY22 Q1	PY2	Pending	MIHR-I and MOMENTUM Hub. This will also be disseminated to external partners as appropriate.	Discussions ongoing with MCGL and partners (WHO, UNICEF, World Bank, PMNCH, Early Childhood Action Network, IRC, Save the Children, and the Arab Network for Early Childhood Development). USAID is interested in moving this work forward. This activity was pushed back to PY2.
1.3	1.3.2c	Safe Childbirth Checklist	Revision/ testing/ lessons learned	Health care providers, national and subnational MOH of the country in which the tool will be tested and implemented, global technical and professional platforms, partners, international organizations, donors, and MOHs in similar settings	FY21 Q2	FY23 Q4	Ongoing	MIHR-I & MOMENTUM Hub	Revised the Safe Childbirth Checklist to reflect newer clinical recommendations around intrapartum care, diagnosis, classification, and management of Preeclampsia/Eclampsia, prevention, and management of PPH, maternal and newborn infection and respectful maternal and newborn care. Based on the recent discussions with AriadneLabs/MAKLab, the checklist will be revised by their expert team to reflect their experience/expertise with implementation. After which, the checklist will be submitted to USAID.
1.3	1.3.2c	PNC checklists	Revision/ testing/ lessons learned	Health care providers, national and subnational MOH of the country in which the tool will be tested and implemented, global technical and professional platforms, partners, international organizations, donors, and MOHs in similar settings	FY21 Q2	FY23 Q4	Ongoing	MIHR-I & MOMENTUM Hub	MIHR has assembled the PNC checklists. USAID MCH team asked to hold off introduction of the PNC checklist and wait for the upcoming revised WHO PNC guidelines, expected to be released in Q1, 2022
1.3	1.3.2c	Psychosocial support toolkit	Revision/ testing/ lessons learned	Health care providers, national and subnational MOHs of the country in which the tool will be tested and implemented, global technical and professional platforms, partners, international organizations, donors, and MOHs in similar settings, MIHR country project staff	FY21 Q4	FY23 Q4	Ongoing	MIHR-I & MOMENTUM Hub	MIHR has assembled the PSS toolkit. MIHR held a discussion with South Sudan team on the feasibility of implementing PSS toolkit in South Sudan and to discuss next steps. MIHR is incorporating additional resources shared at the Maternal Mental Health Consultation into the toolkit.
1.3	1.3.2c	Pediatric Death Audit Tool	Adaptation	Child health care providers at facility level, especially those working in fragile settings; child health task force members and other global actors	FY21 Q3	PY2	Ongoing	MIHR-I & MOMENTUM Hub	Currently identified the Pediatric Death Audit tool. The French version of the tool was shared with DRC and Mali teams. (This tool was not originally listed in the compendium of tools to be developed. However, in Q3, this tool was introduced to the country teams for their consideration.) WHO published the French version of the tool - this version was shared with MIHR country staff.

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1.3	1.3.2f	Guidance on DMPA-SC and self-care for contraception and adolescent-friendly postabortion FP in fragile settings	Adaptation	Government/MOH leadership (policymakers, program planners and implementers) at national and subnational levels; health care providers; professional organizations	FY21 Q3	FY22 Q4	Ongoing	In-country dissemination to MOH and partners; cross-country learning forums; MOMENTUM Hub, MIHR-I	Synthesized guidance on DMPA-SC from the experience by other organizations (e.g., PATH, JSI) across different countries that will inform testing in South Sudan in Q4. Guidance will be developed based on lessons learned during implementation in South Sudan.
1.3	1.3.3.e	Fragile setting technical guidance for immunization to reach zero dose children	Develop-ment/ Drafting	DPEV and Region Epi Programs; District Epi managers from MOH; MIHR MNCH and immunization officers	FY21 Q3	FY23 Q4	Ongoing	N/A - this is an internal tool (in coordination with MCGL and M-RITE)	Developed and disseminated guidance and trained MIHR country teams and district counterparts on tools for zero-dose community identification and tracking of individuals due for services, catch-up vaccination, MOVs, equity analysis and resilience/preparedness. (MOMENTUM-wide activity) Presented draft approach on zero dose jointly with other MOMENTUM awards at the MOMENTUM Share Fair.
1.3	1.3.3 e	RED/REC tool	Testing/ adaptation/ lessons learned	District managers within health institutions; CSO and partners with interest in the planning process in the community; MIHR country project staff	FY21 Q2	2-3 years	Ongoing	N/A - adapted forms will be disseminated internally	Hosted virtual cross-learning workshop with countries. Adaptation of the WHO guidelines will be ongoing in PY2.
1.3	1.3.2a and 1.3.2d	Adolescent Sexual Reproductive Health in Humanitarian Settings Toolkit: 2020 Edition	Adaptation	Government/MOH leadership (policymakers, program planners and implementers) at national and subnational levels; health care providers; professional organizations; international and local NGOs; development partners; academic institutions	FY21 Q3	3-4 years	Ongoing	MIHR-I	The toolkit was shared with the HCDExchange who are developing a practical guidance document that is being developed in addition to the principals for meaningful youth engagement in HCD +ASRH. The toolkit will be highlighted and shared with the wider HCDEXchange community and in the public domain. MIHR will adapt the training packages as relevant for youth engagement and integrated gender during the adaptation of the YCATS in PY2. MIHR will disseminate and use relevant sections while we implement the PY2 male engagement and YCAT activities.

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1.3	n/a	Fragile setting technical guidance for GBV	Field Use	Health care providers; national and subnational MOH of the country; technical and professional platforms, partners, international organizations, donors and MOHs in similar settings	FY21 Q3	FY21 Q4	Complete, but adaptation and identification of guidance for GBV will be ongoing through the life of the project	Guidance will be disseminated to country teams but will remain an internal MIHR document housed on MIHR-I and MOMENTUM Hub	We adapted section I and II from the GBV Quality Assurance Tool: Minimum Care Version for inclusion in our HFA assessment. These questions were piloted during the South Sudan and Mali HFAs during Q3. In Q4, data were analyzed for both countries. There were no missing data indicating the GBV module is appropriate and feasible for an HFA. We distributed the Ebola Virus Disease (EVD) & Sexual and Reproductive Health (SRH): Operational Guidance, which contains guidance for sexual violence survivors. Other guidance distributed to relevant countries includes a French manual for clinical management of sexual violence (Prise en Charge des Survivant(e)s/Victimes des Violence Basees Sur le Genre) developed by IMA, the DRC MOH, and WHO.
1.4	1.4c	Adapted prioritization methodology to select a catalog and common core measures for small and sick newborns for primary and tertiary levels	Adaptation		FY21 Q3	n/a	Dropped	N/A	This will be dropped from the deliverables list based on USAID MCHN team's feedback. USAID would like MIHR to contribute to this process, but the deliverable would not be ours.
1.4.	1.4f	Tools to monitor MNCH experience of care in fragile settings	Adaptation	Care providers and QI teams of supported health facilities and respective communities; national and subnational MOH structures of the country in which the tool will be tested and implemented; global professional and technical WGs; partners and international organizations working on MNCH and experience of care, including fragile settings	FY21 Q3	FY23 Q4	Ongoing	Country teams, MIHR-I & MOMENTUM Hub	Assembled the tools and indicators to monitor experience of care across MNCH; WHO is in the process of finalizing Core Pediatric QoC measures, after which MIHR will reflect the revisions in the draft tools.
1.4.	1.4g	Revised standards for Improving Quality of Maternal and Newborn Care	Testing/ adaptation/ lessons learned	Care providers and QI teams of supported health facilities; national and subnational MOH structures of the country in which the tool will be tested and implemented; global professional and technical	FY21 Q4	FY23 Q1	Ongoing	Country teams, MIHR-I & MOMENTUM Hub	Meeting held with South Sudan team to introduce the activity and MNCH QoC standards and discuss potential implementation in South Sudan.

IR	Activity #	Deliverable	Status	Target Audience	Start Date	Com-pletion Date	FY21 Q4 Implementation Status	Dissemination Plan (for tools that are not internal; where will they be housed? What is the long term use?	End of PY1 Update
		in Health Facilities		WGs, partners and international organizations working on MNCH and experience of care, including fragile settings					
1.4.	N/A	Revised Standards for Improving Quality of Care for Small and Sick Newborns in Health Facilities	Testing/ adaptation/ lessons learned		FY21 Q3	FY25 Q1	Dropped	N/A	Based on the discussion with USAID MNCH team, this activity was dropped from the PY1 work plan and will be incorporated into the newborn care strengthening activity projected to start in PY2.
1.4.	1.4k	Revised Standards for Improving the Quality of Care for Children and Young Adolescents in Health Facilities	Testing/ adaptation/ lessons learned	Child health care providers at facility levels. Child health task force members and other global actors	FY21 Q3	FY24 Q1	Ongoing	Country teams, MIHR-I & Hub	MIHR held a meeting with South Sudan team to introduce the activity and MNCH QoC standards and discuss potential implementation in South Sudan.
1.5	1.5	Health Resilience Definition	Completed	Cross-MOMENTUM partners and other global health actors	FY21 Q1	FY21 Q1	Completed	MIHR-I & MOMENTUM Hub	This was completed and reported on in the last quarter. MIHR currently uses the Health Resilience definition of USAID Global Health which is an adaptation of definition of overall resilience. MIHR presented on the unpacking of the health resilience definition and how it will be applied within MIHR. This definition is already in use as a standard definition of health resilience.
1.5	1.5d & 3.8c	Health Resilience Metrics	Preliminary / Planning	Cross-MOMENTUM partners	FY21 Q3	FY22 Q4	Completed	MERL Plan, MIHR-I & MOMENTUM Hub	Completed and included in PMP, but now MIHR has additional IRs specific to resilience and is in the process of developing indicators for health resilience absorptive, adaptive, and transformative capacities.
1.5	1.5c	Health Resilience Program Brief	Completed	Cross-MOMENTUM partners and other global health actors	FY21 Q3	FY21 Q3	Completed	MOMENTUM website	The program brief for health resilience was published May 25, 2021, on the MOMENTUM website.

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1.5	1.5e	Health Resilience Rapid Appraisal Tool-ARC-D Health tool	Preliminary / Planning	Cross-MOMENTUM partners and global health actors planning to conduct community health resilience assessments	FY21 Q3	FY22	A draft of the ARC-D Health is under review by the MIHR Leadership Team and will be shared with USAID prior to implementation in the field	ARC-D Health will be available for public use once learnings from implementation in countries are consolidated and approved by USAID. In the long term, ARC-D Health will be a major health resilience assessment tool at the community level. ARC-D Health will be housed and disseminated via MIHR website.	The ARC-D tool has been adapted to ARC-D Health to serve as an assessment and planning tool for health resilience at the community level. This tool has undergone review by the MIHR internal resilience technical working group and communications team and is still under review by the MIHR senior management team. The extended time to review was due to the ongoing learning in health resilience within MIHR and globally. USAID has agreed that MIHR apply ARC-D Health in the field as a draft tool in PY2. The toolkit can then be consolidated with the lessons learned from in-country applications to undergo the full review of USAID AOR team in PY2.
	1.6a	GAVI gender and immunization during COVID-19, and GAVI guidelines to restore and improve RI services	Completed	MIHR program officers and district MOH officers	FY21 Q2	FY21 Q3	Completed	Tool is housed on the GAVI website	Guidelines sent to MIHR Child Health and Immunization focal points for application.
n/a	n/a	Gender integration tool	Develop-ment/ Drafting	This tool has been prepared for MIHR staff working on gender interventions at HQ, national and subnational levels, including gender focal points and specialists, non-gender specialists, management, planning, monitoring and evaluation (PME) teams. It may also be a useful resource for government stakeholders working closely with MIHR and for implementing partners	FY21 Q3	FY22 Q4	Being revised for external audienc-es	Country teams, MIHR-I & MOMENTUM Hub	Under review. In PY 1 guidance for gender integration was developed by MIHR Gender Lead at HQ to ensure all work plans and tools are responsive. Once complete, this tool will be the key guidance for country teams to integrate gender in their PY 2 activities with TA on demand basis.

IR	Activity #	Deliverable	Status	Target Audience	Start Date	Com-pletion Date	FY21 Q4 Implementation Status	Dissemination Plan (for tools that are not internal; where will they be housed? What is the long term use?	End of PY1 Update
				working towards gender equality					
RESULT 2: CAPACITY OF HOST-COUNTRY INSTITUTIONS, LOCAL ORGANIZATIONS, AND PROVIDERS TO DELIVER EVIDENCE-BASED, QUALITY MNCH/FP/RH SERVICES IMPROVED, INSTITUTIONALIZED, MEASURED, DOCUMENTED, & RESPONSIVE TO THE POPULATION NEEDS									
2.1	2.1a	Organizational Capacity Assessment guide	Adaptation	MIHR core staff, MIHR country project staff, local partners, and donors who will be involved or have interest in effective capacity assessments, methods, and processes for successful capacity strengthening	FY21 Q2	FY21 Q4	Draft completed	Country teams, MIHR-I & MOMENTUM Hub	Under review.
2.1	2.1b	Capacity Strengthening Strategy	Adaptation	MIHR core staff, country project teams, local partners staff, and donors who will be involved or have interest in MIHR capacity strengthening initiatives	FY21 Q2	FY21 Q4	Draft completed	Country teams, MIHR-I & MOMENTUM Hub	Draft completed and now undergoing internal review. The Capacity Strengthening Strategy will initially be an internal document and will be disseminated to country teams. Key staff from contracted local organizations will also be oriented to the strategy as part of MIHR capacity strengthening initiatives.
2.1	2.1c	Organizational Capacity Assessment (OCA) tool	Adaptation	MIHR core staff, MIHR country project staff, local partners staff, and donors who will be involved in, or have interest in, effective, inclusive, and participatory organizational capacity assessments of our project partners.	FY21 Q2	FY21 Q4	Draft completed	See 2.1a	See 2.1a.
2.3	2.3b	Social Accountability Strategy	Adaptation	MIHR core staff, MIHR country project staff, local partners staff, and donors who will be involved in designing and implementing various mechanisms and protocols of health social accountability initiatives in project countries	FY21 Q2	FY21 Q4	Ongoing	The strategy will be used internally for country selection of social accountability models; lessons learned for documentation will be the next product in PY2	A draft Social Accountability Strategy document - which includes vision, mission, objectives, guiding principles, criteria for selecting social accountability models at a county level, illustrative indicators, etc. - was developed. The draft document is being finalized. The draft criteria were used for social accountability planning and prioritizing approaches in PY2 work plans for South Sudan, Mali, Burkina Faso, Niger, and Sudan in Q3.
RESULT 3: ADAPTIVE LEARNING AND USE OF EVIDENCE IN MNCH/FP/RH PROGRAMMING THROUGH SUSTAINED USAID AND HOST COUNTRY TECHNICAL LEADERSHIP INCREASED									
3.1	n/a	Tier 2 Indicators	Completed	MIHR staff	FY21 Q1	FY21 Q3	Completed	MERL Plan, MIHR-I & MOMENTUM Hub	Submitted to USAID June 30, 2021, as part of the MERL Plan. USAID approved the MERL Plan July 26, with a

IR	Activity #	Deliverable	Status	Target Audience	Start Date	Com-pletion Date	FY21 Q4 Implementation Status	Dissemination Plan (for tools that are not internal; where will they be housed? What is the long term use?	End of PY1 Update
									request to add health resilience indicators. Update on new indicators provided in Q4.
3.1	3.1b	Country MEL plan template	Develop-ment/ Drafting	County Programs & country project offices	FY21 Q1	FY21 Q2	Completed	N/A - this an internal document	A draft country MEL plan template has been developed but is being refined as MIHR develops the MEL Plan in each country. As a living document/template, it will be updated as needed based on feedback through the country work planning processes.
3.1	3.1e	Fragility, Crisis Sensitivity, and Complexity (F2C) Assessment	Completed	Country projects & will inform MI\HR core	FY21 Q1	FY21 Q3	Completed (version 1)	MIHR-I & MOMENTUM Hub	F2C Assessment, adapted from the RERA, was approved by USAID. F2C was translated into French in Mali. F2C work was initiated in South Sudan and is about to begin in Mali. Other countries planning for F2C are DRC, Burkina Faso, Tanzania, Niger, and Sudan. F2C will be revised based on feedback from teams in the field who have used it.
3.1	3.1f	MIHR routine data database with dashboard	Develop-ment/ Drafting	MIHR core & country levels	FY20 Q4	FY21 Q4	Contract issued	Once developed, will be installed on all staff computers	During Q3, MIHR contracted with tech company Dimagi for their CommCare product for mobile/digital data collection support, a solicitation for the MERL system (for data storage, data management, and analysis) was issued, and planning began for training on Power BI that will be used for data analysis and data visualization.
3.1	3.1h	DQA handbook/HMIS review	Develop-ment/ Drafting	Country MEL teams and MEL counterparts	FY21 Q1	FY21 Q4	Drafted and under internal review	MIHR-I & MOMENTUM Hub	Guidance modified to focus on a rapid review of a country's HMIS (which includes a rDQA). This was drafted in Q4 and is under internal review. When finalized, this will be a module in a MEL Handbook that will be a living document and updated as needed.
3.1	3.1i	MEL Supportive Supervision Manual	Develop-ment/ Drafting	Country MEL teams and MEL counterparts	FY21 Q4	FY21 Q3	Drafted and under internal review	MIHR-I & MOMENTUM Hub	This will now be modified to a guidance and not a manual. It was drafted in Q4 and has been distributed internally for feedback/revisions. When finalized, it will be a module in a MEL Handbook, that will be a living document, to be updated as needed.