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Maternal and Child Survival Program

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Submitted by:
MCSP Partnership

Submitted by:
Jhpiego Corporation in cooperation with:
Save the Children Federation, Inc., John Snow, Inc.,
ICF International, Results for Development Institute,
Program for Appropriate Technologies in Health,
Population Services International, and CORE Group
Along with:
Associate Partners—Broad Branch Associates,
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Communications Initiative, and Avenir Health

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Table of Contents

Annexes

Abbreviations

AA	Associate Award
AAP	American Academy of Pediatrics
ACNM	American College of Nurse-Midwives
ACOG	American Congress of Obstetricians and Gynecologists
ACS	Antenatal corticosteroids
ACT	Artemisinin-based combination therapy
ADMSA	Advance distribution of misoprostol for self-administration
AFRO	WHO Regional Office for Africa
AMTSL	Active management of the third stage of labor
ANC	Antenatal care
AOR	Agreement Officer's Representative
ART	Antiretroviral therapy
ASC	Community Health Worker
ASRH	Adolescent sexual and reproductive health
ASSIST	Applying Science to Strengthen and Improve Systems
BBA	Broad Branch Associates
BCC	Behavior change communication
bCPAP	Bubble continuous positive airway pressure
BEmONC	Basic emergency obstetric and newborn care
BFCI	Baby-friendly community initiative
BFHI	Baby Friendly Hospital initiative
BMGF	Bill & Melinda Gates Foundation
BP	Blood pressure
CBC	Competency-based midwifery curriculum
CBD	Community-based distribution
CBNC	Community-Based Newborn Care
CCA	Clean Clinic Approach
CCM	Community case management
CDC	Centers for Disease Control and Prevention
CEmONC	Comprehensive emergency obstetric and newborn care
CHMT	County Health Management Team
CHN	Community health nursing (Ghana)
CHP	Community health platform
CHPS	Community-Based Health Planning and Services
CHV	Community health volunteer
CHW	Community health worker
CHX	Chlorhexidine
CI	Communications Initiative
COP	Community of practice
CRMA	Caribbean Regional Midwives Association
CSE	Civil society engagement
CSHGP	Child Survival and Health Grants Program
CSO	Civil society organization
CSPro	Census and Survey Processing System
CYP	Couple-years of protection
D&A	Disrespect and abuse
DC	Demand creation
DCEI	Interagency Strategic Consensus for Latin America and the Caribbean
DDS	Departmental Health Directorate
DFID	Department for International Development
DHS	Demographic and Health Survey
DOB	Day of Birth
DQA	Data Quality Assessment
DRC	Democratic Republic of the Congo
DRH	Directorate of Reproductive Health
ECEB	Essential Care for Every Baby
ECSB	Essential Care for Small Babies
EmONC	Emergency obstetric and newborn care
ENAP	Every Newborn Action Plan
ENC	Essential newborn care
EPCMD	Ending preventable child and maternal deaths
EPI	Expanded Programme on Immunization
EPMM	Ending preventable maternal mortality
ETAT	Emergency Triage Assessment and Treatment
EVD	Ebola Virus Disease
EWEC	Every Woman Every Child
FLHW	Frontline health worker
FMOH	Federal Ministry of Health
FP	Family planning
FP2020	Family Planning 2020
FTYP	First-time/young parents
FY	Fiscal year
GA	Gestational age

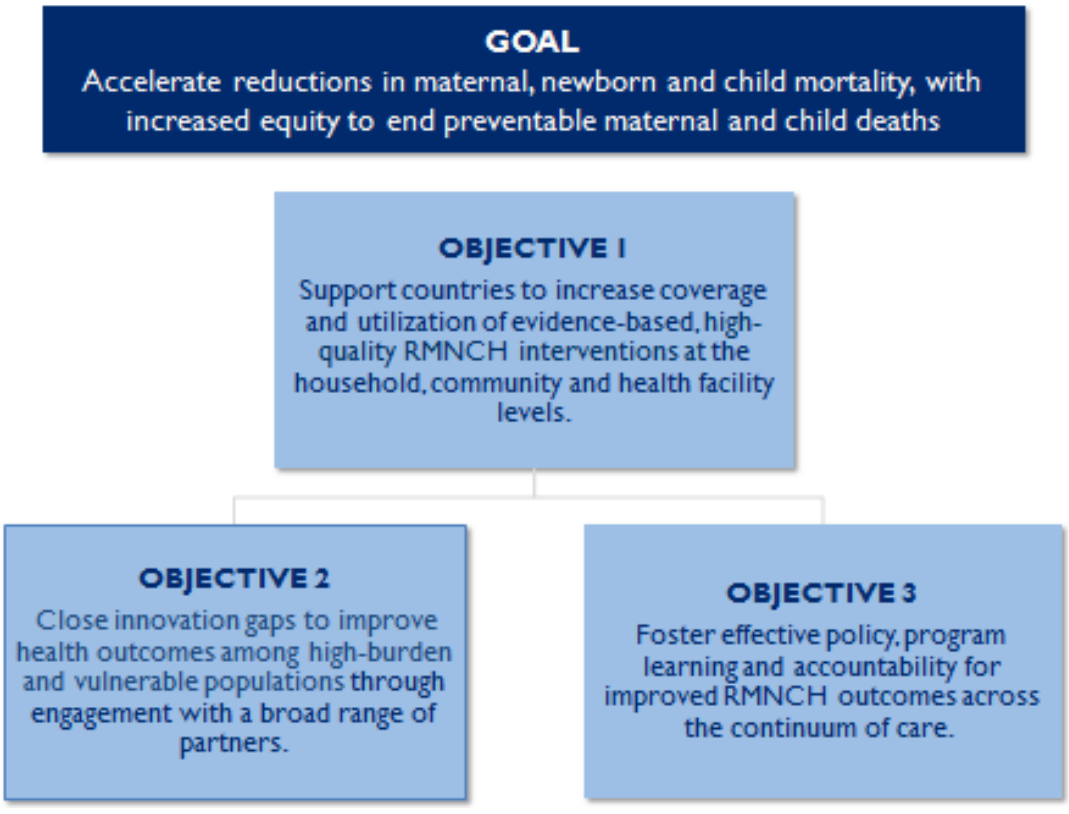
GBV	Gender-based violence
GF	Global Fund
GHS	Ghana Health Service
GIS	Geographic information system
GMNHC	Global Maternal Newborn Health Conference
GTR	Regional Maternal Mortality Reduction Task Force
HBB	Helping Babies Breathe
HBS	Helping Babies Survive
HC3	Health Communication Capacity Collaborative
HCD	Human Capacity Development
HDC	Health Data Collaborative
HEP	National Health Extension Program
HEW	Health extension worker
HFA	Health facility assessment
HIS	Health information system
HMIS	Health Management Information System
HMS	Helping Mothers Survive
HQ	Headquarters
HRH	Human Resources for Health
HS	Health systems
HSA	Health Surveillance Assistant
HSS	Health systems strengthening
HSS/E	Health systems strengthening and equity
iCCM	Integrated Community Case Management
IFA	Iron-folic acid
IFHP	Integrated Family Health Program
IIP	Institute for International Programs
IMAM	Integrated management of acute malnutrition
IMCI	Integrated Management Of Childhood Illness
IPC	Infection prevention and control
IPTp	Intermittent preventive treatment of malaria in pregnancy
IPTp-SP	Intermittent preventive treatment of malaria in pregnancy with sulfadoxine-pyrimethamine
IPV	Inactivated polio vaccine
IR	Implementation research
IRB	Institutional review board
IT	Information technology
ITN	Insecticide-treated net
IYCF	Infant and young child feeding
JHSPH	Johns Hopkins Bloomberg School of Public Health
JHSPH/IIP	Johns Hopkins Bloomberg School of Public Health, Institute for International Programs
JHU	Johns Hopkins University
JSI	John Snow, Inc.
KM	Knowledge management
KMC	Kangaroo mother care
KPC	Knowledge, practices, and coverage
L&D	Labor and delivery
LAC	Latin America and the Caribbean
LAM	Lactational amenorrhea method
LARC	Long-acting reversible contraceptive
LGA	Local Government Authority
LiST	Lives Saved Tool
LLIN	Long-lasting insecticide-treated net
M&E	Monitoring and evaluation
MAL&OPDD	Malaria and Other Parasitic Diseases Division
MAMA	Mobile Alliance for Maternal Action
MCDMCH	Ministry of Community Development, Mother and Child Health
MCH	Maternal and child health
MCHIP	Maternal and Child Health Integrated Program
MCPC	*Managing Complications in Pregnancy and Childbirth*
MCSP	Maternal and Child Survival Program
MDG	Millennium Development Goal
MDSR	Maternal Death Surveillance and Response
MEC	Medical Eligibility Criteria
MH	Maternal health
MHTF	Maternal Health Task Force
MICS	Multiple indicator cluster survey
MiP	Malaria in pregnancy
MIYCN	Maternal, infant, and young child nutrition
MMEL	Measurement, monitoring, evaluation, and learning
MMI	Model maternity initiative
MNCH	Maternal, newborn, and child health
MNH	Maternal and newborn health
MNMA	Myanmar Nurses and Midwives Association
MNMC	Myanmar Nurse and Midwife Council
MOH	Ministry of Health
MOHSS	Ministry of Health and Social Services

MOHSW	Ministry of Health and Social Welfare
MoU	Memorandum of understanding
MPDSR	Maternal and perinatal death surveillance and response
MRN	Model referral network
MSD	Measles Second Dose
MTOT	Master Training of Trainers
MTUMA	*Mbinu Timilifu kwa Usimamizi wa Mifumo ya Afya* (Comprehensive Approach to Health Systems Management)
NFM	New Funding Model
NGO	Nongovernmental organization
NMCP	National malaria control program
OR	Operations research
ORS	Oral rehydration solution
ORT	Oral rehydration therapy
PAC	Postabortion care
PDQ	Partnership-Defined Quality
PDSR	Perinatal Death Surveillance and Response
PE/E	Pre-eclampsia/eclampsia
PEI	Polio Eradication Initiative
PEPFAR	United States President's Emergency Plan for AIDS Relief
PHCU	Primary health care unit
PMI	President's Malaria Initiative
PMNCH	Partnership for Maternal, Newborn and Child Health
PMP	Performance monitoring plan
PMTCT	Prevention of mother-to-child transmission of HIV
PNC	Postnatal care
PNDA	Perinatal death audit
PPE	Personal protective equipment
PPFP	Postpartum family planning
PPH	Postpartum hemorrhage
PPIUCD	Postpartum intrauterine contraceptive device
PPIUD	Postpartum intrauterine device
PSBI	Possible severe bacterial infection
PTB	Preterm birth
PTFU	Post-training follow-up
PY	Program year
Q	Quarter
QI	Quality improvement
QoC	Quality of care
R/CHMT	Regional and Council Health Management Team
R4D	Results for Development
RBM	Roll Back Malaria
RDT	Rapid diagnostic test
REC	Reaching Every Child/Community
RED	Reaching Every District
RH	Reproductive health
RHSA	Rapid Health Systems Assessment
RI	Routine immunization
RMC	Respectful Maternity Care
RMNCH	Reproductive, maternal, newborn, and child health
SBC	Social and behavior change
SBCC	Social and behavior change communication
SBCE	Social, Behavioral and Community Engagement
SBM-R®	Standards-Based Management and Recognition
SDGs	Sustainable Development Goals
SEC	*Soins Essentiels Communautaires* (Essential Community Care)
SEHAT	System Enhancement for Health Action in Transition
SES	Socioeconomic status
SMC	Seasonal malaria chemoprevention
SMGL	Saving Mothers, Giving Life
SP	Sulfadoxine-pyrimethamine
SPHCDA	State Primary Health Care Development Agency
SRH	Sexual and reproductive health
SSQH	*Services de Santé de Qualité pour Haïti*
SUN	Scaling Up Nutrition
TA	Technical assistance
TAG	Technical Advisory Group
TF	Task Force
TOR	Terms of reference
TOT	Training of trainers
TRT	Technical reference team
TWG	Technical working group
UBT	Uterine balloon tamponade
UDV	*Universidad da Vinci*
UI-FHS	Universal Immunization through Improving Family Health Services
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WASH	Water, sanitation, and hygiene
WHO	World Health Organization
ZIKV	Zika virus

About the Maternal and Child Survival Program

The Maternal and Child Survival Program (MCSP) is a global, $560 million, 5-year cooperative agreement funded by the United States Agency for International Development (USAID) to introduce and support scale-up of high-impact health interventions among USAID's 25 maternal and child health (MCH) priority countries, as well as other countries. The ultimate goal of MCSP is to contribute to USAID's ambitious goal of ending preventable child and maternal deaths (EPCMD) within a generation. MCSP supports programming in reproductive, maternal, newborn, and child health (RMNCH); immunization; family planning (FP); nutrition; water, sanitation, and hygiene (WASH); malaria; and HIV prevention, care, and treatment. MCSP engages governments, policymakers, health care providers, civil society, faith-based organizations, and communities in adopting and accelerating proven approaches to address the major causes of maternal, newborn, and child mortality and improve the quality of health services from household to hospital. MCSP further focuses on cross-cutting areas, such as health systems strengthening (HSS), household and community mobilization, gender integration, Social and Behavior Change Communication (SBCC), measurement and use of data for decision-making and learning, and digital health. MCSP is implemented by a consortium of agencies led by Jhpiego in partnership with Save the Children; John Snow, Inc. (JSI); PATH; ICF; Results for Development; Population Services International; the CORE Group; Johns Hopkins Bloomberg School of Public Health, Institute for International Programs; Avenir Health; the Communications Initiative; and Broad Branch Associates. MCSP's goal and strategic objectives are presented in Figure 1 below.

Figure 1. MCSP goal and strategic objectives



Introduction

With its second program year (PY) completed, MCSP has made significant progress in advancing USAID's bold commitment to EPCMD within a generation. MCSP's expansion in PY 2 to 24 countries contributes valuable experience and results to the search for effective approaches to EPCMD. As the global health community continues to debate how to monitor progress against the Sustainable Development Goals (SDGs) and mobilize the resources needed to realize them, MCSP's programming in these countries informs these discussions with real-time lessons learned.

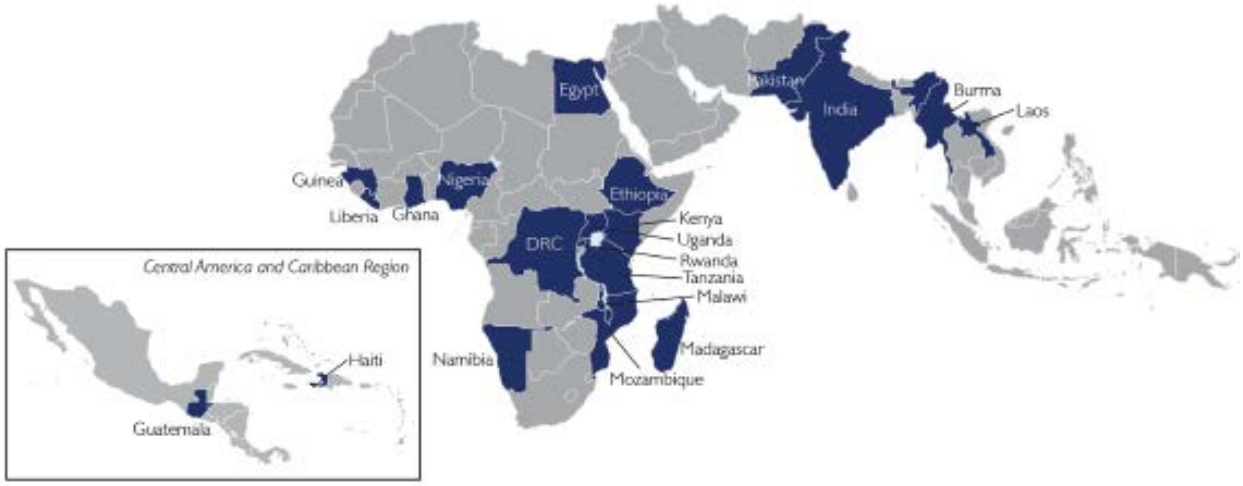
The ability to leverage strong global, regional, and country platforms uniquely positions MCSP to contribute to EPCMD. MCSP aligns with and is guided by key global initiatives, mechanisms, and strategies shaping the global health environment, including the SDGs; the Global Strategy for Women's, Children's and Adolescents' Health; and the Global Financing Facility.

Ensuring equity in access to health resources got renewed attention this past year. The 2016 report, *Acting on the Call: Ending Preventable Maternal and Child Deaths,* outlines the progress made in each of the priority countries and also informs the efforts that partners, including MCSP, must make to give the bottom two wealth quintiles the same opportunities and access to health interventions as the rest of the population. To ensure the quality of maternal health (MH) care for all women and guarantee access to care for those left behind or those most vulnerable, the 2016 Maternal Health Lancet Series emphasizes the critical roles of evidence, health systems (HS), equity, quality, and sustainable financing.

This global context and evolving landscape have also informed MCSP's programming at the country level. The Global Maternal Newborn Health Conference (GMNHC, held in Mexico City, October 2015) and the International Conference on Family Planning (ICFP held in Indonesia, January 2016) framed much of the prioritization, discussion, and momentum for PY 2 activities around FP and maternal and newborn health (MNH). MCSP's country platform continues to present a tremendous opportunity to expand the MCSP footprint while responding to emerging health needs such as Ebola, Zika, and urban health challenges. PY 2 also saw USAID add Burma as the 25th EPCMD country.

PY 2 witnessed a rapid growth of field programs, from 34 workplans in 22 countries at the end of PY 1 to 41 workplans in 24 countries in PY 2. Please see a map of country programs in Figure 2 below. As of September 30, 2015, MCSP witnessed an 83% growth in overall field support in PY 2 as compared to total obligated field support funds, which reflects the expanded scale of country work.

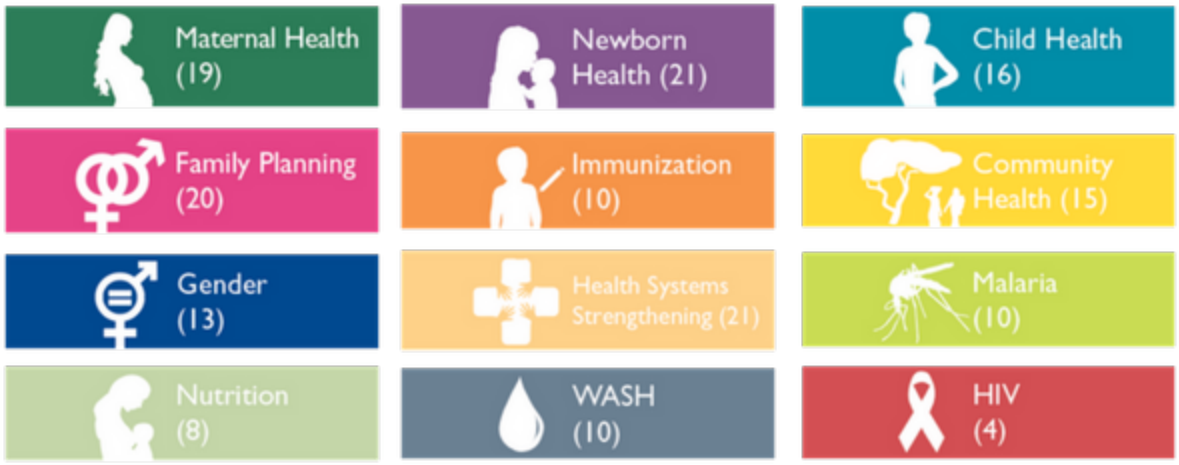
Figure 2. Countries where MCSP works



MCSP's strong country footprint and technical platform have enabled the program to adapt to new and emerging health needs, such as urban health, Ebola, Zika, and early childhood development (ECD). New country programs were initiated in India (urban health), Guatemala (integrated RMNCH), Uganda (maternal, newborn, and child health- MNCH), Pakistan (FP), and Ghana (ECD and nutrition).

Of the 41 country programs in PY 2, approximately 43% are one- to two-year programs, 37% are two- to three-year programs, and 20% are four- to five-year programs with varying scope and size. At the end of PY 2, MCSP was implementing many comprehensive programs that include several technical areas in MCSP countries. Figure 3 lists the number of countries where MCSP supported different evidence-based RMNCH technical interventions.

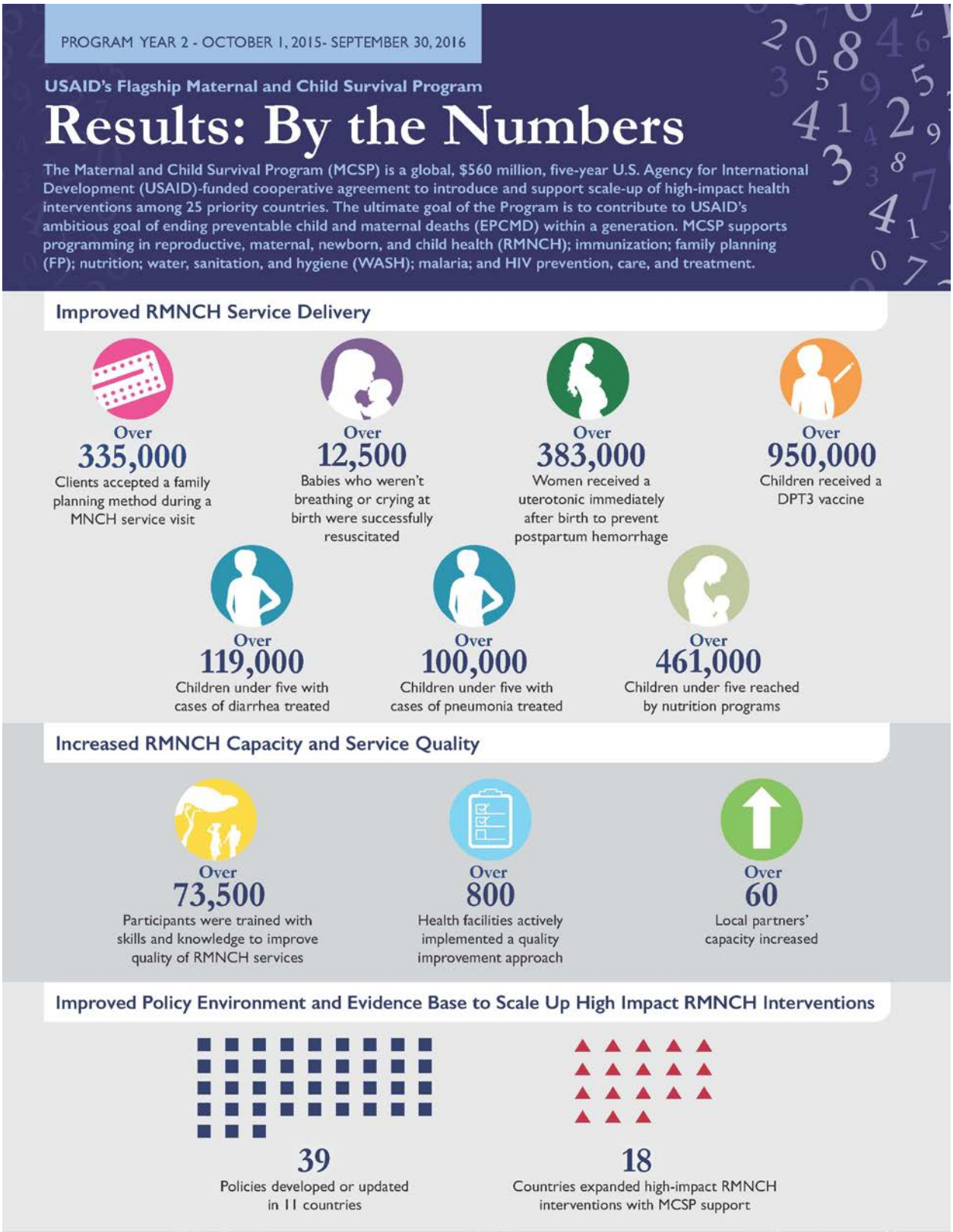
Figure 3. Number of countries where MCSP supported various technical interventions



Highlights of Key Results

Results for select key performance indicators for the program are presented in the infographic that follows while the full set is provided in Annex B: Global Performance Monitoring plan.

Figure 4. MCSP by the numbers



1 OBJECTIVE 1

Support countries to increase coverage and utilization of evidence-based, high-quality RMNCH interventions at the household, community, and health facility levels

In order for priority countries to reach national and global health targets, they need to sustainably reach high coverage, quality, and equity for high-impact interventions. Across all its technical areas, MCSP supports over 30 high-impact RMNCH preventive and treatment interventions proven to reduce maternal, newborn, and child mortality (shown in Annex H). MCSP's efforts at the global level promote supportive RMNCH policies and strategies and effective leadership and partnership structures to enable high-burden countries to effectively implement these interventions. MCSP helps to lay the groundwork for achieving sustainable impact at scale for high-impact interventions through active engagement with the World Health Organization (WHO) and with key interagency groups, such as the Integrated Community Case Management (iCCM) Task Force Secretariat, Gavi, Ending Preventable Maternal Mortality (EPMM) Working Group, Every Newborn Action Plan (ENAP) working group, the MCSP-established Prevention and Management of Postpartum Hemorrhage (PPH) Implementation Technical Working Group (TWG), Scaling Up Nutrition, Chlorhexidine TWG, FP2020, Kangaroo Mother Care (KMC) Acceleration Partnership, the WHO MNH Quality of Care Network, and other global leadership efforts.

Scaling Up High-Impact RMNCH Interventions

In most countries, MCSP directly assists the Ministry of Health (MOH) to reach high coverage in targeted geographic areas, as well as providing assistance at the national level to support the creation of robust leadership, management, and partnership structures to learn from, expand, and replicate experiences elsewhere as part of scale-up efforts. In **Haiti**, for example, MCSP is supporting all regions of the country and working across community and facility levels. In other countries, such as **Guinea** and **Ghana**, MCSP provides direct support in about half of the country. In others, MCSP has a more focused geographic area of direct support. But in all cases, MCSP has national influence to improve the enabling environment and influence the replication of effective approaches. In MCSP-supported regions, MCSP works closely with regional MOH counterparts, partners, and, often, private facilities to tailor implementation strategies to the local context and to help stakeholders reach and sustain high levels of effective coverage for high-impact interventions. MCSP then works to sustain the gains through strengthened health and community systems, thus achieving sustainable impact at scale and making progress toward EPCMD goals. MCSP's efforts always have the objective of improving the coverage, quality, and/or equity of high-impact interventions. The specific objectives and strategies that are employed depend on national priorities, context, and the most feasible service delivery mechanisms.

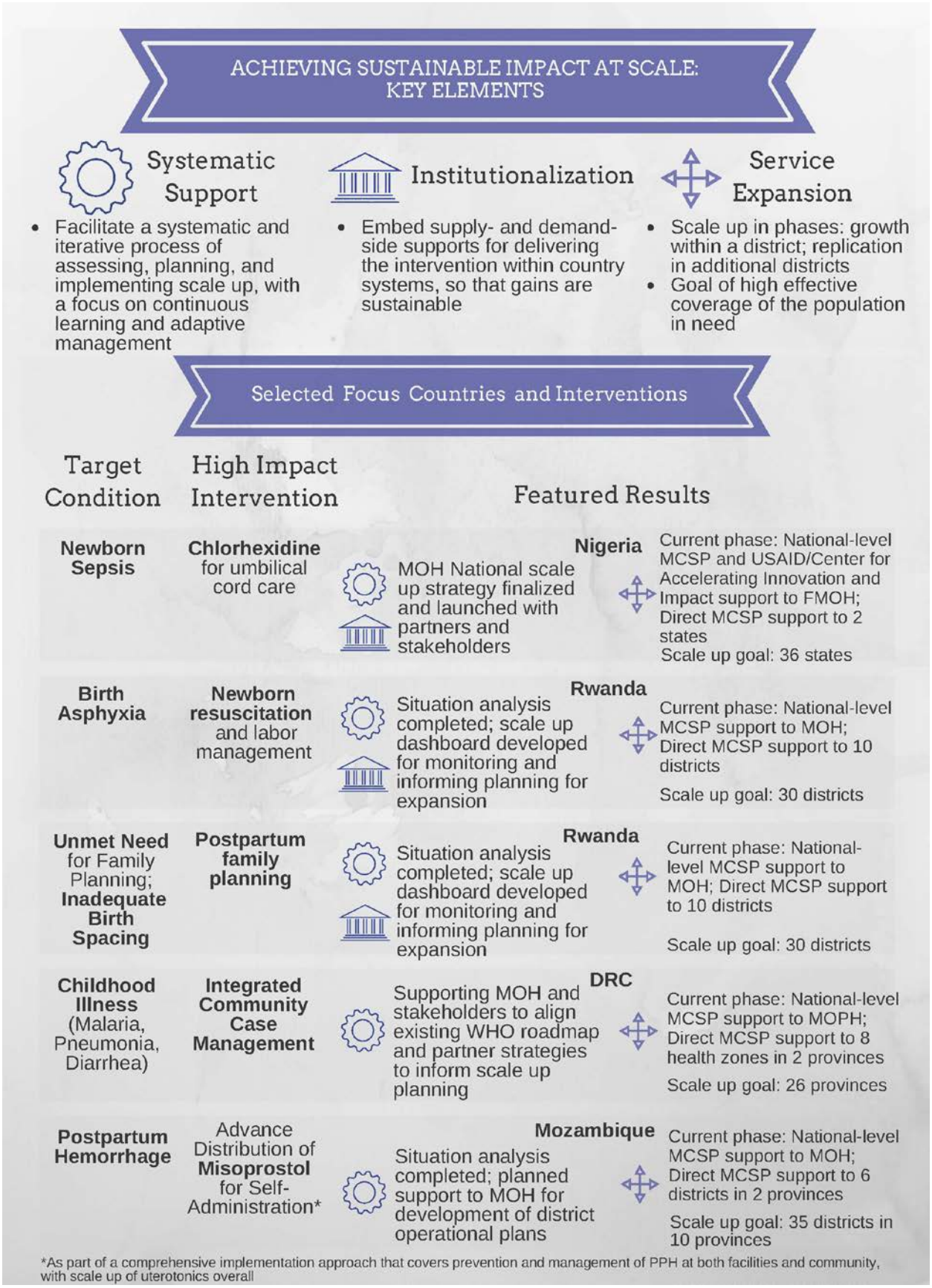
MCSP is providing intensive support to the country-led design and implementation of scale-up strategies for five high-impact RMNCH interventions in the following countries:

- Advance distribution of misoprostol for self-administration (ADMSA) in **Afghanistan** and **Mozambique**;
- Newborn resuscitation and essential newborn care (ENC) in **Rwanda**;
- Chlorhexidine (CHX) for newborn sepsis prevention in **Nigeria, Rwanda**, and **Liberia**;
- Postpartum family planning (PPFP) in **Rwanda**; and
- iCCM in **Democratic Republic of the Congo** (DRC).

MCSP also continues to learn and apply lessons from the Maternal and Child Health Integrated Program (MCHIP) **Bangladesh** Associate Award's (AA's) work to help the MOH scale up CHX.

The figure below outlines selected key progress made by the countries with focused support for scale-up. In PY 2, MCSP has also begun to facilitate diffusion of best practices for scale-up across countries through country-to-country sharing of lessons emerging from this focused support, as well from broader scale-up efforts by other MCSP countries and other global partners. Through both the focused and broader efforts, MCSP supports the documentation and identification of best practices in the areas of strengthening MOH-led governance structures and partnerships at district and national levels; conducting structured scalability readiness assessments; developing explicit scale-up plans; and developing strategies and mechanisms for adaptive management of the scale-up process at district and national levels, including scale-up dashboards.

Figure 5. Focused support for scale-up of RMNCH interventions in selected MCSP countries



Improving Service Quality

Improving the quality of routinely delivered high-impact interventions is another focus for MCSP's assistance for the achievement of sustainable impact at scale. Early in PY 2, the program conducted a landscape assessment of quality improvement (QI) approaches being applied in program countries across technical areas. The findings demonstrated that most MCSP countries are promoting a combination of QI approaches rather than a single approach or branded method. The assessment also demonstrated that MCSP-supported quality activities often focus on multiple levels of the system, including community, facility, district, subnational, and national. Further, PY 2 landscape results demonstrated that MCSP-supported countries are at varying stages of maturity in terms of their quality systems and structures (e.g., presence of national quality strategy, national MOH quality division, regional/district quality focal points, established QI teams, regular tracking, and use of prioritized quality measures).

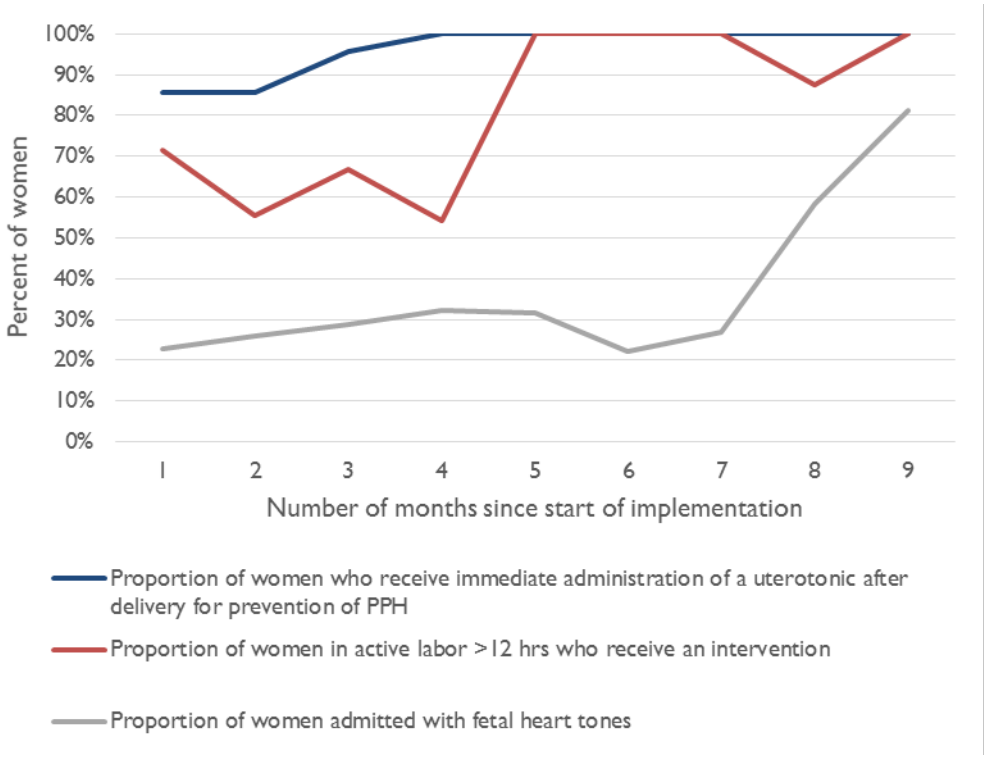
In PY 2, MCSP continued to refine and apply a core set of cross-cutting program QI principles at country level to address critical quality gaps in RMNCH services, emphasizing regional/district quality governance structures, support to frontline QI teams, and continuous capacity development to apply clinical, data, and QI skills. In many countries, MCSP promoted the program's core QI principles within the context of the complementary WHO MNH quality of care framework. Indeed, by the end of PY 2, the program had introduced the WHO QoC [quality of care] MNH framework to country counterparts at the national and sub-national level in **Rwanda, Nigeria, Madagascar**, and **Tanzania**.

In PY 2 the program also promoted smarter integration of RMNCH services using QI mechanisms in several countries. For example, the program used QI approaches to strengthen delivery of integrated high-impact MNH and PPFP interventions on the Day of Birth (DOB) in **Nigeria, Mozambique, Liberia, Madagascar, Guinea, Rwanda,** and **Haiti.**

The following country examples illustrate progress made in PY 2 to improve quality of RMNCH services.

In **Madagascar**, MCSP supported more than 275 primary health centers and four regional hospitals to track key service utilization and QoC measures using standardized dashboards. In PY 2, an intensive QI effort was launched in four regional hospitals, in close collaboration with regional MOH managers, to improve routine integrated MNH interventions and to improve management of maternal and newborn complications, with an initial focus on newborn asphyxia, PPH, and pre-eclampsia/eclampsia (PE/E). In PY 3, the program is supporting more intensive expansion of QI approaches to primary health centers, including those using the standardized dashboards, and to four additional regional hospitals. QI teams in regional hospitals are supported by program and MOH regional quality focal points to identify and understand critical quality gaps, to test sustainable changes to close gaps, and to regularly monitor and analyze a small number of QoC process and outcome measures to assess if care is improving. On-site support to QI teams includes regular coaching for strong QI team functioning, including regular capacity-building for essential clinical, QI, and measurement skills. Hospitals and health centers have demonstrated improvements in institutional coverage of lifesaving interventions. For example, in PY 2, at 275 primary health centers, the proportion of women screened for PE/E through systematic documentation of blood pressure during antenatal care (ANC) visits increased from 38% to 99%, the proportion of women receiving an immediate postpartum uterotonic increased from 84% to 96%, and the proportion of newborns receiving four elements of essential newborn care increased from 69% to 93%. In four regional hospitals, improvements in intrapartum QoC and concurrent decreases in perinatal mortality were recorded over a period of nine months, as demonstrated in Figure 6. Additional results are highlighted in the maternal health section of the report.

Figure 6. Quality of maternity care in four regional hospitals in Madagascar, November 2015 to September 2016 (N = 2,021 deliveries)



Note: *the Y-axis reflects months of implementation instead of months/dates because each hospital started implementation at different times (in different months).

In **Rwanda**, targeted training and mentorship activities implemented by MCSP to build clinical skills and provider confidence have contributed to improving trends in QoC and service delivery for women and children (see Figures 7 to 10). In PY 2, the proportion of babies who received postnatal care (PNC) within two days of childbirth increased from 38% to 53% from Quarter 1 (Q1) to Q4. The number of newborns not breathing at birth for whom resuscitation actions were initiated increased significantly over PY 2, from 987 newborns in Q1 to 1,392 newborns in Q4. The proportion of women who received an immediate postpartum uterotonic increased from 85% in Q1 to 93% in Q4 (a total of 101,062 women delivered in Q4). These promising trends show improvements in key RMNCH indicators that will lead to better health outcomes for women and their families. Through MCSP's QI and ongoing mentorship approaches, MCSP expects to continue to improve the quality of services received by beneficiaries in Rwanda.

Figure 7. Key immediate newborn care indicators in Rwanda

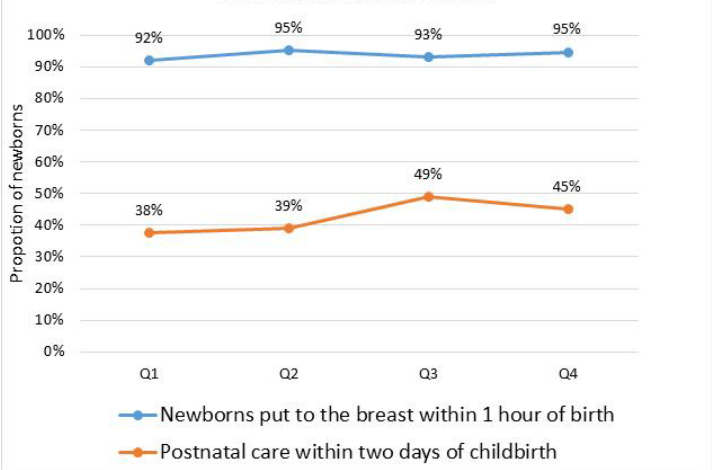


Figure 8. Number of newborns not breathing at birth who were resuscitated in Rwanda

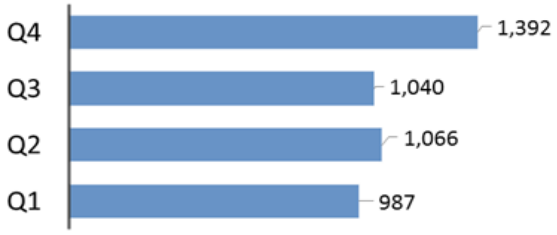


Figure 9. Service utilization in MCSP-supported facilities in Rwanda

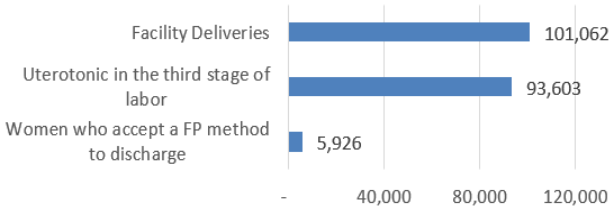
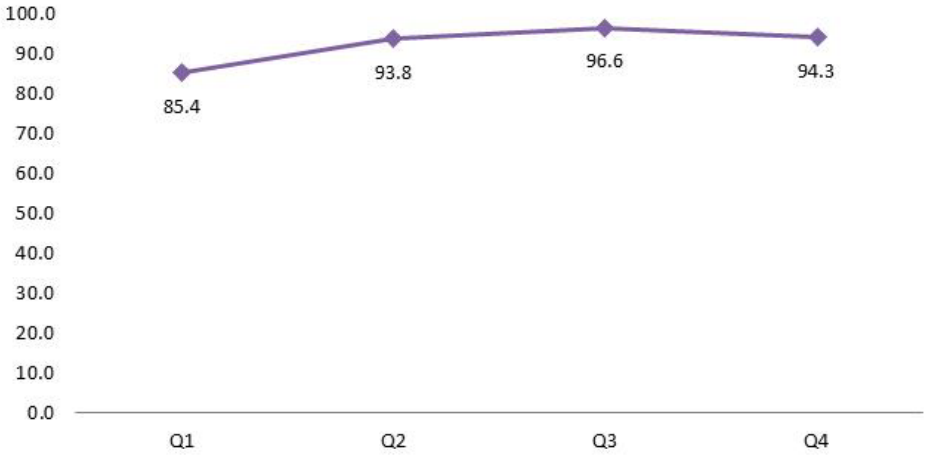


Figure 10. Percentage of women receiving immediate uterotonics postdelivery for PPH prevention in Rwanda



Liberia conducted a midline assessment to determine project progress in 72 of the 77 MCSP-supported facilities. The MOH Essential Package of Health Services (EPHS) Clinical Standards were used to assess the quality of services provided in each of the EPHS technical areas. Findings show improved adherence with standards at midline as compared with baseline adherence prior to the start of the MCSP intervention. MCSP program efforts in Liberia have emphasized provision of essential infrastructure support and improved clinical practice, with a focus on on-site, competency-based support that includes regular simulation and clinical practice. Service delivery utilization has improved in tandem with improved adherence with clinical standards. For example, the proportion of pregnant women with at least four ANC visits in 77 program-supported facilities in program-supported has increased from 48% at baseline (October to December 2015) to 59% at midline in July to September 2016. The proportion of women attending antenatal care who receive at least two doses of IPT increased from 64% at baseline to 89% at midline.

Figure 11. Clinical standard assessment scores for Liberian health facilities

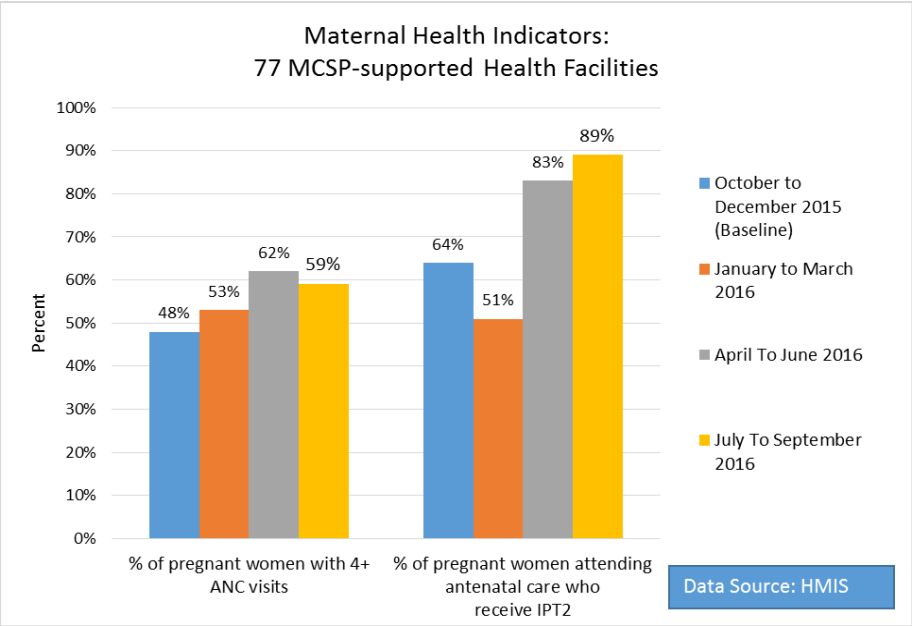
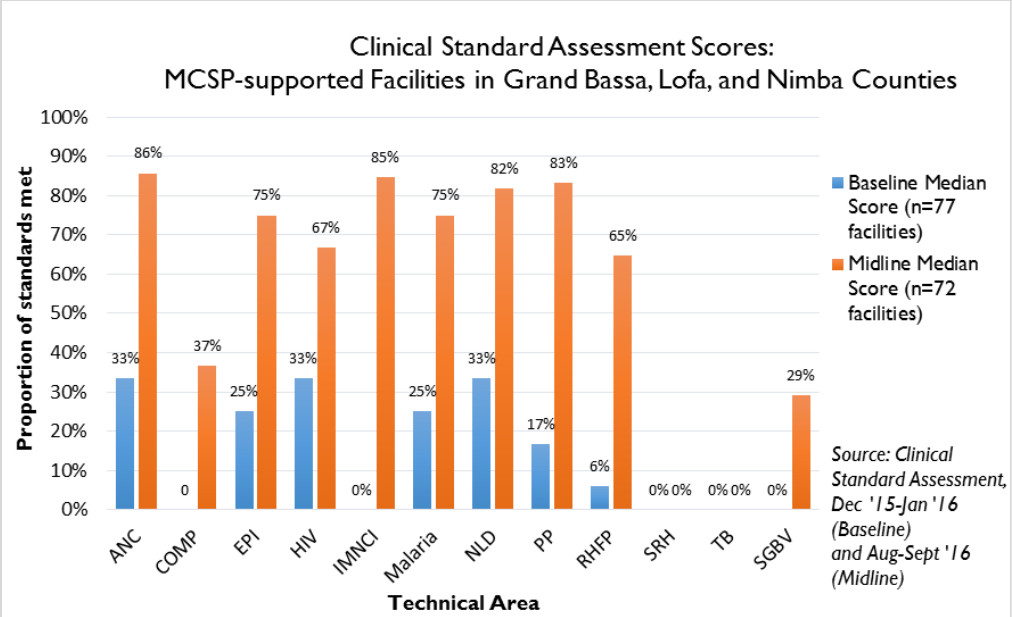


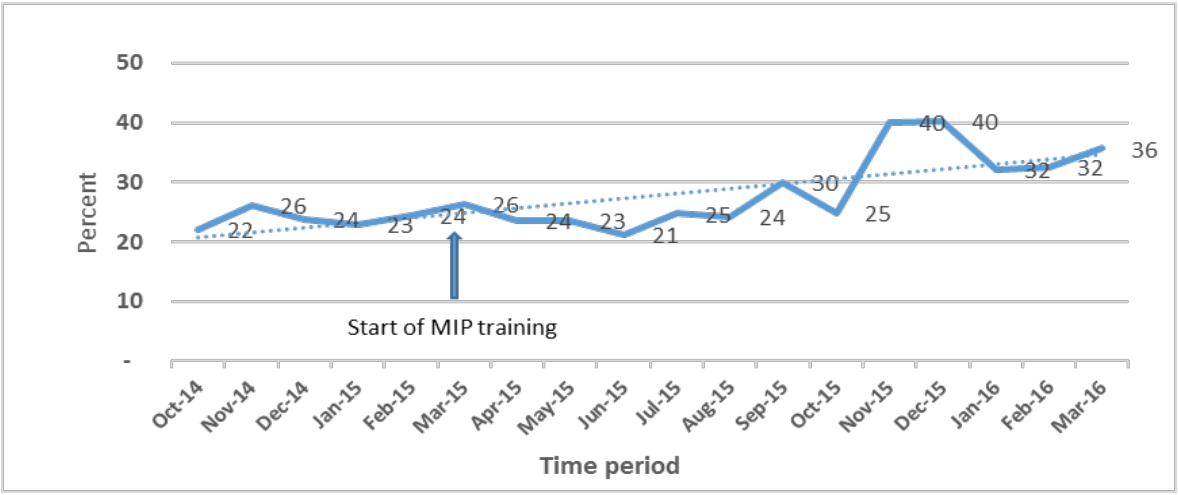
Figure 12. ANC attendance indicators in Liberian health facilities



Community Outreach and Advocacy to Improve Intervention Uptake

During PY 2 in **Kenya**, the Kenya Malaria Indicator Survey 2015 released findings showing a 16% increase in IPTp1 (dose 1) from 51.3% to 67.3% and a 13% increase in IPTp2 from 42% to 55%. These gains were concentrated around the lake and coastal endemic zones where MCSP has been working. MCSP focused on the counties of Homa Bay, Bungoma, Migori, and Kisumu to work with community health volunteers (CHVs) and train them to sensitize pregnant women to start IPTp early in the second trimester. This was associated with a 12% increase (24% to 36%) in the proportion of women attending first ANC visit at ≤20 weeks of gestation, as seen in the MOH ANC registers (see Figure 13). At the national level, MCSP led advocacy efforts in collaboration with MOH on procurement of sulfadoxine-pyrimethamine (SP). As a result of these efforts, the government, the President's Malaria Initiative (PMI), and UNICEF agreed to purchase stock of SP expected to last through 2019.

Figure 13. Proportion of pregnant women in Bungoma, Kisumu, and Migori counties (Kenya) who attended ANC 1 at <20 weeks gestation



Focusing on Equity to Increase Impact and Improve Quality

In some cases, the main issue for maximizing the achievement of sustainable impact at scale and ensuring quality is the need to improve shortfalls in coverage among specific groups or areas. In these cases, MCSP activities have an explicit focus on equity. MCSP continues to address aspects of equity through technical interventions across countries and by working with countries to identify equity interventions that can be measured and tracked. Through the shifting of service delivery channels in several countries, MCSP is implementing pro-equity interventions in several countries (see Table 1).

Table 1. Implementation of Pro-Equity Interventions by Country

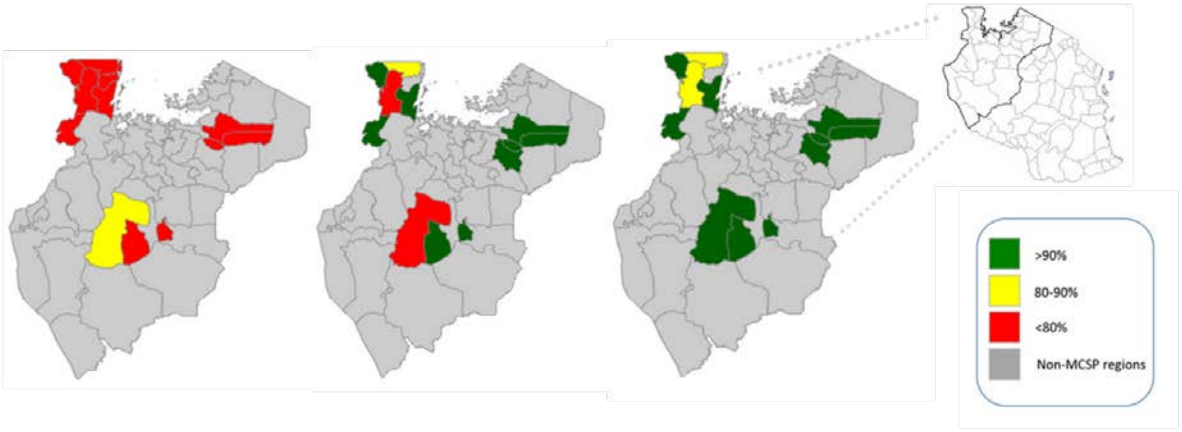
Approach	Countries
Reaching Every District/Reaching Every Community (RED/REC)	Uganda, Kenya, Malawi, Nigeria, Tanzania, Zimbabwe, Madagascar, Liberia, India, Pakistan, Haiti
Advance Distribution of Misoprostol for Self-Administration (ADMSA)	Mozambique, Haiti
Community use of chlorhexidine	Ethiopia, Mozambique
Integrated Community Case Management (ICCM)	DRC, Rwanda, Mozambique, Zimbabwe, Kenya, Nigeria, Haiti, Burma

To address the socioeconomic inequities that pose barriers to accessing RMNCH services, MCSP is engaging at both national and community levels.

- In **Burma,** MCSP supported the government to use 2014 census data to create and share wealth indices and quintiles at various geographical levels so implementers of MNCH activities can easily assess if their interventions are pro-poor.
- In **Mozambique**, MCSP focuses on communities that are relatively far from health facilities. MCSP is expanding the scale-up of community-level packages for MNH by mapping community health structures and community health workers (CHWs), training CHWs, and supporting implementation of prevention of PPH at the community level. Efforts are also under way to use disaggregated data to see communities where referral could be improved. To capture data on economic status of beneficiaries, socioeconomic status data is being incorporated within knowledge, practices, and coverage (KPC) in Mozambique to analyze equity impact. MCSP is also addressing gender equity issues through specific strategies, interventions, and tools to guide gender integration into over 12 country programs.

- In **Tanzania**, MCSP continued to advance targeted support to increase equitable coverage of immunization, in collaboration with the Ministry of Health, Community, Development, Gender, Elderly and Children. Based on the results of a needs assessment in low-performing councils in MCSP-supported regions, MCSP trained regional and council officials and health facility workers on the Reaching Every Community (REC) approach, oriented over 800 CHWs on immunization services with a focus on defaulter tracing and community sensitization, and oriented nearly 800 Health Facility Governing Committee members on immunization services, with an emphasis on their roles and responsibilities in enhancing health facility and community linkages for immunization service delivery. Addressing one of the main system bottlenecks identified in these regions, the challenge of transportation for distribution of vaccines and outreach sessions and supportive supervision has been reduced, and now over 80% of distribution and supervision routes are conducted as planned. Most of the planned outreach immunization sessions are also implemented. As a result, immunization coverage rates have increased (as indicated in Figure 14 below), dropout rates have decreased, and the number of unvaccinated and under-vaccinated children has been significantly reduced. Now all of these previously low-performing regions and districts meet the global and Tanzanian national goals for district-level Penta3 immunization coverage of $\geq$ 80%, and most have achieved coverage of 90%. Best practices and lessons learned from these regions are now being used to inform the Government of Tanzania's support to other low-performing regions and councils. For more information about MCSP's efforts to increase equity of interventions implemented in EPCMD priority countries, please refer to the section below on *Equity*.

Figure 14. Trends of Penta3 Coverage in MCHIP and MCSP focus regions in Northwestern Tanzania



- In **Ethiopia,** the KPC survey showed that it takes an average of 60 minutes to reach the nearest health center for 46%, and 30 minutes to an hour for 33% of the sample. There were variations seen across regions, with access to a health center more difficult in Tigray and Amhara (see Table 2). Other equity-related variables that were included in the study were age, education levels, household assets, and religion. Analysis by women's demographic characteristics showed that women with secondary or higher education were twice as likely (P<0.00; 95% confidence interval: 1.5-2.8), and 1.2 times as likely (P<0.05; 95% confidence interval: 1-1.5) to disclose pregnancy compared with those who have no education. Education has positive association with ANC: women with at least primary education were more likely to attend ANC than those with no education (odds ratio=3.2, [95% confidence interval: 2.3-4.4], p=0.000). To address some of the issues around equity, following an agreement with MOH, MCSP is providing more supportive supervision to health posts that are "hard to reach" and "needy."

Table 2. Time to nearest health center, by region—Ethiopia

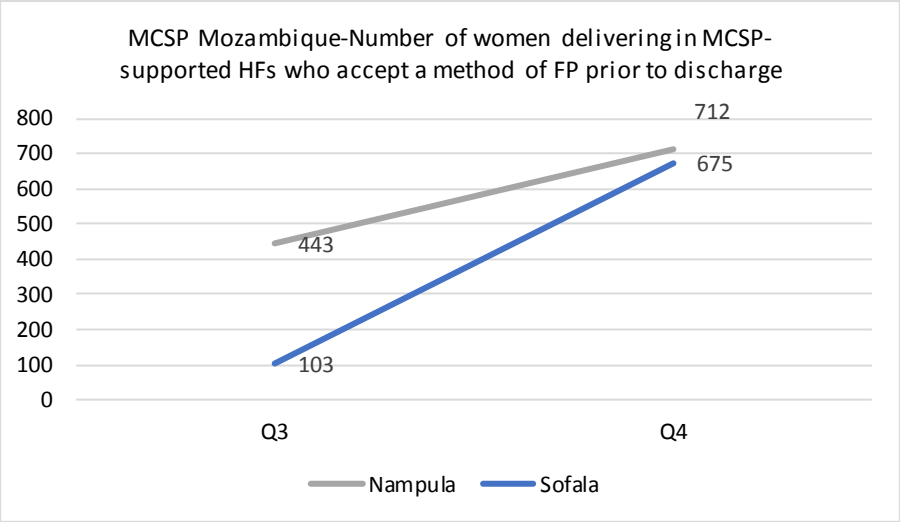
Time in minutes	Region				Total (N=1906)
	Tigray (N=181)	Amhara (N=810)	Oromia (N=420)	Southern Nations, Nationalities, and Peoples (N=495)	
	n (%)	n (%)	n (%)	n (%)	N (%)
Median	75 min	90 min	45 min	60 min	60 minutes
Less than 15	3 (2%)	71 (9%)	101 (24%)	51 (10%)	226 (12%)
Less than 30	1 (1%)	67 (8%)	69 (16%)	48 (10%)	185 (10%)
30 to 60	85 (47%)	196 (24%)	118 (28%)	221 (45%)	620 (33%)
More than 60	92 (51%)	476 (59%)	132 (31%)	175 (35%)	875 (46%)

Developing Human Capacity

MCSP programs continued to make progress in PY 2 on implementing a range of human capacity development (HCD) approaches tailored to national priorities to help reach program objectives of coverage, quality, and scale. MCSP's work on HCD spans pre-service education, continual professional development, and in-service training and mentoring, and leverages existing supervisory systems to support health worker performance, all with the goal of improving quality of services. In **Ghana** and **Liberia**, where program efforts focus on strengthening pre-service education, MCSP reached all midwifery and nursing schools in the country in PY 2 to contribute to a better-prepared and -equipped health workforce. Complementary HCD approaches such as mentoring, coaching, and frequent competency-based in-service trainings were implemented in multiple countries in PY 2, including **Laos, Rwanda, Liberia, Ethiopia, Madagascar**, and **Nigeria**, where MCSP is strengthening health worker capacities at multiple levels of the HS.

- In **Laos** in PY 2, MCSP developed skills among a core set of mentors to promote ongoing sustainable mentorship to all sites after MCSP program support ends in the country.
- In **Rwanda, Nigeria**, and several other countries, MCSP is working with country counterparts to support regular reinforcement of skills through frequent, on-site training and mentoring activities.
- In **Burma**, through the establishment of learning and performance improvement centers in PY 2, MCSP helped create mechanisms for providers to access standardized, hands-on training to deliver safe clinical care to mothers and newborns. These skill centers serve as regional learning hubs and eventually as a mechanism for the government to coordinate and administer high-quality in-service training and continuing professional education activities.
- In **Mozambique**, integrated trainings in FP and basic cervical cancer prevention helped contribute to a 60% increase in women accepting a FP method prior to discharge in program-supported facilities in Nampula Province and more than a five-time increase in program-supported facilities in Sofala Province from Q3 to Q4 (see Figure 15 below).

Figure 15. Number of women delivering in MCSP-supported health facilities in two provinces in Mozambique who accept a family planning method prior to discharge



OBJECTIVE 2

Close innovation gaps to improve health outcomes among high-burden and vulnerable populations through engagement with a broad range of partners

In PY 2 six of the seven innovations—possible severe bacterial infection (PSBI) treatment, gestational age (GA) estimation, first-time/young parents (FTYP), Reaching Every Community (REC)/QI, bubble continuous positive airway pressure (bCPAP), and uterine balloon tamponade (UBT)—have gained some momentum in several countries. Of the prioritized innovations, FTYP has moved from assessment to development in Madagascar along the innovation pathway to scale (see Box 1). REC/QI, UBT, and bCPAP introduction is underway in Uganda, Laos, and Nigeria, respectively, through training of mentors and providers. Figure 16 provides an overview of the innovations, countries where these innovations are being implemented and key progress made in PY 2.

Box 1. Early results: First-time/young parents—Madagascar

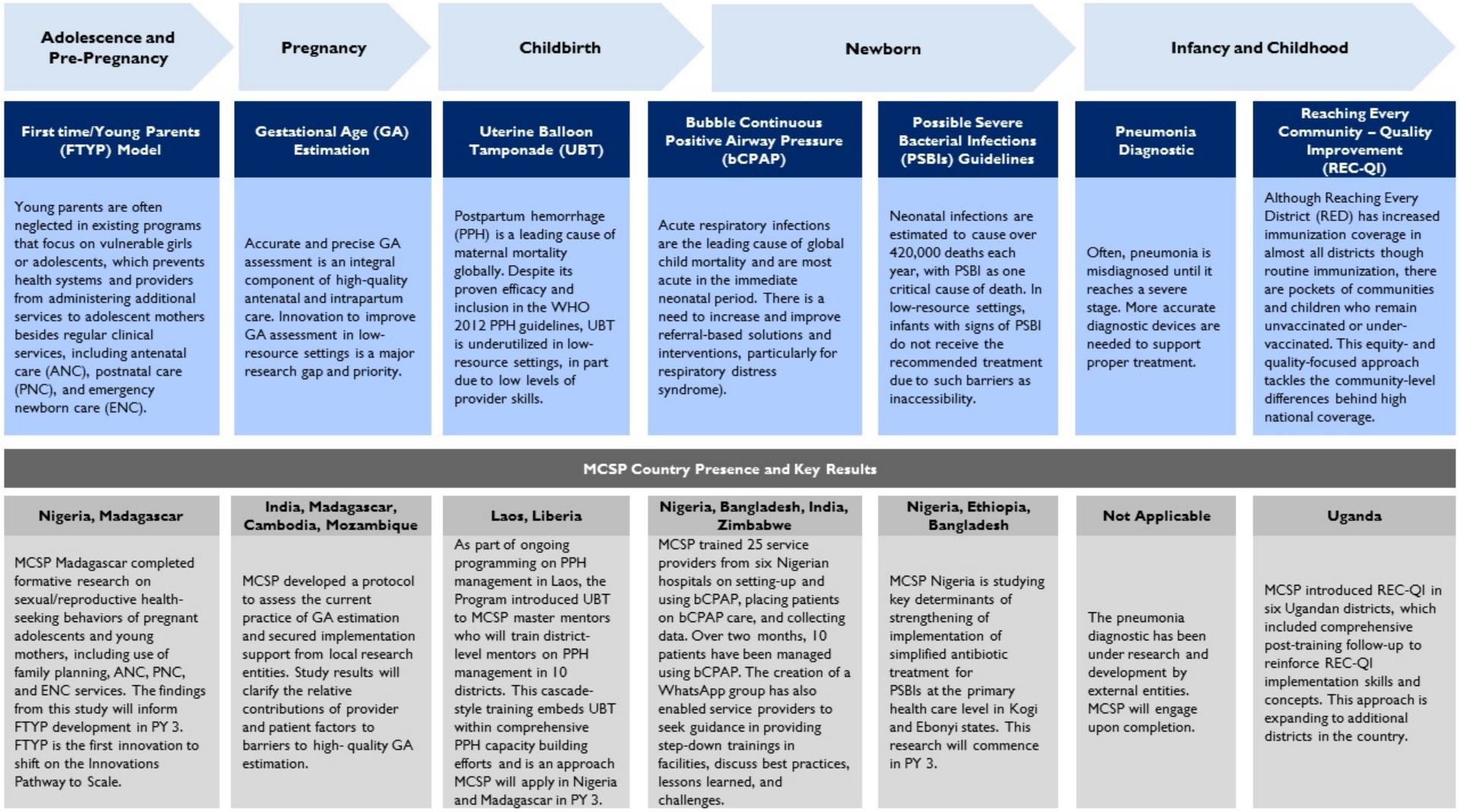
The results of the formative study from six health centers found 16% of young people under 25 years old began using family planning (FP) services following first childbirth, with 92% opting for depot medroxyprogesterone acetate. Determinants of FP use included availability of a variety of methods, availability of free or low-cost methods, and a welcoming and efficient health center. Conversely, determinants of non-use included lack of information, fear of getting an incision for an implant, and potential side effects. The decision to space birth and use FP was most often driven by the young mother and by community and facility-based service providers, though greater support for birth spacing was associated with higher educational levels of the mother's partner. Of women who gave birth in one of the six health centers in the study, 46% were less than 25 years old. Only 30.5% of women seen in prenatal care gave birth in a health center. Only 12.2% of pregnant women made all four prenatal care visits.

This and other results from the study indicate the need for improvements to health services to make them more attractive to young people. These include:

- Building capacity for youth-friendly health services in training programs for health providers and community health workers.
- Improving hours (specific to youth), organization, and the price of services (information on prices and transparent pricing).
- Encouraging all initiatives to improve the level of education and socioeconomic levels of households, because these contribute directly or indirectly to the use of SRH services by young parents.

MCSP will package and disseminate the formative research tools for use by programmers interested in targeting this unique and underserved group. MCSP Nigeria is using the tools to conduct its own formative research and will apply the results for cross-country learning for global application.

Figure 16. Innovations to close key gaps in coverage, quality, or equity



In addition to these seven formal technological innovations, MCSP is engaged in innovative programming approaches in several countries to improve quality and close gaps in services. In **Haiti,** for instance, the Program's Clean Clinic Approach (CCA; *Sant Sante Pwop*) began with a rapid assessment of 22 facilities. MCSP used those results to work with national and local government and health facility management to create minimum WASH standards for the country's health facilities and introduced those standards to participating sites. Working with the government, MCSP then helped health facility staff prioritize improvements, create action plans, build on the infection prevention and control standards, and monitor progress. Social recognition is the reward for facilities that make progress. After each inspection, results from participating facilities are shared publicly, creating healthy competition among facilities. Those that progress rapidly receive recognition more widely on the radio and via social media. These efforts are leading to significant WASH improvements in Haitian facilities. By the first monitoring visit, participating health facilities had improved their "clean clinic" score by an average of 14 points from baseline (using a 100-point scorecard). MCSP continues to work in Haiti to not only improve facility WASH management but also monitor client satisfaction and attendance.

In **Ghana**, MCSP has collaborated with Leti Arts in mobile gaming to create an interactive malaria story application called *Hello Nurse* to improve pre- and in-service learning outcomes. It is a mobile platform learning tool for case management and malaria prevention at the community and facility level. Rollout of this tool as a supplement to classroom learning will take place at 38 midwifery schools and 12 community health nursing schools by the end of 2017.

To address service gaps and siloed services in **Liberia** and other countries, MCSP is supporting capacity-building of comprehensive emergency obstetric and newborn care (CEmONC) with improved newborn care and PPFP services. This innovative and much-needed approach requires supportive supervision and performance standards. By addressing all of these content areas simultaneously on site and with guided practice, district and county health staff were able to use QI tools to uncover system breakdowns such as equipment problems, unclear staff roles, missing skills, and other institutional limitations that prevented patients from receiving the care they needed. This model of integrated skills building of providers in sites is now being replicated in Liberian facilities not supported by MCSP.

More recently, MCSP is seeking to address the challenges around the under-utilization of the lactational amenorrhea method (LAM) through a **LAM design challenge** that brings together "unlike minds" from a range of sectors and experiences to develop innovative ways to increase LAM uptake. Although LAM is not well understood by women or health care providers, it is an ideal transition method for women who are not ready for another modern contraceptive method after birth, yet have an unmet need for spacing or limiting a future pregnancy.

Innovating to Improve Lives

Due to the existence of key gaps in coverage, quality, and equity of health services, current implementation of proven high-impact interventions may be insufficient to address the leading causes of mortality and to reach ambitious global targets for ending preventable maternal, newborn, and child deaths in the next generation. The Maternal and Child Survival Program (MCSP) seeks to support promising innovations that address these gaps.

Definition of Innovation: *What innovation means*

"Novel business or organizational models, operational or production processes, or products or services that lead to substantial improvements in executing against development challenges. Innovations are not limited to products, drugs, or diagnostics, but could also include a novel approach or application of a technology, service or intervention." (USAID)

Key Innovations & Countries: *What we do and where*

UBT

Uterine Balloon Tamponade

A postpartum hemorrhage management intervention assembled using locally readily-available materials, including a Foley catheter and condoms.

Countries: Laos, Liberia

EGA

Estimating Gestational Age

Innovation that improves gestational age estimation in order to provide appropriate, time-sensitive interventions in antenatal and intrapartum care.

Countries: India, Cambodia

REC-QI

Reaching Every Community – Quality Improvement

Building on the Reaching Every District strategy, REC-QI focuses on equitable immunization coverage via quality improvements processes, data-driven strategies, and local ownership.

Countries: Uganda

FTYP

First Time / Young Parents Model

A model to facilitate health systems and health providers in providing the appropriate services for young parents who are often neglected in existing programs.

Countries: Nigeria, Madagascar

PD

Pneumonia Diagnostic

A diagnostic device that is redesigned with community case management experts and community health workers to improve the challenges in accurately diagnosing pneumonia in its early stages.

Countries: In research and development with external organization

Bubble CPAP

Bubble Continuous Positive Airway Pressure

A simple, cost-effective intervention to reduce neonatal mortality due to respiratory distress syndrome. The Bubble cPAP was designed for low-resource settings.

Countries: Nigeria, Zimbabwe, Bangladesh, & India

PSBI

Guidelines for Possible Serious Bacterial Infections

Guidelines with evidence-based recommendations to identify serious infections and to use simple, safe and effective antibiotics rather than solely resorting to referral of hospital treatment.

Countries: Nigeria, Ethiopia, & Bangladesh

Innovation Phases: *The stages of our innovation work*

Phase	Status and Reach	Innovations in this Stage
Assessment	Preliminary Priority Setting and Design	EGA
Development	Preliminary Priority Setting and Design	FTYP, PD
Introduction	One / Several Districts	PSBI, Bubble CPAP, REC-QI, UBT
Expansion	Expanded Fraction of Target Population	

Innovations Highlight: *A featured story from our innovation work*

Adolescent pregnancy is a key contributor of maternal, perinatal and infant mortality globally. Of the 17 million girls (19 years old and under) giving birth each year, many lack agency, are unaware of available family planning (FP) services, and are often treated under the generic cohort of "expectant mothers" rather than with adolescent-friendly support relevant to their developmental age and stage. MCSP is focused on developing and introducing the First Time Young Parents model in Madagascar. The Program led formative research on what factors influence adolescents' intentions to seek services and to use ante-natal care, post-natal care, and FP (including post-partum FP) services at relevant times in their reproductive life course. Through this study, we found that services must be designed to appeal to youth and that initiatives should focus on improving education and socio-economic status within households. In the upcoming year, MCSP plans to use these formative study results to design a Madagascar-specific model for first time/ young parents.

3 OBJECTIVE 3

Foster effective policy, program learning, and accountability for improved RMNCH outcomes across the continuum of care

Supporting Global Goals

The ability to leverage strong global, regional, and country platforms uniquely positions MCSP to contribute to USAID's bold commitment to EPCMD within a generation. MCSP aligns with and is guided by key global initiatives, mechanisms, and strategies shaping the global health environment, including the SDGs; Every Woman Every Child (EWEC); the Partnership for Maternal, Newborn, and Child Health (PMNCH); and others.

During PY 2, MCSP shared country, regional, and global experiences by organizing and participating in several strategic global meetings and forums. Participation at these events helped MCSP share evidence garnered from implementation; promote dialogue on best practices, successes, and failures; and foster knowledge sharing and exchange.

Mexico City to Copenhagen: MCSP's engagement as a key convening partner for the first Global Maternal Newborn Health Conference (GMNHC), held in Mexico City in October 2015, helped shape the overall design of the conference, with a focus on three central themes that remain critical to MCSP work: integration, quality, and equity. MCSP representatives from 12 countries plus US headquarters (HQ) attended the event, which resulted in outlining 10 critical actions. A follow-up GMNHC event took place in April 2016 in Washington, DC, to build on the momentum generated from the conference and the lead-up to the 2016 Women Deliver conference in May 2016. The GMNHC follow-up event, which included a panel discussion facilitated by MCSP, emphasized the importance of looking at data within context, moving beyond mortality to morbidities and development, and bringing together multi-sector stakeholders.

MCSP had a small yet influential presence at the 2016 Women Deliver conference, the largest gathering in a decade around women and girls' health and rights. MCSP representatives participated in three highly influential panels around unmet need in the midwifery workforce, achieving coverage and improving outcomes on malaria in pregnancy (MiP), and respectful care for mothers and babies. MCSP led six live demonstrations at its booth and held an FP Voices interview. MCSP also assisted with the Young Midwives in the Lead Midwifery Symposium, which brought together 32 midwives from 31 countries under the age of 35, focusing on enhancing their leadership and advocacy skills for engaging in national policy dialogues from an evidence-based perspective. After the GMNHC, there was renewed urgency in Kenya and other countries to encourage the national TWG to operationalize established policies around scaling up high-impact interventions. In Mozambique, the MOH updated the national operational plan based on selected best practices shared at the conference.

Photos (L-R): Speaker at the GMNHC (Miguel Sanchez/Global Maternal Newborn Health Conference); Panelists at Women Deliver (Liz Eddy/MCSP); Dr. Ariel Pablos-Méndez speaking at MCSP/MHTF event (The Wilson Center)

Immunization in Africa: MCSP collaborated closely with the WHO, the African Union, the Bill & Melinda Gates Foundation (BMGF), USAID, and other key stakeholders on the first Ministerial Conference on Immunization in Africa in February 2016, in Addis Ababa, Ethiopia. MCSP's technical leadership for the event included contributing to and co-leading development of key technical briefs, developing an infographic on routine immunization, ensuring strong media and communications engagement leading up to the conference, and planning the civil society side event. All 54 countries signed the Ministerial Declaration, which outlines the commitment to increase investments for immunization and prioritizes equitable access to and high levels of immunization. MCSP will continue to work alongside WHO, UNICEF, and other partners to ensure commitments are kept and immunization services become a national priority.

Moving the dial on FP: In addition to participation at the International Conference on Family Planning, MCSP co-hosted the PPFP Global Meeting Follow-Up Auxiliary event building on the Accelerating Access to Postpartum Family Planning meeting, hosted by FP 2020 in June 2015 in Chiang Mai, Thailand. The auxiliary workshop, attended by over 130 people from 20 countries, provided an opportunity to learn about the progress made by countries since the 2015 PPFP Global Meeting, discuss challenges faced when implementing PPFP action plans, and continue the momentum to propel the PPFP global movement into the future. MCSP staff from Guinea, Madagascar, India, and Rwanda attended the workshop and identified challenges and opportunities to scaling up PPFP in their respective countries. Country representatives left with more refined action-oriented plans to "move the dial" on PPFP.

MCSP continues to provide support to countries on their action plans, working to accelerate PPFP and engaging USAID and partners to implement strategies. Significant progress has been made in some countries. In India, the MOH approved the PPFP action and incorporated it into the national-, state-, and district-level action plans. In Madagascar, the plan has been incorporated into key FP strategic documents (the integrated FP strategic plan/ and the National Costed Action Plan). See Box 2.

Box 2. Global plans in action—Madagascar

The Government of Madagascar officially pledged its commitment to the Family Planning 2020 (FP2020) initiative's goal of ensuring universal access to sexual and reproductive health services by 2020. To galvanize this commitment, MCSP led a consortium of partners, including WHO and UNFPA, to organize the first-ever national conference to establish a common vision and ensure synergy in the implementation of the FP2020 action plan. The meeting brought together over 400 participants from all 22 regions of Madagascar, including representatives from every level of the health care system, representatives from five governmental ministries, parliamentarians, international funders, members of civil society organizations, and implementing partners. After three days of deliberations, attendees left as FP champions and proud owners of a Regional Action Plan to revitalize FP. MCSP will follow up and provide technical support where needed to ensure the integration of these plans in the National Budgeted Action Plan, as well as its successful implementation at the local level. The conference also resulted in the engagement of parliamentarians who mobilized to advocate for FP and prioritize the adoption of a reproductive health law that increases access for women. The health minister also committed to achieving contraceptive prevalence of 50% by 2020.

Other events: MCSP also convened key technical meetings around PPH, respectful maternity care (RMC), and care for the small and sick newborn. Each of these meetings brought together key stakeholders and country representatives to ground evidence within the operational realities of countries. MCSP will play a key role in developing concrete implementation guidance for countries to encourage cross-country learning and sharing, which emerged as a key need.

Global Guidelines and Policy to Influence Action

MCSP continued to play a key technical leadership role in shaping RMNCH policy and action informed by country implementation experiences at global and national level. Box 3 highlights a few examples of national policy leadership efforts.

Box 3. Influencing national policy

National Mentorship Guidelines—Rwanda
MCSP collaborated with the MOH to develop the national mentorship guidelines and tools, as well as the national strategy for quality improvement and facility accreditation.

National Community Health Worker (CHW) Strategy and Policy – Tanzania
MCSP helped the Ministry of Health and Social Welfare develop and disseminate the CHW Strategic Plan and policy nationally and is in the process of finalizing the CHW RMNCH training curriculum.

Putting Breastfeeding Back on the Agenda – Malawi
In close partnership with the MOH, WHO, and UNICEF, MCSP spearheaded the revitalization of BFHI in 10 hospitals and three high-volume centers of excellence. As a result, Malawi now has revised its breastfeeding policies and training materials to reinstate the Ten Steps to Successful Breastfeeding.

Since 2014, the Lives Saved Tool (LiST) has been used to estimate the impact of scaling up key interventions in USAID's priority countries. For the 2016 Acting on the Call report, MCSP prepared analyses focused on inequity and subnational scenarios and based on coverage by wealth quintile. The report featured figures and graphs based upon Lives Saved Tool outputs for the 25 priority countries and included models for 10 additional countries in a supplemental subset. In addition, MCSP supported an analysis of the 26 provinces in DRC based upon the most recent Demographic and Health Survey 2013-2014 data to inform the finalization of the country's National Health Plan for 2016-2020.

At the global level, MCSP continues to provide close technical support to develop and refine the WHO MNH QoC framework and accompanying country QI implementation guidance. Using the experience from Rwanda and Mozambique, WHO has—with MCSP support—started recent work to expand its QoC framework to incorporate child health standards, quality statements, and quality measures. MCSP is highly engaged with planning for the launch of the WHO MNH QoC Network in the first-wave countries. MCSP QI work across all program technical areas aligns closely with the WHO MNH QoC framework, country QI implementation guidance, and MCSP's common core QI principles as a collaborative effort across all program teams.

MCSP worked with WHO, UNICEF, and other global players in child health to map the current global child health landscape. The recommendations offer insight on how leadership in the child health arena may be strengthened and repositioned to attain better outcomes under the SDGs. The full report is available at http://bit.ly/CHMapping.

MCSP was involved in the revision of the Reaching Every District (RED) Approach Guidelines, which aim to highlight equity and integration as key health components. MCSP supported harmonizing the guidelines to incorporate integrated child survival approaches and updating the planning and monitoring tools of the RED approach. Once it is final, MCSP will field test the adapted version of the RED/REC guidelines in up to three MCSP countries. MCSP will document the process and outcomes, synthesize the lessons learned, and share promising practices from ongoing work.

MCSP played key roles in the Gavi joint appraisals of eight countries (Nigeria], Zimbabwe, Tanzania, Kenya, Malawi, Pakistan, Madagascar, and Mozambique) and was partially involved in two countries (Uganda and Haiti). The appraisals are a joint effort by such partners as WHO, UNICEF, the Centers for Disease Control and Prevention (CDC), USAID, and in-country agencies to assess progress, identify technical assistance (TA) gaps and priorities, and strengthen multiyear planning. In PY 2, MCSP also supported the historic WHO-led global switch from trivalent to bivalent oral polio vaccine. MCSP successfully removed all trivalent supplies in 11 countries while ensuring that planning, logistical, and monitoring arrangements were effective and that health care workers were receiving appropriate training and supervision to administer the new vaccine.

MCSP continues to work with stakeholders to improve accountability and ownership, and leverage complementary resources at the country level, which is imperative to eventually achieving systemic change. Box 4 below highlights a promising approach in Nigeria.

Box 4. Accountability and ownership are key to expanding childhood immunization—Nigeria

Broad-scale immunization of infants under a year old is essential to both save lives and control the spread of preventable diseases. Yet in some regions of northern Nigeria, DTP immunization programs reach as few as 2.6% of infants, the lowest rate in the country and among the lowest in the world. However, a unique partnership model may soon reverse that trend by encouraging political will within the Bauchi and Sokoto state governments in northern Nigeria to respond to this challenge. A new three-year, four-signatory Memorandum of Understanding (MoU) between the State Primary Health Care Development Agencies (SPHCDAs), USAID/Nigeria through MCSP, BMGF, and the Dangote Foundation gives these state governments responsibility for strengthening and expanding immunization programs.

To ensure financial and political buy-in by health officials in Bauchi and Sokoto, the three donor partners contribute to a "basket fund" to which the state partners add an equal share. That amount increases each year until the state partners are ultimately covering the full cost of the immunization programming, with the donor partners providing technical assistance and other systems-strengthening support. This funding structure ensures ownership by the Nigerian Government. The SPHCDAs in Bauchi and Sokoto are accountable for reaching targets within the MoU implementation period, while technical assistance and capacity-building support from the donor partners help achieve sustainability. The MoU model also supports the Nigerian Government's efforts to improve administration of health services by integrating services "under one roof"—the SPHCDAs—rather than dividing them among several different health agencies.

Consistent with our shared objectives with the PMNCH global initiative and the EWEC global strategy, MCSP is also closely involved in such global TWGs and initiatives as the Health Data Collaborative (HDC), EPMM, and the ENAP TWGs, which each present a forum for MCSP to share country experiences with metrics and measurement, disseminate relevant tools, and inform the global dialogue based on implementation experience. WHO, the Maternal Health Task Force (MHTF), and USAID, along with MCSP, facilitated a series of technical consultations to reach consensus on the second-phase EPMM indicators. These aim to align metrics to ensure greater harmonization in tracking progress toward EPMM and achieving SDG targets. Consensus was reached on 12 indicators and 4 priority areas for further indicator development and testing. These indicators are being harmonized with the ENAP core metrics for a joint global maternal newborn monitoring framework.

MCSP conducted a health management information system (HMIS) review of 24 of the 25 EPCMD countries for MNH and 23 of the 25 EPCMD countries for child health. This review seeks to advance global and country understanding of which of the new WHO-recommended routine RMNCH indicators, including those recommended under the new WHO MNH Quality Framework, are in national HMIS systems. It will provide key global players and implementers with an understanding of the data realities at the country level, starting from the facility. In PY 2 the review's preliminary data and analysis were produced for MNH data elements.

To improve the use of data for decision making, MCSP Tanzania is providing technical support to the MOH to improve interoperability of data across multiple information systems. The system would allow health workers to seamlessly follow individuals along the continuum of care and across disconnected systems and cadres of care providers while improving overall use of data for decision-making.

Knowledge Management and Communications

MCSP staff contributed to and authored over 30 peer-reviewed articles across technical areas, as shown in Annex F. The articles include research on such topics as monitoring iCCM, measuring the quality of labor and delivery care using quantitative indicators, assessing service availability and readiness of MNCH services at public health facilities in Madagascar, and understanding polio immunization social norms in Nigeria.

Globally, MCSP gained 5,958 new followers on Facebook and Twitter in PY 2. The total number of Facebook fans increased by 46.4%, with a 38.4% increase in Twitter followers over the prior year. The MCSP website in PY 2 had 96,829 page views and 39,700 sessions (according to Google analytics). Visitors from 183 countries accessed the site; the top five countries were the United States, India, Rwanda, Kenya, and Nigeria. MCSP frequently posts new content to the website, including blogs about key technical areas, updates, and success stories from countries (see examples of the last at Annex D).

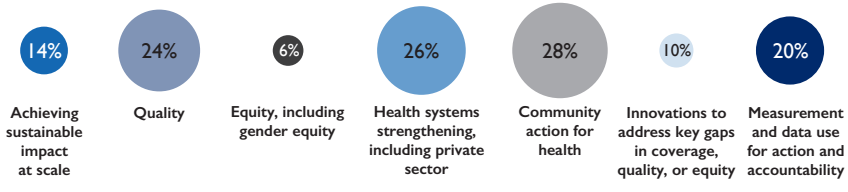
SO3: Foster effective policy, program learning, and accountability for improved RMNCH outcomes across the continuum of care

Learning for Improved Policy and Implementation

The Maternal and Child Survival Program (MCSP) supports both implementation and learning and is designed to facilitate the development and dissemination of best practices for addressing system bottlenecks to accelerate progress toward achieving high coverage, quality, and equity for high impact interventions which in turn contributes toward making sustainable progress in eliminating preventable child and maternal deaths.

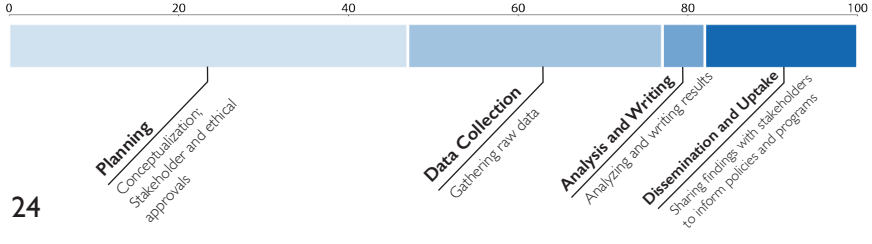
Themes: *Our implementation and learning themes**

*Most learning questions fall under more than one theme.



Learning Theme	What Theme Entails
Achieving sustainable impact at scale	Scaling up high impact interventions and health system components; supporting countries to accelerate achievement of sustainable high and effective coverage and institutionalization through systematic management of the scale up process by Ministries of Health and partners
Quality	Improving care on the day of birth, including respectful maternity care; identifying the most effective and sustainable quality improvement approaches for RMNCH service provision in various contexts
Equity, including gender equity	Improving equity of key high impact interventions by focusing on groups marginalized by socioeconomic and geographic status; increasing male engagement in family health including birth preparedness; reducing gender based violence; improving services for adolescents
Health systems strengthening, including private sector	Introducing novel methods for pre-service and in-service training of health providers; improving tracking of patients across levels of the health system and improving coordinated care through referral networks; integrating service delivery; strengthening subnational management capacity
Community action for health	Supporting community and civil society organizations; fostering community mobilization for improved use of and access to RMNCH services; increasing community-based service provision; introducing community based health information systems
Innovations to address key gaps in coverage, quality, or equity	Building evidence needed to adapt and improve innovations; supporting progress on the pathway from development and introduction to expansion and full scale-up
Measurement and data use for action and accountability	Testing new indicators; strengthening health management information systems, promoting data visualization and use to help drive better practice at all levels of health systems

Status of Learning: *The stages of our learning work*



Learning Highlight: *A featured story from our learning work*

Feeding junk foods is common in children under two, and may displace exclusive breastfeeding in the first six months or nutritious foods after six months of age, contributing to excess energy intake, nutrient deficiencies, and poor development. MCSP assessed relevant factors and country policies; recommendations include providing supportive environments to discuss reducing or eliminating introduction of junk foods, and helping health providers understand healthy versus unhealthy weight gain. In Egypt, MCSP is incorporating counseling on junk food consumption for infants and young children into the national community health workers curriculum, as part of strengthening infant and young child feeding practices.

Policy Influence:

MCSP has influenced 34 policies in PY2

Acute respiratory infection accounts for 18% of under-five deaths in Nigeria. Patent and proprietary medicine vendors (PPMVs) are the first source of care for most common childhood illnesses, but were not permitted to dispense Amoxicillin Dispersible Tablets (DT), an antibiotic used to treat pneumonia in children. MCSP supported the Federal Ministry of Health to build consensus with stakeholders and align national policies to allow trained PPMVs in communities to use Amoxicillin DT for treatment of uncomplicated pneumonia, thereby addressing a key cause of child mortality.

Accountability & Data for Action:

Using tools and ingenuity to turn data into action that improves RMNCH

In Tanzania, MCSP supported the Community Scorecard approach, a social accountability-based quality improvement process. MCSP and local civil society organizations reviewed key indicators with community representatives, examined barriers to utilization of RMNCH services and adoption of related behaviors, and facilitated development of action plans to generate demand for RMNCH services, improve referrals by creating linkages between health facilities and the community, and create transport mechanisms at community level to facilitate access to health facilities, with the aim of reducing preventable child and maternal deaths.

Summary of Achievements by Technical Area

The following sections are organized by the technical areas outlined in MCSP's second project year core-funded workplan. These sections provide some context for MCSP's work as well as highlights of first-year accomplishments supporting MCSP objectives. Accomplishments primarily supported through field funds are included as the Addendum.

MATERNAL HEALTH

MCSP's MH programming aligns with and supports USAID's Maternal Health Vision: reducing leading direct and indirect preventable causes of maternal morbidity and mortality. In PY 2, MCSP's MH work focused on:

- Strategic technical global leadership and support to MCSP country programs to strengthen delivery of high-impact and respectful antenatal, intrapartum, and postpartum MH interventions.
- Support for introduction (e.g., UBT) and scale-up (e.g., ADMSA, magnesium sulfate for PE/E) of key components of comprehensive and integrated MNH programming.
- Distillation of learning across countries to accelerate progress at the country level and to contribute to global learning and initiatives.

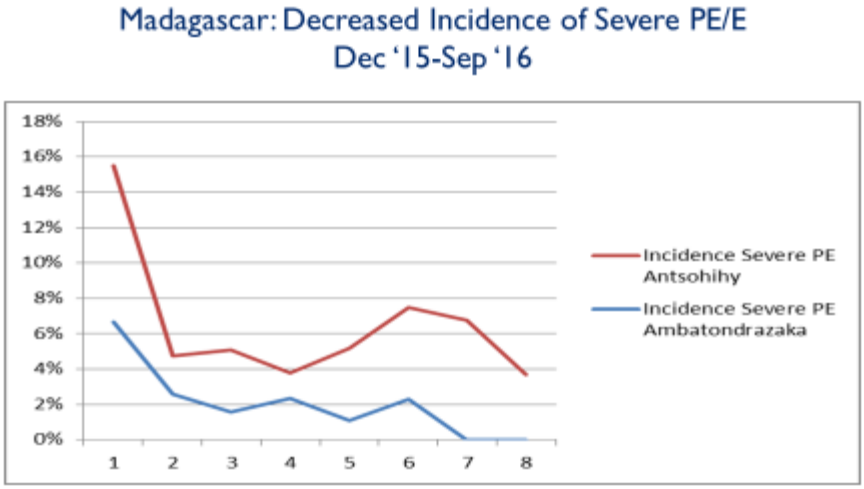
Accomplishments

- In collaboration with WHO and global partners, MCSP contributed to the development of WHO QoC MNH measures and country QI implementation guidance in PY 2 and provided technical support for planning for the launch of the WHO-led MNH Quality Network in early 2017. In collaboration with USAID, the MH team successfully advocated for inclusion of two MCSP/MCHIP countries as "first-phase" countries in the WHO Quality Network (Nigeria and Bangladesh) and initiated support to Nigeria and Bangladesh to prepare for participation in the 2017 Quality Network launch meeting. With supplemental core support, these first-phase countries will benefit from and make important contributions to the network and learning platform. MCSP's deep engagement with the WHO Quality network technical leadership team positions the program well to extend network approaches and learning to all MCSP MNH country programs beyond the WHO first-phase countries (e.g., Madagascar, Mozambique, Haiti, Rwanda) and to distill learning across multiple countries.
- Building on the outputs of an MCSP 2015 Regional Respectful Maternity Care (RMC) meeting in Tanzania, MCSP convened a two-day RMC meeting in Q3 of PY 2 in Washington with the participation of USAID implementation partners, researchers, and MCSP country representatives from Kenya, Haiti, Rwanda, Nigeria, and Ethiopia. Synthesizing the latest evidence, including findings from recent USAID-supported RMC implementation research, participants examined feasible measurement/ assessment methods (quantitative and qualitative) to inform design, implementation, and monitoring of RMC and mistreatment reduction efforts as part of comprehensive MCSP MNH programs. Outputs of the meeting are being synthesized into process-oriented country RMC operational guidance that will strengthen design, implementation, and monitoring of program country RMC implementation in PY 3. The operational guidance (to be finalized in PY 3) builds on country program RMC implementation experience in Tanzania, Nigeria, Rwanda, and other countries. The guidance also addresses key challenges common in RMC program implementation in large MNH programs, including monitoring women's experience of care.

- MCSP established a PPH Implementation TWG, which convened in Washington for the first time. The 49 participants included representatives from USAID, Management Sciences for Health, Merck for Mothers, PATH, Monash, the Applying Science to Strengthen and Improve Systems (ASSIST) Project implemented by University Research Co., PRONTO International, MHTF, Gynuity, and other organizations, as well as MCSP country program representatives from Rwanda, Ethiopia, Haiti, Nigeria, and Kenya. The meeting explored implementation gains and outstanding needs for contextual program strategies that balance PPH prevention and management at the community and facility levels. In PY 3, MCSP will continue to manage the PPH TWG as a forum for sharing PPH implementation experience and will support a PPH TWG subcommittee to develop a PPH conceptual implementation framework for low-resource settings. MCSP will continue to foster linkages between the global PPH Implementation TWG and MCSP country programs working on PPH. This will ensure that the latest evidence and comprehensive PPH prevention and management approaches are incorporated into MCSP country programming.
- MCSP continued to collaborate with WHO on two important products in PY 2. MCSP participated as a core member of WHO's ANC recommendations expert review group. MCSP also developed a section on implementation considerations informed by program ANC implementation experience at the country level. In PY 3, MCSP will co-develop summary briefs with WHO on the new ANC recommendations and incorporate the new recommendations into country program ANC activities as appropriate. MCSP also continued to work with WHO to update the *WHO Managing Complications in Pregnancy and Childbirth (MCPC)* manual, which has been a vital resource for health care providers around the world since initial publication in 2000. With supplemental financial support from Jhpiego, MCSP collaborated with WHO to update significant portions of the manual based on state-of-the-art MH evidence. The second edition of the MCPC manual will be published in early 2017. In PY 3, MCSP will collaborate with WHO to disseminate the updated MCPC manual and associated derivatives, including a synthesis briefer, and will support country programs to adopt and use updated MCPC guidelines for policy reform and program implementation.
- In partnership with WHO, MHTF, and USAID, MCSP contributed to the development and dissemination of a journal article published in *BMC Pregnancy and Childbirth*[1] in PY 2, which described the process of developing 12 (first-phase) MH indicators for global monitoring as part of an EPMM metrics framework developed in PY 1 with MCSP support. In PY 2 the program also contributed to the development of phase 2 EPMM indicators focused on social, political, and economic determinants of MH. Through its close collaboration with EPMM, WHO, and other MH monitoring efforts, the program is making an important contribution to advancing global MH measurement frameworks.
- In countries with MNH activities (including Haiti, Kenya, Tanzania, Nigeria, Liberia, Rwanda, and Madagascar), MCSP worked to strengthen routine integrated care for mothers and newborns on the day of birth, a time of high risk for mother and newborns. Country activities focused on strengthening delivery of routine, high-impact intervention packages tailored to labor, immediate postpartum, and early PNC phases, including building capacity of providers and managers to calculate and analyze a small number of DOB MNH/PPFP measures. Country-level support also focused on strengthening prevention and management of obstetric complications across the antenatal, intrapartum-, and postpartum continuum with special emphasis on PPH and PE/E. In the MCSP-supported Ambatondrazaka and Antsohihy Regional Hospitals in Madagascar, the institutional incidence of severe PE/E decreased from 7% to less than 2% and from 15% to 4%, respectively, from Q 1 to Q 4 in PY 2. This is likely due to improvements in early detection and evidence-based management of PE/E prior to development of severe features (see Figure 17 below.)

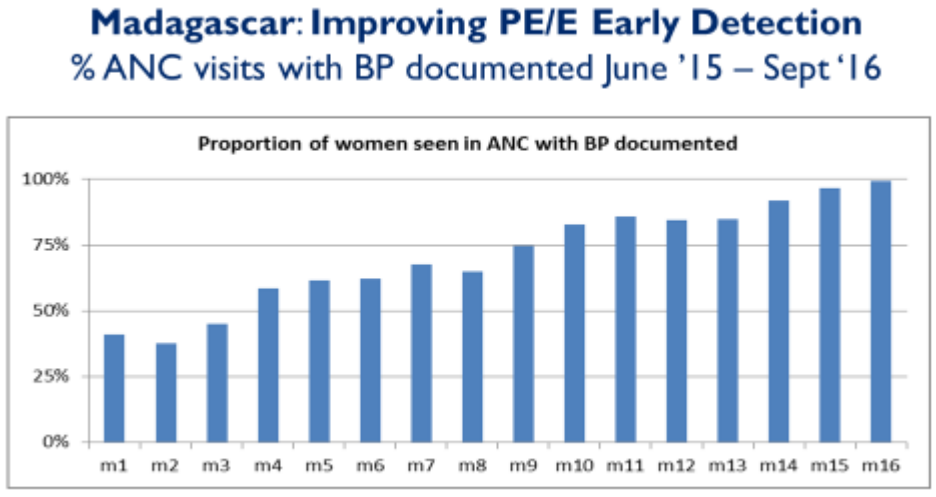
[1] http://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-016-1035-4?utm_source=MHTF+Subscribers&utm_campaign=c2fd0fdc5b-MH_Buzz_20160912&utm_medium=email&utm_term=0_8ac9c53ad4-c2fd0fdc5b-183800101

Figure 17. Declining trend in incidence of severe PE/E at 2 Regional Hospitals in Madagascar



- In PY 2, the program supported MH service-delivery strengthening efforts in **Tanzania**, with a focus on supportive supervision/clinical mentorship activities and use of data for decision making, for both routine care and management of obstetric complications. This resulted in improved quality of supervision visits and use of MH data for decision making. Illustrative quality measures being tracked and visualized at the facility level include uterotonic for prevention of PPH, newborn resuscitation, and initiation of postpartum breastfeeding.
- In **Madagascar**, the program expanded efforts initiated in PY 1 to strengthen MH services in primary health centers (*Centres des Soins Intégrés*) and introduced a QI intervention to improve quality of routine and complications care in four regional hospitals. This intervention focused on best practices in routine care and prevention and management of PPH and neonatal asphyxia in a first phase. Results of health center and hospital QI efforts at the end of PY 2 demonstrate encouraging improvements in QoC and health outcomes. Figure 18 shows an upward trend in measurement of BP during ANC to detect PE/E at primary health centers.

Figure 18. Improved screening for PE/E among ANC clients at 275+ health centers in Madagascar; (N= 133,320 ANC consultations)



- In addition to clinical technical support, country MH program support focused on cross-cutting areas essential for delivery of high-quality MH care, including:
    - Strengthening provider and manager core competencies (clinical and QI) through on-site capacity-building, with regular reinforcement of skills.
    - Ongoing supervision and mentoring by district and regional managers.
    - Building the capacity of providers and managers to regularly collect and use priority MH results for decision-making.
    - Strengthening favorable national policy and national/regional/district governance structures in support of MH services. For example, in Nigeria, Haiti, Rwanda, Tanzania, and Nigeria, the program strengthened supervision structures at the regional and district levels, including regular use of dashboards by facility and district managers for decision making in Madagascar (see country annual reports).
- MCSP advanced work with the Federal Ministry of Health in **Nigeria** to develop a national MNCH quality policy framework. MCSP then worked with the State MOH in Kogi and Ebonyi states to define a state QI operational plan to accelerate improvements in quality of MNH services. These state QI operational plans are now being implemented with a strong focus on supporting front-line QI teams and tracking priority MH quality measures (process and outcome.)
- The program introduced the use of UBT as part of comprehensive PPH case management in several country programs in PY 2. UBT was in the early introduction stage in Liberia and Laos. In Liberia, MCSP led activities to strengthen integrated MNH/FP service delivery in the Liberia General Hospital and introduced UBT into clinical mentorship and QI activities for comprehensive PPH management. UBT activities are included in PY 3 country workplans for Nigeria, Uganda, and Madagascar, among other countries.
- MCSP continued to promote and strengthen the use of Maternal and Perinatal Death Surveillance and Response (MPDSR) systems in targeted country programs and contributed to global and regional efforts to expand and improve use of MPDSR. At the country level, MCSP programs in Haiti, Kenya, Liberia, Mozambique, Nigeria, Rwanda, and Zimbabwe (MCHIP AA) worked to strengthen MPDSR implementation, including linkages with ongoing QI efforts and efforts to strengthen maternal information systems. MCSP supported MOHs to update national MPDSR policies and guidelines; oriented district- and facility-level MPDSR teams in Nigeria, Liberia, Tanzania, and elsewhere to updated national and WHO guideline; and provided ongoing support to MOHs to operationalize and strengthen MPDSR systems. At the global level, MCSP contributed to the WHO Maternal Death Surveillance and Response (MDSR) TWG, sharing MCSP country experience and program priorities. (See the Africa Bureau section of this report for additional program activities related to MPDSR, including a four-country MPDSR regional assessment.)
- Although essential for providing high-quality obstetric and perinatal care, accurate and precise **GA estimation** is difficult to achieve in most low-resource settings. MCSP supported two GA-focused activities in PY 2, each intended to improve the accuracy and precision of GA estimation to support clinical decision-making, including timely initiation of high-impact interventions (e.g., initiation of IPTp-SP early in the second trimester and management of threatened preterm birth and severe PE/E). Progress was made in the design and launch of a multi-year Asia Bureau-funded study on GA estimation in India and Cambodia as discussed under Objective 2. MCSP developed and began field testing a Toolkit to Increase Early and Sustained IPTp Uptake, for use by providers, to improve timely initiation and completion of IPTp-SP according to WHO guidelines. Field testing of this toolkit began in PY 2; the toolkit will be finalized in PY 3 and incorporated into country programming to strengthen ANC. Through the Asia study and the Toolkit to Increase Early and Sustained IPTp-SP Uptake, along with country implementation learning, MCSP is contributing to innovative resources and implementation approaches to improve estimation of GA in low-resource settings.

- With **PPH** a leading direct cause of death for women during childbirth, MCSP is examining innovative ways to increase community- and home-based use of prophylactic uterotonics for prevention of PPH during the third stage of labor in home births. Through a systematic study of misoprostol scale-up for PPH prevention, MCSP is evaluating in-country contextual factors in Mozambique and Afghanistan (both within and outside MCSP control). These factors may enable or restrict successful scale-up (both increased coverage and institutionalization) of ADMSA for prevention of PPH in home births.

    - In partnership with the MOH in **Mozambique**, MCSP began a situational analysis and collected data on ADMSA implementation experiences in the six program districts, both of which will inform future scale-up efforts to expand ADMSA to additional facilities and/or districts.

    - With assistance from MCSP, the program in **Afghanistan** has supported the development of a National Scale-up Plan endorsed by the Ministry of Public Health, and finalized a learning resource package. As a result of multiple advocacy meetings, ADMSA is now included as a core intervention in Afghanistan's provincial System Enhancement for Health Action in Transition (SEHAT) contracts to nongovernmental organizations (NGOs), the mechanism whereby the government of Afghanistan contracts with NGOs to deliver the country's Basic Package of Health Services. By ensuring inclusion of ADMSA in the SEHAT contracts, MCSP is contributing to the sustainability of this life-saving intervention after the bilateral project ends. As part of scale-up activities, the program has conducted a training of trainers (TOT), trained CHWs, and oriented health managers to community-based prevention of PPH, linked to ongoing facility-based PPH prevention programming. The program also secured a supply of misoprostol and, through local SEHAT NGOS and CHWS, distributed misoprostol to women within the community, 62% of whom used it for PPH prevention in home deliveries. The program is helping to generate valuable learning on implementation approaches to increase quality and coverage of community-based PPH prevention interventions in low-resource settings.

NEWBORN HEALTH

MCSP's newborn health programming aims to accelerate reductions in newborn mortality due to the three main causes of death: infections, prematurity, and complications of pregnancy. To support this goal, MCSP provided global leadership in newborn health in PY 2, focusing on strengthening country plans and strategies, improving metrics and measurement, and strengthening the delivery of high-impact newborn health interventions through QI and HCD approaches. The newborn team has also continued to help countries scale up high-impact interventions that most countries are not already operating at scale: Helping Babies Survive (HBS) practice guidelines, CHX, and KMC. Building on progress made in PY 1, MCSP continued to leverage key global initiatives such as the ENAP and the WHO QoC Framework, as well as platforms such as the Kangaroo Mother Care Acceleration Partnership (KAP). This has helped to guide MCSP's work at the global and country levels and to serve as opportunities to facilitate knowledge sharing between countries and across the global MNH community to advance the newborn health agenda.

Accomplishments

- Through the ENAP Country Implementation Group, MCSP shared the experiences of its country programs in engaging in the ENAP tracking process, including challenges faced in institutionalizing the process at the country level. MCSP countries included in this process were Rwanda, Mozambique, Madagascar, Ethiopia, and Bangladesh (MCHIP AA). The intent of the ENAP tracking tool was that it be used as part of a collaborative process across government and partners to collect, review, and use data to inform newborn health programming. However, many countries encountered difficulties in making this process collaborative because it was not integrated within national review and tracking processes.

- MCSP took on co-leadership of the Newborn Resuscitation Technical Resource Team and facilitated the first face-to-face meeting of the group in August. The face-to-face meeting brought together eminent country and global representatives who reviewed key achievements of the group, disseminated key products for countries to use (including Reprocessing Guidelines and a landscape analysis of neonatal airway interface devices, both from PATH), and discussed plans for the future functioning of this partnership forum.
- As co-lead of the KMC Acceleration Partnership (KAP), MCSP engaged stakeholders, including MOHs in Nigeria, Ethiopia, Rwanda, Bangladesh, and India, in the design of the first regional community of practice (COP) meetings, which are planned for early PY 3. The purpose of the KAP COP is bring together countries that are forerunners in systematically scaling up KMC. The regional COP workshops will provide members with a platform to share learning and discuss challenges in order to further catalyze progress on KMC within their respective regions.
- MCSP contributed to the development and dissemination of global MNH guidelines and related materials, including WHO guidelines on the perinatal death audit (PNDA). MCSP led the development of a policy brief summarizing the PNDA guidelines; the brief was disseminated as part of the WHO launch of the PNDA guidelines and related materials. In collaboration with WHO and global partners, MCSP contributed to the development of the WHO QoC MNH standards and measures for Improving MNH Care in Health Facilities, released in PY 2.
- In PY 2, MCSP newborn, MH, and FP teams collaborated to strengthen routine integrated care for mothers and newborns on the DOB. This involved refining and promoting the conceptual framework and strategy to strengthen the quality of routine, high-impact MNH interventions during the labor, immediate postpartum, and early postnatal periods, with a specific emphasis on inclusion of QoC measures. Nigeria, Haiti, and Tanzania received support to use the approach as a way to strengthen capacities for not only health service delivery but also QI, data management, and overall HSS.
- As part of its work to explore and advance alternate approaches to HCD for MNH, MCSP supported country programs in Laos (Asia Bureau funding), Burma, Liberia, and Rwanda to strengthen capacities through on-site, one-on-one mentoring of service providers for improved care of mothers and newborns on the DOB.
    - Rwanda has taken leaps forward in improving facility deliveries (Figure 19), yet newborn mortality reduction has been slower compared with under-5 mortality rates. MCSP implemented a QoC and Low Dose High Frequency approach that uses mentoring as the main method of capacity-building. In collaboration with district health leadership, MCSP used these approaches to strengthen essential newborn care, newborn resuscitation, and care for small newborn services in district hospitals and health centers in MCSP-supported areas. Preliminary data (Figure 20) reveal positive changes in key indicators for newborn care.

Figure 19. Distribution of newborn services and deaths in Rwanda, results taken from baseline facility survey, MCSP 2016

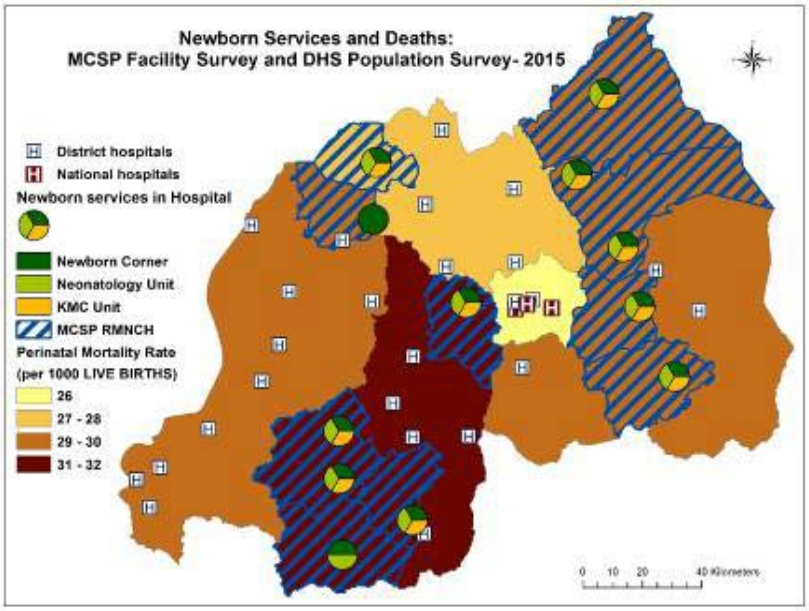
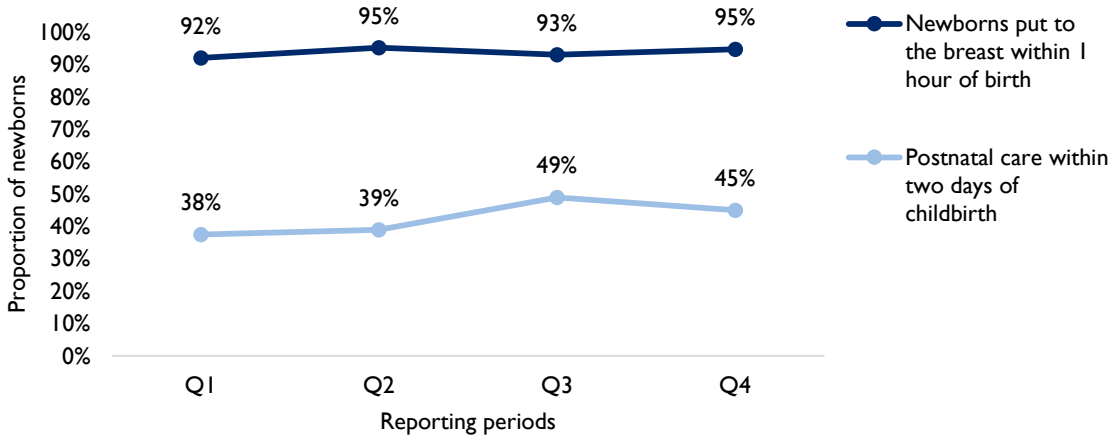
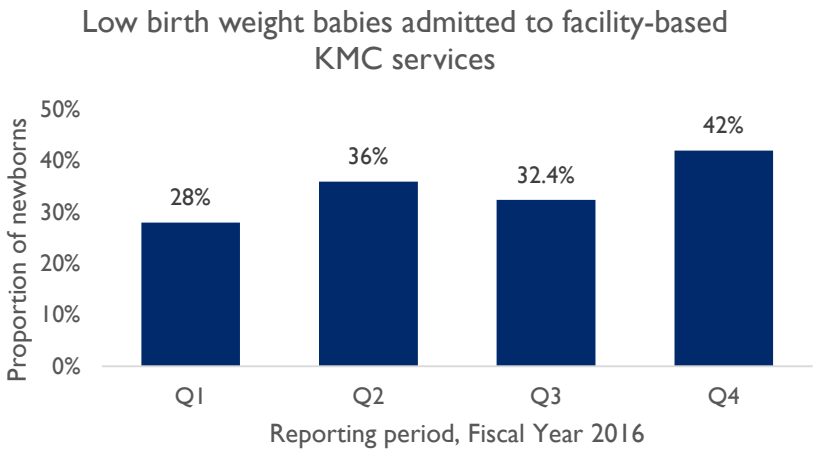


Figure 20. Trends in newborn health-related indicators in MCSP-supported areas of Rwanda for fiscal year 2016





- MCSP also expanded use of the HBS package as an approach for improving capacity of health service providers to provide essential newborn interventions.
    - In Burma, MCSP contributed to national-level discussions to support the integration of HBS into the national package for integrated management of childhood illness. This has resulted in a preliminary agreement to review existing integrated management of neonatal and childhood illnesses (IMNCI) modules and strengthen the current newborn components.
    - In Haiti, MCSP supported TOT on Helping Babies Breathe (HBB) and Essential Care for Every Baby; follow-on trainings will take place at national training centers in Mirebalais and Milot.
    - On a global level, MCSP collaborated with the American Academy of Pediatrics (AAP) and Laerdal to translate the Essential Care for Small Babies (ECSB) package into French, in response to the need for newborn health materials that can be used in francophone countries. The final version of the French ECSB curriculum should be available in early PY 3.
- MCSP worked to advance the scale-up of high-impact interventions such as CHX. In Nigeria, MCSP supported the finalization of the national CHX strategy, including an expanded monitoring and evaluation (M&E) section, and helped to establish a national mechanism for collection and review of CHX implementation data. In Liberia, MCSP supported national-level discussions with key stakeholders to inform the development of a national CHX scale-up plan.
- MCSP continued its engagement with global partners on PSBI and contributed to shaping the operationalization of the WHO PSBI guidelines. MCSP contributed to the joint statement supporting the WHO guidelines, which will support advocacy efforts with professional bodies to elicit their support for the implementation of the guidelines. Recognizing the need for coordinated discussion and decision-making around PSBI efforts, including global learning, MCSP organized a consultation with USAID, the Saving Newborn Lives (SNL) program, and other key partners to discuss the way forward on PSBI, including the identification of potential MCSP countries for implementation.
- MCSP also supported USAID to convene a consultation with key partners to more broadly discuss existing approaches and future directions for sick newborn care. Key outcomes of the meeting included establishment of a partners' forum and agreement to conduct a situation analysis to gather information on care of sick newborns, including those receiving sepsis management at health facilities. This will be a priority area for MCSP in PY3, and will serve as an opportunity to highlight management of PSBI as part of a broader approach to caring for sick newborns.
- MCSP continued its efforts to improve care of small babies through accelerating uptake of bCPAP in countries with newborn programs. At the request of USAID and the Center for Accelerating Innovation and Impact, MCSP facilitated bCPAP market assessments in two country programs (MCSP India and MCHIP Bangladesh), with a third assessment planned for Nigeria in early PY 3. These assessments aim to contribute to the design of a strategy to introduce and scale up bCPAP in both public and private health facilities in the two countries. In Nigeria, MCSP is also supporting the testing of bCPAP as an innovation to improve outcomes for preterm babies. This activity includes training of health service providers on the identification and management of eligible newborns, and will help inform scale-up of the device in the country's health facilities. To date, providers at six hospitals have been trained and are using the device.

CHILD HEALTH

In an effort to respond to new child health SDG challenges and plan for innovative strategies, limit fragmentation, and focus on a comprehensive package of child health interventions, it is important to understand the landscape of child health actors and funders at the global level. Implementing key recommendations of studies on global leadership in child health, MCSP has developed comprehensive child health service delivery programs. In PY 2, the child health portfolio of interventions and country programs

expanded, and MCSP was able to strengthen services in facilities and communities in a growing number of countries (Figure 21). MCSP also helped countries maximize resource mobilization opportunities and ensure that include measures to improve QoC. By examining country HMIS and associated DHIS 2 systems, MCSP will be able to use both primary and secondary data to identify strengths, gaps, and opportunities to improve its support to countries. As the iCCM landscape shifts from pilots to supporting countries to scale-up, there is an increased opportunity to collect new evidence, data, and experiences from others and also from the direct MCSP experiences of supporting scale up in DRC and potentially Nigeria. This knowledge can be shared through the CCM [Community Case Management] Task Force. These lessons will be fed back into MCSP country programs to promote successful and integrated community-based child health services.

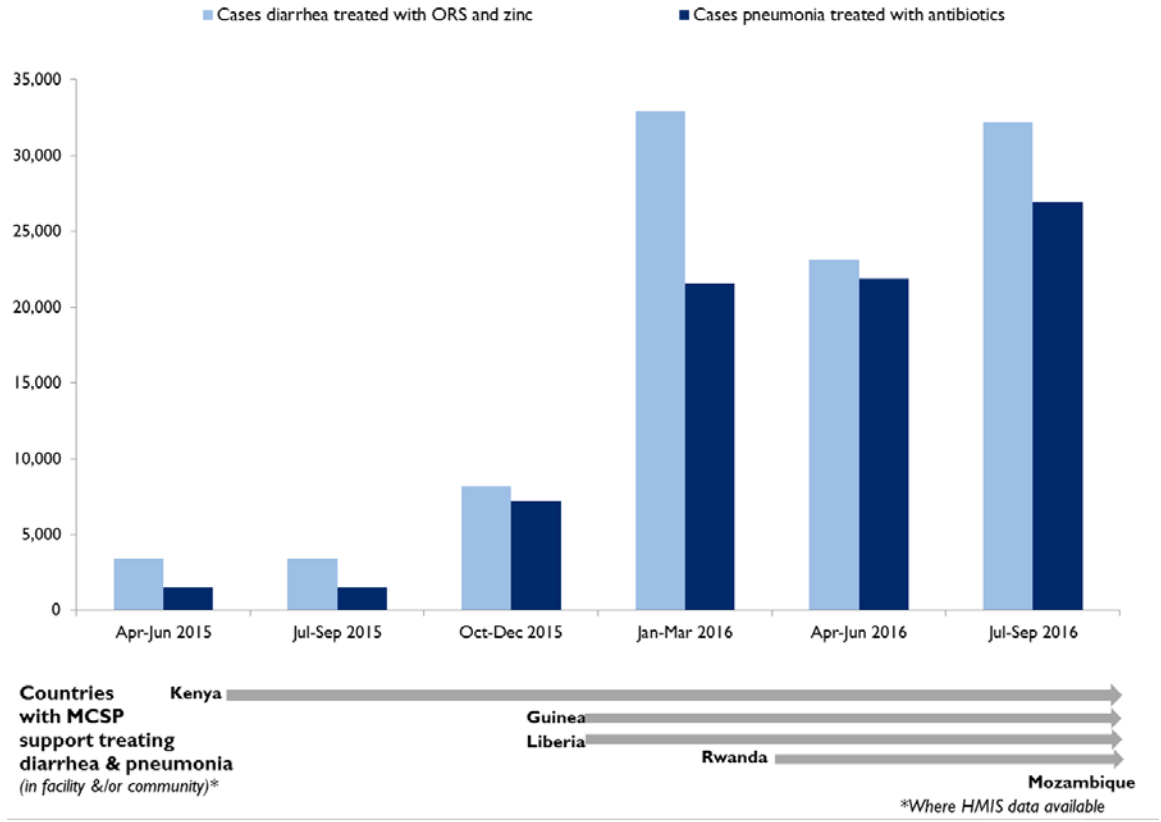
Accomplishments

- MCSP contributed to the global conversation around child health, to ensure that child health receives continued attention in the post-MDG era. To this end, MCSP participated in and contributed to the WHO meeting to guide the strategic global review of integrated management of childhood illness. Simultaneously, MCSP initiated and completed the review of global leadership in child health, in an effort to evaluate the evolution of child health since 2000 and the networks of stakeholders and leaders involved. The recommendations from the authors offer insight as how to strengthen and reposition global leadership for child health to attain better outcomes under the SDGs. MCSP worked to convene a high-level panel at the CORE Group Fall Conference to present and discuss the findings of both reports and foster discussions about how donors and implementing partners can coordinate to achieve the same vision, reduce duplication, and use a more holistic approach to child health that avoids "silos." Both reports have informed the development of USAID's forthcoming child health strategy and reinvigorated the partnership of WHO/UNICEF for child health leadership.
- MCSP documented successes and challenges encountered in applying different QI approaches to child health services. The report, *Focused Review of Successful Quality Improvement Initiatives Aimed at Compliance With Evidence-Based Practice Guidelines for Child Illness Care*, identified many successful models for improving QoC for child health and identified common elements. These include 1) frequent and sustained repetition of guidelines; 2) monitoring and feedback of performance data to providers, managers, and decision-makers; 3) provision of simplified decision-support tools that can also be used to record patient data; and 4) team-based problem-solving. Based on these findings, MCSP has taken more of a holistic view of quality, and has adopted the eight domains of WHO's QoC framework for MNH to identify areas of priority in child health to improve the provision and experience of care for children and their caregivers.
- MCSP initiated Emergency Triage Assessment and Treatment (ETAT) activities in Rwanda and Haiti. ETAT training teaches health workers to triage all sick children when they arrive at a health facility, into those with emergency signs, with priority signs, or non-urgent cases, and how to provide emergency treatment for life-threatening conditions. By revising and institutionalizing these training packages, health facility workers are able to improve the quality and efficiency of child health services they provide, decreasing the impact of delay of care and improving outcomes overall. The successes and lessons from implementation of ETAT in the MCHIP Zimbabwe program have been used to inform MCSP ETAT activities, including those of MCSP Rwanda. In PY 2, MCSP Haiti and Rwanda programs started to plan south-south collaboration, and in PY3 experienced Rwandan ETAT master trainers will conduct ETAT training in Haiti. In Burma, MCSP planned for the support to and integrated ETAT activities developed by the MOHs in collaboration with WHO and UNICEF, which combines a QI approach into a training package for the country. These country-level experiences help feed back into MCSP's overall QI work, providing new insights as to how to remove barriers to increase access of care and improve facility-level performance.
- To advance learning in data quality and collection across USAID priority and non-priority countries, MCSP conducted a review of DHIS 2 system rollout and a review of HMIS forms to inform data collection, quality, and use for child health service delivery. MCSP, with the aid of the iCCM Task Force, produced a brief detailing the status of DHIS 2 platform rollout and inclusion of community indicators in DHIS 2 in various countries. By updating this "living document" on CCMCentral.com as countries

advance in the process of rolling out DHIS 2, child health program managers can stay abreast of data collection efforts.

- Building off the DHIS 2 review work, the iCCM M&E Subgroup worked to update the iCCM indicator guide (produced under MCHIP) to shorten the list of routine iCCM indicators recommended for all implementing countries. Using this short list of indicators, and looking at HMIS registers to see which indicators are collected, MCSP remains well positioned to recommend new indicators and data points for inclusion into DHIS 2 and into the HMIS register when revisions take place, as was done through MCSP Nigeria in PY 2. By ensuring countries are collecting accurate data that paints a comprehensive picture, MCSP country programs can better identify bottlenecks and successes and be more reactive to priorities of governments and communities.

Figure 21. Number of cases of diarrhea in children under 5 treated with oral rehydration solution (ORS) and zinc, and number of cases of pneumonia in children under five treated with antibiotics in MCSP-supported areas from April 2015 to Sept 2016 * (*from MCSP MCSP-supported countries with available data)



IMMUNIZATION

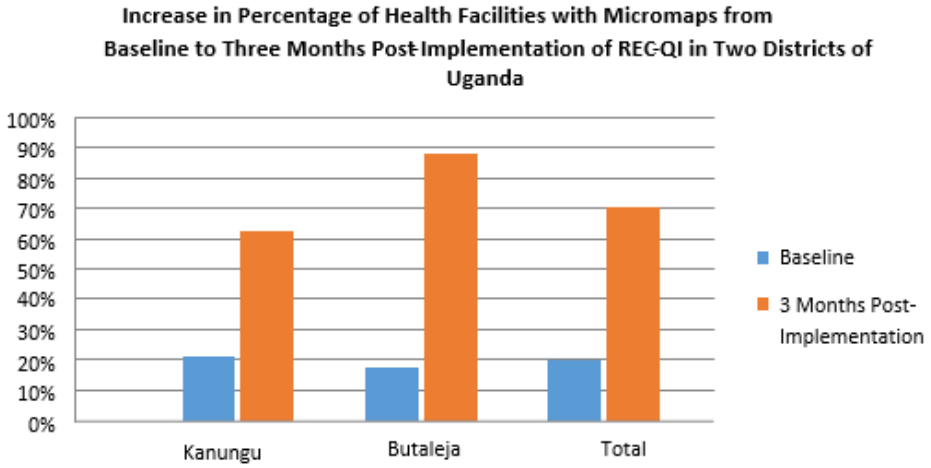
In PY 2, MCSP continued to support improvements in the quality and reach of immunization services to the world's unreached children and strengthen immunization systems through its global technical leadership and influence. MCSP also supported the introduction and rapid scale-up of new vaccines in 10 counties. MCSP continued to share country experiences around immunization to shape the global agenda on coverage and equity.

MCSP played a major role in taking the next step in the Polio Endgame strategy by being actively involved in the historic polio vaccine switch discussed earlier in the report. Moving forward into the next project year, MCSP is prepared to seize upon opportunities to increase focus on closing equity gaps and strengthening urban immunization while better coordinating its activities with those of USAID to enhance and complement the US Government's large investments in GAVI.

Accomplishments

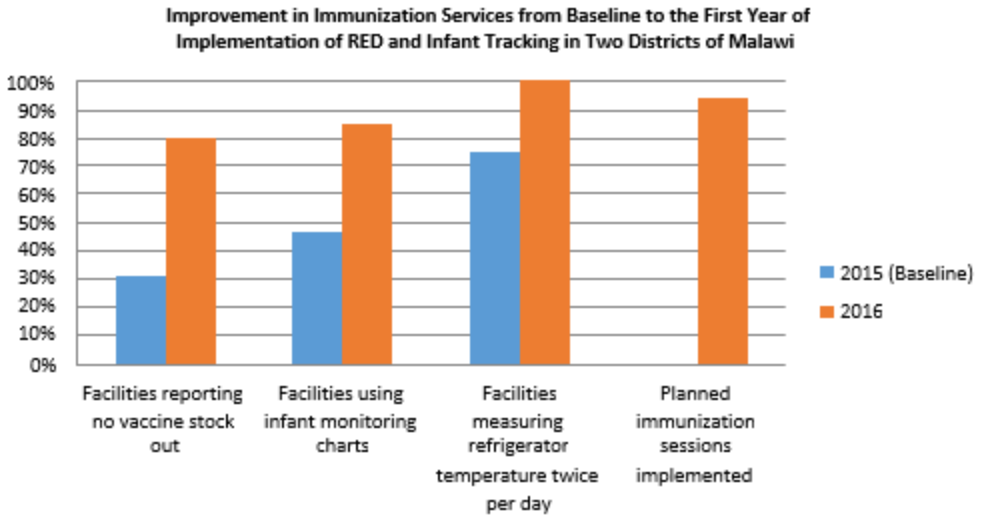
- Through its participation in WHO's Vaccine Management and Handling Working Group, MCSP contributed to the development of over a dozen effective vaccine management modules and a guideline on vaccine packaging. As a result, guidance is now available to the global community and to countries that reflects pragmatic country experiences garnered from MCSP country interventions. MCSP will help its countries implement these guidelines to ensure that the vaccines children need are available, safe, and effective.
- MCSP participated in revising the RED guide for the WHO AFRO region to include a greater focus on equity, community engagement, integration, and urban populations. Once completed, these contributions will further MCSP's goal of vaccinating every child while ensuring that children who receive vaccines also have access to other critical health services. Over the coming year, MCSP will assist its countries to adapt and implement these revisions.
- For the groundbreaking Ministerial Conference on Immunization in Africa, in which all 54 African countries participated, MCSP and UNICEF co-led the development of the ministerial brief on community involvement, contributed to four other ministerial briefs, ensured diversity and strength of civil society organization (CSO) involvement, and developed a social media toolkit. MCSP's efforts contributed substantially alongside WHO, the African Union, UNICEF, BMGF, and other partners to the passage of the Addis Declaration on Immunization. The signatories now include 80% of African countries, which have agreed to make immunization services a national priority and a cornerstone of development. MCSP is now helping WHO with the development of a roadmap to implement the Declaration and will work with its countries to further the implementation process through high-level advocacy and the involvement of CSOs.
- Through its participation in the WHO/UNICEF Global Vaccine Action Plan Vaccination Demand Working Group, MCSP helped organize and lead a Technical Partners' Meeting on Communication and Community Engagement for Immunization in New York from March 8 to 10, 2016. This meeting led to a paradigm shift in the definition of demand for immunization to recognize the combined role of individuals, the community, and decision makers in generating and sustaining demand. The strategy that will be developed based on this definition will inform the plans of MCSP, UNICEF, and other partners' field staff.
- MCSP continues to support countries' efforts to adapt the RED/REC approach. With MCSP's support, Kenya deepened its TA at subnational levels to close equity gaps that have been noted since the recent decentralization of health services to the counties. Through regular supportive supervision, training, and focused data quality assessments, more children are being reached by a strengthened county management team.
    - Mozambique rolled out the RED/REC approach and is reaching the underserved through improved service quality and integrated outreach.
    - Tanzania focused on the poorest-performing districts and made significant improvements in immunization performance. Tanzania's operation financing has also improved as a result of comprehensive council planning and budgeting supported by MCSP.
    - Two districts in Uganda began implementing an REC-QI strategy called micromapping, a participatory approach to reorganizing outreach strategies by mapping the communities in a catchment area and ensuring they all have access to an outreach site (see Figure 22).

Figure 22. Health facilities with Micromaps for REC-QI in two districts of Uganda



- Field staff shared first-hand experiences at the first-ever Exchange of Best Practices Workshop on Reaching Every District/Community, Equity and Child Survival Integration in the East and Southern Africa Region, which brought together 22 countries. MCSP strongly influenced a catalytic workshop design that incorporates adult learning methodologies not typically used by WHO. Major outcomes resulting from this collaboration with WHO and UNICEF include draft country plans for 20 countries in the East and Southern Africa region; a compilation of technical materials and publications on RED, equity, and integration now available for use; a synthesis of best practices; and a strengthened partnership with WHO and UNICEF. MCSP will continue to be involved in disseminating the lessons learned through these meetings and helping its countries stay abreast of and implement new developments in RED/REC.
- Working with partners such as WHO, UNICEF, and CDC, MCSP played a valuable role in the annual Gavi Joint Appraisals in eight countries (Nigeria, Zimbabwe, Tanzania, Kenya, Malawi, Pakistan, Madagascar, and Mozambique) and was partially involved in two countries (Uganda and Haiti). Through this joint effort by partners, these countries assessed progress, identified TA gaps and priorities, and strengthened multiyear planning. MCSP is now assisting its countries to implement the recommendations developed during their Joint Appraisals.
- Through MCSP's collaboration with other partners, 11 countries completed the historic WHO-led global polio vaccine Switch, successfully removing all trivalent supplies nationwide. MCSP's efforts resulted in effective planning, logistical, and monitoring arrangements and ensured that health care workers were trained and supervised to administer the new vaccine. The Switch represents an important next step in the global eradication of polio.
- This year, through MCSP and other partners' support, 10 countries introduced and supported the rapid scale-up of life-saving vaccines nationwide, including measles-rubella, measles second dose, inactivated poliovirus, rotavirus, and pneumococcal conjugate vaccine. MCSP country teams built on MCHIP experiences with planning, training, and supervision to ensure greater efficiency and speed in new vaccine introduction than ever before, as well as high uptake.
- This year, MCSP continued exploring its learning question around using infant tracking to improve routine immunization and other health interventions by supporting the full implementation of all five components of RED and infant tracking in two districts (368 communities) in Malawi and completing baseline data collection. The baseline data indicate that immunization coverage is high for all antigens, but that the quality of immunization is poor because the vaccines are often administered in invalid doses. MCSP is supporting the districts and health facilities in strengthening the system, so the quality improves; MCSP has started monitoring process indicators for improvement in quality. See Figure 23 for additional initial results of this study. Related to the Malawi infant tracking activity, the Nigeria RI program has proposed a learning question to determine whether engaging traditional barbers and other community resource persons can be an effective way to identify and refer newborns to RI services, with the aim of reducing left-outs and improving timeliness of vaccinations.

Figure 23. Improvements in immunization services in two districts in Malawi



FAMILY PLANNING / REPRODUCTIVE HEALTH

MCSP's strategic approach to FP centers on preventing unintended pregnancies, with a focus on pregnancies linked with poorer MNCH outcomes. To accelerate achievements toward FP2020 and EPCMD goals, MCSP's focus in PY 2 was on reaching women giving birth too soon after a prior pregnancy through the scale-up of PPFP and FP integration along the MNCH continuum of care. A second focus was to explore effective ways to provide appropriate care to adolescent mothers and their partners within MCSP programs. MCSP is also developing and testing innovative strategies to expand FP method choice, engage men, and assess the incidence of pregnancy failures as a result of concurrent use of implants and antiretroviral therapy. However, no results are yet available to report on these innovations.

Accomplishments

- The global momentum for PPFP scale-up generated at the 2015 Chiang Mai meeting continues, thanks to the continuing commitment of the PPFP Steering Committee. The focus of the steering committee work changed over time. From the start, MCSP planned key contact points at the Mexico City GMNHC and the Indonesia International Conference for Family Planning to review the countries' progress on their action plans. As MCSP passed those conference milestones, the focus of the steering committee changed to amplifying country efforts. The FP2020 team worked closely with MCSP to redesign a landing page on its website as a resource for all partners working to support PPFP scale-up in those countries. MCSP, Jhpiego, FP2020, USAID, and BMGF also developed a steering committee workplan for finding other ways to track country progress. Interactions of the committee with countries in progress and surveys helped identify key challenges- the scarcity of resources for TA for training/scaling up and demand generation; resistance from some quarters about the new Medical Eligibility Criteria; limited understanding of what PPFP is within country level stakeholders in some countries; and difficulties in measurement. Greater understanding of country needs led to an expansion of the steering committee membership and increased investment by MCSP, USAID, and others in PPFP measurement issues.
- After four months of engagement with partners with expertise in the subject, MCSP held a LAM Design Challenge to address the under-utilization and poor understanding of LAM by women and health care providers, even though LAM is an ideal transition method for women who are not ready to opt for another modern contraceptive method after birth, yet have an unmet need for spacing or limiting a future pregnancy. Seventy-four unlike-minded participants volunteered to design innovative solutions for

supporting women to practice exclusive breastfeeding and to recognize and act upon cues that they need to transition to another method of contraception before fertility returns. While the details of each proposed solution and further development of the best ideas (such as a reframing of LAM as a transition method, or the use of behavior prompts) are still to be discussed internally and with USAID, MCSP has already increased awareness of the challenges with LAM among participants. One Johns Hopkins University student said, "As someone who comes from India, I took breastfeeding for granted, but [this event] made me realize that breastfeeding is hard and women need support and attention to help them practice LAM effectively." Film footage from the event will become a promotional video to galvanize more support for LAM advocacy.

- MCSP Rwanda has a specific objective to scale up PPFP. MCHIP had introduced postpartum intrauterine devices (PPIUDs) in a few health facilities, but those were not located in current MCSP districts. The Rwanda team visited those sites and captured lessons learned from early implementation before rolling out service delivery in 4 out of 10 districts. Large-scale training of ANC, maternity, and FP staff in PPFP counseling was conducted, followed by clinical training in postpartum insertion of IUDs. Training in implants and other methods took place in parallel through an eight-week on-the-job training approach sanctioned by the MOH. The Rwanda team also collected PPFP uptake data before counseling training, in the period between counseling and PPIUD training, and finally in the period after training. Through onsite mentoring and supportive supervision that integrates PPFP support with MNH care, the team is also testing whether tracking the results of FP counseling helps with reaching high acceptance within an ongoing QI program. Figures 24 and 25 show the ability of district teams to track coverage of counseling and results of this counseling.

Figure 24. Provision of postpartum family counselling in Rwanda

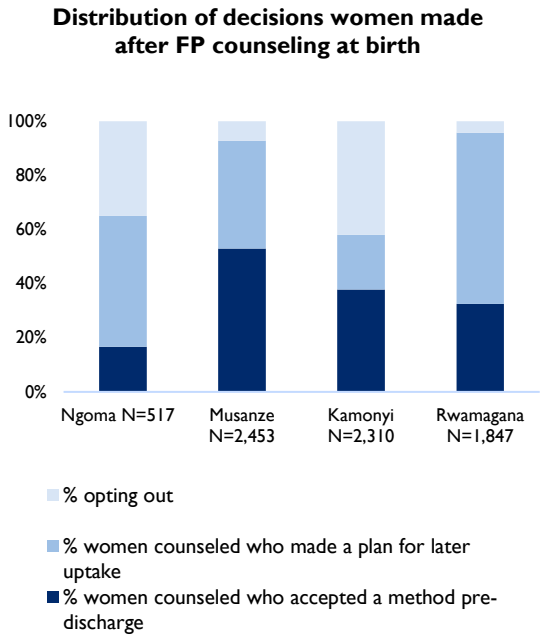
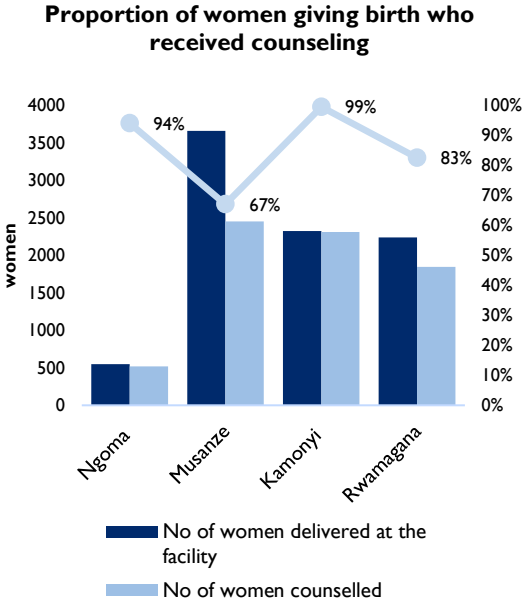


Figure 25. Uptake of postpartum family planning in Rwanda



- In Madagascar, MCSP conducted qualitative formative research for first-time and young parents. In the study's six health centers, service records showed that 16% of young people under 25 years old began using FP services following first childbirth, with 92% opting for Depo Provera. Determinants of FP use included availability of a variety of methods, availability of free or low-cost methods, and a welcoming and efficient health center. Conversely, determinants of non-use included a lack of information, fear of getting an incision for an implant, and potential side effects. The decision to space birth and use FP was most often driven by the young mother and community- and facility-based service providers, though greater support for birth spacing was associated with higher education levels of

the mother's partner. Currently, the team in Madagascar is using this information to design interventions that address the needs of adolescent first-time parents.

- MCSP mentored health care workers and management at the Liberia Government Hospital in the integration of DOB services, including PPFP and CEmONC. This onsite event included training in PPIUD and implant insertion and removal. Several women giving birth at the facility were able to receive an implant, IUD, or other method as the providers practiced their new counseling and clinical skills under the supervision of their MCSP mentors. The hospital staff also identified several gaps in their hospital's ability to provide high-quality integrated care and CEmONC, and developed action plans to address these weaknesses. For example, the hospital was able to create a warm place for newborns to be kept before joining their mothers and an area for neonatal resuscitation in their delivery room. This hybrid approach of onsite training and support to optimize the delivery of care is part of MCSP's growing experience on how to move from less efficacious group-based training to a more holistic and direct approach to capacity-building.

MALARIA

MCSP works on the global, national, and local levels to provide high-quality malaria control services to pregnant women and young children. With a focus on MiP and iCCM, MCSP continued in PY 2 to provide technical leadership to scale up high-quality malaria interventions and to improve the quality of national MiP programs. MCSP also ensures that global and national malaria strategies are harmonized to promote delivery of comprehensive care.

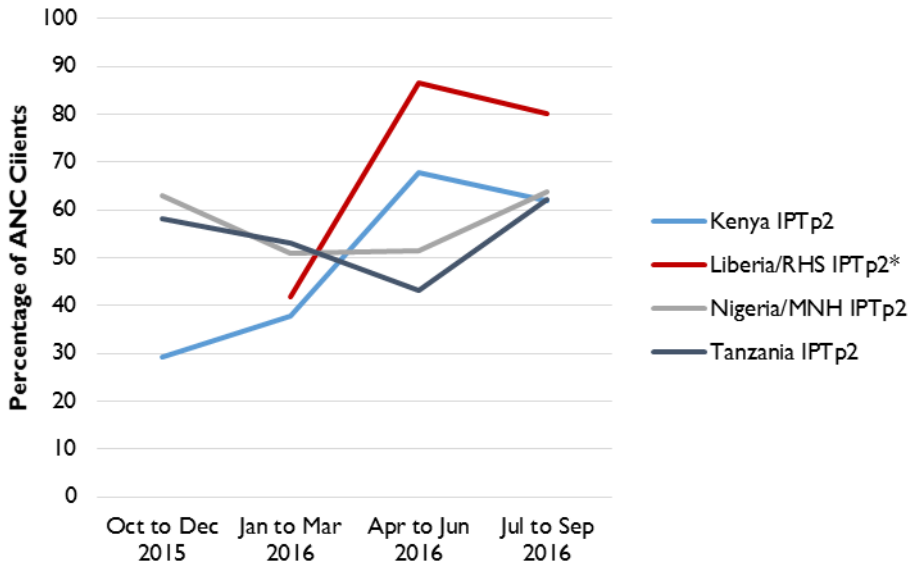
Accomplishments

- For the second year in a row, MCSP's Malaria Team Lead served as co-chair to Roll Back Malaria's MiP Working Group. Through the work of its core partners, the Working Group continued to support the linkage between global policy and country practice to accelerate MiP programming. July's annual meeting highlighted the development of new MCSP-supported MiP products and tools to improve uptake of key MiP interventions, including an MiP infographic developed by the Project with input from the Working Group. Partners disseminated new MiP research to help guide policy, and representatives from national malaria control programs (NMCPs) shared best practices to promote MiP coordination and scale-up.
- MCSP began study preparations to determine whether community delivery of IPTp-SP can fill existing gaps to reach the new IPTp coverage targets in three districts in Burkina Faso. The study protocol and tools have been developed; data collection will begin in PY 3. This study will add to the broader evidence base on the effectiveness of community-based distribution (CBD) of IPTp in different settings. The study is particularly relevant given recent recommendations from WHO on the delivery of ANC interventions at the community level.
- MCSP Burma conducted an assessment of ANC services, including MiP, in three regions. Findings show that ANC providers had low knowledge and skills about provision of high-quality ANC, and about prevention and treatment of MiP. These findings will inform PY3 efforts to sensitize the NMCP and update educational materials on ANC/MiP.
- In Kenya, 2,344 CHVs trained by MCSP registered and encouraged new pregnant women at their homes to seek ANC and begin IPTp early in the second trimester in Bungoma County. The CHVs also helped identify previously registered women who were not attending ANC and refer them to ANC for MiP services. Through the CHVs, 44,133 pregnant women were reached, contributing to a 12% increase (24% to 36%) in the proportion of pregnant women starting ANC attendance by 20 weeks of pregnancy between October 2014 and March 2016. This community-based approach is being replicated in three additional counties and will expand to other malaria-endemic counties. MCSP supported provision of MiP

interventions, including IPTp and insecticide-treated nets, through facility-based ANC services in six countries, including Tanzania, Nigeria, Liberia, Kenya, Madagascar, and Mozambique.

- Trends in IPTp2 uptake in four MCSP-supported countries improved over time despite major stock-outs of SP in two of those countries. Stock-outs of SP are an ongoing challenge to our efforts to scale up IPTp in multiple countries, including Kenya, Tanzania, and Madagascar. Tanzania has also experienced stock-outs of rapid diagnostic tests and artemisinin-based combination therapy. To help resolve the problems leading to stock-outs, MCSP played an advocacy role in both Tanzania and Kenya, encouraging counties in Kenya to procure their own SP through County Health Funds, for example. See Figure 26 for trends in IPT2 uptake among ANC clients in Kenya, Nigeria, Liberia and Tanzania.

Figure 26: Trends in IPTp2 uptake in Kenya, Liberia, Nigeria, and Tanzania



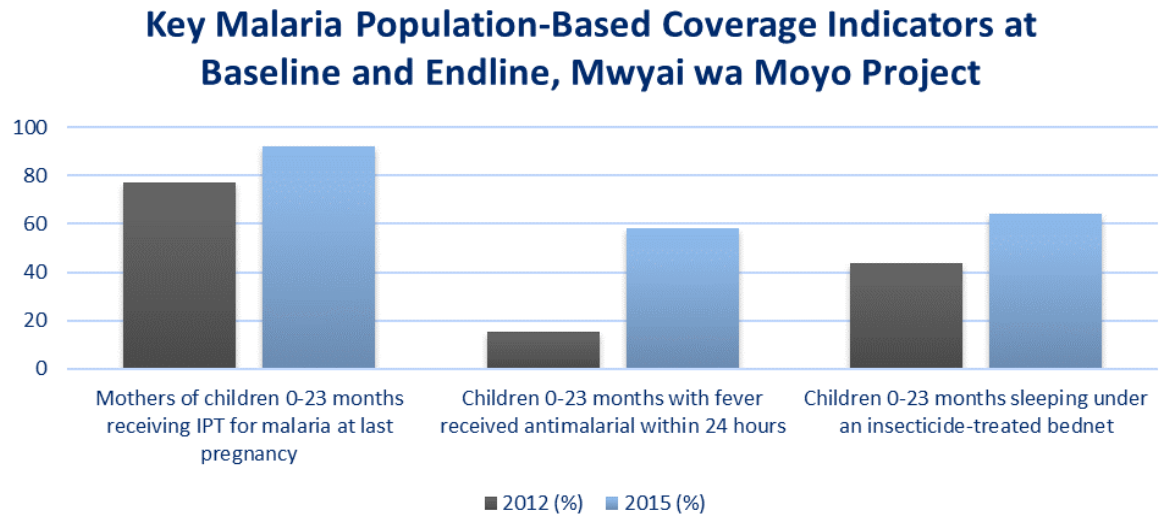
* Liberia/RHS was not implementing during October–December 2015.

- MCSP Ghana, PMI, and Leti Arts collaborated to create an interactive malaria story app called Hello Nurse. This mobile platform learning tool for case management and malaria prevention is rolling out as a supplement to classroom learning at 38 midwifery schools and 12 community health nursing schools by the end of 2017. The purpose of the app is to increase the retention and application of key aspects of malaria interventions.
- MCSP disseminated the findings from the five finalized Global Fund (GF) New Funding Model (NFM) Concept Note Review reports prepared by MCSP. These reports document experience negotiating the inclusion of iCCM into the GF NFM concept note for malaria in five USAID-supported countries (Ghana, Kenya, Uganda, Nigeria, and Zambia) that applied for NFM funding. The reports, which offered insight on strategies to promote collaboration to more efficiently scale up iCCM, were shared with relevant fora (global and in-country) to inform future resource mobilization efforts. For example, in Uganda, MCSP shared the report with a joint mission team from the GF, United Nations Population Fund (UNFPA), UNICEF, and CCM financing task team in November, as well as the CCM TWG. Relevant stakeholders acknowledged that a funding opportunity for iCCM had been lost and plan to be more prepared for future resource mobilization opportunities in the future.
- MCSP represented the iCCM Task Force leadership at the UNICEF-convened Regional Meeting on Scaling Up iCCM in Nairobi in February. The meeting offered an opportunity to participate in country planning sessions to identify gaps in programs and needs for TA, and to support scale-up of iCCM in conjunction with the Financing Task Team. The meeting also provided an opportunity to connect with child health program managers, particularly in countries where MCSP does not have MCSP offices to build the working relationships necessary to coordinate through the iCCM Task Force. This network of

child health managers has provided country-specific iCCM information to update the CCMCentral.com country webpages.

- A total of seven Child Survival and Health Grants Program (CSHGP) grantees with malaria interventions received support for one or more of the following: writing operations research reports and briefs, developing final evaluation briefs, and participating in an MCSP-led workshop on developing theories of change. In addition, one grantee with 100% focus on malaria received support for submission of an abstract to the American Society of Tropical Medicine and Hygiene, which was accepted as a poster presentation ("Effectiveness of Social & Behavior Change Communication and Repair Kits on Long-Lasting Insecticide-treated Bed Nets in Benin"). In response to a special request from USAID, MCSP provided TA to Humana People to People Congo, a new Integrating Community Health grantee, to develop a theory of change and an M&E framework supporting CHW programming in different technical areas, including malaria. Please see the Community Health section for additional information on TA to CSHGP grantees.

Figure 27: Key malaria indicators from a household KPC survey at baseline and endline from the Mwyai wa Moyo Project implemented by Save the Children in Blantyre District, Malawi (Data obtained from Final Evaluation Report, to which MCSP provided TA; All with significant increase over baseline)



NUTRITION

Child malnutrition contributes to 45% of child deaths. MCSP works to support evidence-based intervention approaches to prevent and reduce malnutrition in the first 1,000 days of life— during pregnancy through 2 years of age—by integrating nutrition into RMNCH platforms. MCSP focuses on three programmatic areas to prevent child and maternal malnutrition:

- Improving infant and young child feeding (IYCF) practices, especially supporting MCSP countries to remove barriers to exclusive breastfeeding and scale-up of baby-friendly initiatives.
- Improving maternal diet to address barriers to adequate diet during pregnancy and lactation.
- Integrating approaches to address maternal anemia, an underlying cause of maternal death.

MCSP also works to integrate nutrition into other health areas, such as maternal and child health and FP, which is a critical yet often overlooked element of global nutrition programming. MCSP continues to promote and update the Anemia Prevention and Control Toolkit—developed under MCHIP—with the latest evidence

on the prevalence, causes, and consequences of anemia. MCSP also promotes guidance on how to design and monitor anemia programs, through the lens of an integrated package (i.e., iron-folic acid [IFA] supplementation, anti-malarials, and deworming) and consideration of multisectoral approaches. Under MCSP, the nutrition portfolio has more than doubled in country presence and activities since 2014, and field funds for country programs are in line with MCSP's strategic approach for nutrition. MCSP identified gaps in current programming to address barriers to exclusive breastfeeding, maternal diet, junk food consumption and CBD of IFA supplementation by reviewing literature and experience about effective approaches, which will be applied to the "how" of country-level programming in PY 3.

Accomplishments

- In PY 2, MCSP showcased global and country-level experiences through key conferences and fora, such as the USAID Breastfeeding Symposium, the Fall and Spring CORE Group Global Health Practitioner Conferences, and the GMNHC, primarily on country experiences addressing barriers to exclusive breastfeeding, MCSP experience on baby-friendly community initiatives (BFCIs), best practices for anemia prevention and control, and integration of nutrition into FP.
- MCSP co-led the CORE Group Nutrition Working Group, with Action Against Hunger and International Medical Corps, which included developing the workplan and sharing what MCSP Nutrition has learned at two CORE Group conferences. This provided continuity of leadership over the past several years.
- MCSP provided technical leadership on formative research to inform programming on IYCF, integration of LAM and PPFP, and active engagement with the MIYCN-FP (Maternal, Infant, and Young Child Nutrition and Family Planning) TWG, in partnership with the Family Planning team.
- MCSP worked with DRC, Egypt, Haiti, Ghana, Guatemala, Kenya, Malawi, Mozambique, Pakistan (under MCHIP), and Tanzania for integrated nutrition activities to strengthen and build capacity at the facility and community levels in the RMNCH platform. The team supported evidence-based intervention approaches for facility- and community-level development and/or adaptation of guidelines, training curriculums, program tools, and formative research—such as integration of LAM, IYCF, and PPFP in Tanzania—that will yield valuable insights on program design and "the how" of program implementation for nutrition integration into the RMNCH platform.
- MCSP has initiated formative work in DRC on integration of nutrition into iCCM for the first time in-country. MCSP also began engagement on the nutrition subgroup of the iCCM Task Force, which brought renewed attention to the prevention of malnutrition and to strengthening of IYCF practices, which, to date, had only focused upon treatment of acute malnutrition within emergency contexts.
- MCSP advanced work on implementation of baby-friendly initiatives to improve IYCF practices in Kenya and Malawi, from guideline development to capacity-building and rollout. In Kenya, MCSP—in collaboration with the MOH and UNICEF—led the finalization of first-ever, national-level BFCI Implementation Guidelines, BFCI M&E tools, and the IYCF counseling package, which guides implementation of BFCI for the country. In PY 3, MCSP Kenya will roll out training and monitoring of BFCI in MCSP focus areas, which include documentation of improvements in IYCF practices. In Malawi—in collaboration with MCSP and MOH—MCSP updated the WHO Baby Friendly Hospital initiative (BFHI) 20-hour course, and existing behavior change communication materials – such as BFHI job aids and tools – to include the latest guidance on nutrition and HIV in partnership with BFHI master trainers. In the coming year, MCSP will work to improve implementation and exclusive breastfeeding practices in selected hospitals and center of excellence.
- In Haiti, MCSP is developing counseling materials (e.g. job aids, counseling cards, and checklists) to address barriers to exclusive breastfeeding, following the completion of prior formative work, with finalization in early PY 3.
- In Kenya and Haiti, MCSP is developing materials based on formative work to improve counseling on maternal anemia, especially on misperceptions of the side effects of IFA supplementation. These counseling materials will be used in TOT and for capacity-building for facility- and community-level providers to improve nutrition counseling in these areas, which remain weak.

- MCSP completed three draft review articles and three draft technical briefs. These publications address three of four learning priorities for MCSP Nutrition: 1) examining barriers to exclusive breastfeeding to improve IYCF practices, 2) addressing barriers to maternal nutrition, and 3) documenting experiences with CBD of IFA supplements. Landscape interviews with nutritionists in seven EPCMD countries took place to assess policies and programs to address major barriers to adequate food intake during pregnancy and to exclusive breastfeeding, effective implementation of CBD of IFA supplementation, and factors influencing junk food consumption by children under 5. Findings from these publications and interviews will be integrated into trainings and SBCC in-country programming for PY 3.
- MCSP finalized and disseminated a technical brief, "Junk Food is a Feeding Problem among Infants and Young Children: Evidence and Program Implications for Low and Middle Income Countries." The brief addresses prevalence of and factors related to junk food consumption in children under 2 years old and relevant policies in EPCMD and Feed the Future priority countries. Findings from the technical brief will be integrated into trainings and/or SBCC for IYCF in-country (Egypt) in PY 3.
- MCSP completed a review of at least 25 country policies in EPCMD and Feed the Future priority countries for all four learning priorities and incorporated it into the four technical briefs to provide context on progress in countries to address barriers to maternal nutrition, IYCF, junk food consumption among infants and young children, and CBD of IFA.

Water, Sanitation, and Hygiene

MCSP's WASH programming focuses on USAID's vision to make WASH a normative part of MNCH for EPCMD. In PY 2, MCSP's WASH work developed and piloted a platform for WASH programs in health facilities, accelerated infection prevention and control improvements in countries affected by Ebola, supported community sanitation efforts, and contributed to global learning around opportunities for integration of WASH and MNCH programming.

Accomplishments

- In Haiti, MCSP continued to implement and monitor its pilot WASH activities in health care facilities (the Clean Clinic Approach, or CCA). Initial results were promising; after the second inspection visit to 10 health facilities, average WASH scores increased by 13%. The intervention has now been rolled out to 21 health facilities in the Northern region. Learning from implementation at these facilities will be critical to inform the effectiveness of CCA and determine how to scale it across additional districts in Haiti.
- MCSP also supported a national sensitization workshop on the CCA in Haiti, which included participants from WHO, the MOH, and NGO partners.
- In DRC, MCSP supported a rapid assessment for 10 WASH programs in health care facilities. Results from the assessment are captured in Table 3.

Table 3. Results from a rapid health facility assessment in DRC

Indicator	Number of facilities
Water point on grounds	8
Functional water point on grounds	1
Soap for handwashing	4
Staff dedicated for cleaning latrines	3
Sufficient waste management facilities	1
Products for disinfecting surfaces	3

Indicator	Number of facilities
Surfaces that were visibly clean	2
Materials for hygiene promotion	1

Following the assessment, an initial 10 health facilities were selected to pilot implementation of the CCA in PY 3.

- MCSP completed a multi-sectoral (including WASH, Nutrition, and Child Health) assessment on implementation of oral rehydration therapy (ORT)/Zinc corners in Kenya. Results from the assessment demonstrated mixed success of the corners' application. While most facilities had functional ORT/Zinc corners, the extent to which ORT corners are used and the quality of care and counseling varied widely.
- Following cancellation of the newborn handwashing study in Kenya in the first half of PY 2, the team developed a new study design to focus on improved hygiene practices around the period of birth. The study will be carried out in Nigeria, with implementation due to start in Q1 of PY 3. This study will complement existing DOB activities in Nigeria focused on strengthening the delivery of integrated, routine, and high-impact interventions before, after, and during the labor period. Findings from this study inform the design and integration of a hygiene behavior change package into the DOB platform in Nigeria and elsewhere.

MEASUREMENT, MONITORING, EVALUATION, AND LEARNING

MCSP has advanced its measurement, monitoring, evaluation, and learning priorities for PY 2, including:

- Providing global leadership for improved metrics, tools, and methodologies.
- Strengthening country-level measurement of coverage, quality, and equity.
- Strengthening country-level data collection, visualization, and use.
- Supporting country-level information for program planning, performance monitoring, and accountability.
- Supporting action-oriented learning to improve RMNCH outcomes.
- Supporting scale-up of prioritized high-impact interventions and introduction of promising innovations.

MCSP has continued to promote strategies to drive the use of key RMNCH information for management, accountability, and learning. Efforts included ensuring that countries measure the most useful, valid, and feasible data (i.e., indicator testing activities); determining if countries record and report recommended RMNCH measures (i.e., HMIS reviews); and promoting use of routine RMNCH data for management and accountability (i.e., data use resource package). Learning activities also continue to follow the strategy of focusing on "short loop" and practical learning aimed at improving implementation practices to drive high coverage, quality, and equity for high-impact interventions. Even though MCSP has only reached its midpoint, 20% of planned learning activities are already at the analysis or dissemination stage, as described in more detail below.

Accomplishments

- MCSP, through its participation in the ENAP and EPMM metrics working groups, contributed to the design of the joint ENAP and EPMM MNH indicator testing study, including the development of the study protocol and data collection tools. This multi-country study, co-led by WHO and the London School of Hygiene and Tropical Medicine, will assess the validity of proposed new indicators for collection through national health information systems (HISs). The study is being implemented in Tanzania, Bangladesh, and Nepal. MCSP Tanzania was invited to join the country-level Technical Advisory Group for the study as well. Results from this study will inform WHO guidance to countries on monitoring national progress toward SDG goals.

- MCSP contributed to the workplan development of two of the working groups of the Health Data Collaborative (HDC). The HDC is a joint initiative of WHO, the World Bank, and USAID to improve country capacity to measure progress on the SDGs. MCSP has joined two working groups, the community HIS (a sub-group of the facility and community information system group) and digital health and interoperability. The groups will discuss results of key MCSP efforts, including the HMIS review and the Visualizing and Using Routine RMNCH Data at Health Facilities Resource Package. By participating in these working groups, MCSP aims to influence the design, adoption, and strengthening of routine and non-routine data and measurement systems at the country level, and will expand the program's reach to additional countries beyond those directly supported by MCSP.
- MCSP continues contributing emerging lessons from its ongoing learning as well as learning from others about best practices for an "intermediary organization" that can help MOHs effectively scale up. These include leadership and partnership development approaches, streamlined scale readiness assessments, strategic and operational planning for scale, and "light touch" scale-monitoring approaches. MCSP contributed to the development of several global materials on scale-up through participation in COPs and key technical meetings:
    - MCSP contributed feedback to the USAID Center for Accelerating Innovation and Impact's "Ready, Set, Launch" country-level product launch planning guide to advise on best practices for the scale-up process focusing on product-focused interventions. Innovators and implementing agencies are the primary audiences for the guide, but MCSP has advised that the audience also include MOH decision makers.
    - MCSP contributed to a position paper and TWG meeting, "Empty Scale Up," convened by SNL in May. Next steps include engaging global stakeholders to present the results and develop consensus recommendations on practice improvement.
- The CCM Taskforce M&E sub-group, with MCSP support, identified 10 key indicators to monitor CCM implementation and drafted guidance sheets for each indicator. The reference sheets will inform discussions about generic iCCM indicators for DHIS 2 under the HDC community sub-group.
- MCSP increased the use of routine RMNCH data for decision-making in multiple countries and created a new global training and supervision resource package on data use for decision-making in low-resource settings. The Tanzania, Rwanda, Madagascar, and Nigeria programs strengthened the capacities of providers and supervisors to analyze, visualize, and use data in daily work, aided in many cases by reusable health facility wall charts to track trends for priority indicators and by a geographic information system (GIS) mapping capacity-building workshop in Rwanda. In Tanzania, Rwanda, and Madagascar, facility staff are routinely updating wall charts with data visualizations using service delivery data and discussing the data during meetings of staff in facilities implementing QI interventions with MCSP support.
- MCSP developed a comprehensive Routine RMNCH Data Use resource package that includes a facilitator manual, participant manual, and multiple job aids for use by providers and supervisors. The resource package is targeted primarily at health facility-based providers and district level supervisors and is intended to promote use of RMNCH service delivery data at the point of care.
- MCSP advanced plans for feasibility and validity testing of selected RMNCH indicators, including indicators from ENAP, EPMM, and WHO MNH QoC framework lists. As part of ongoing program implementation in Nigeria, Madagascar, Tanzania, and DRC, MCSP has incorporated RMNCH indicator feasibility testing plans. MCSP developed and shared a study protocol and tools with external stakeholders, and countries have incorporated testing activities into their workplans for fiscal year 2017. MCSP initiated the Facility Perinatal Mortality indicator testing study, which focuses on testing both feasibility and validity, in Tanzania. This new indicator has the potential to serve as a sentinel measure of the quality of intrapartum care. Many both within and outside Tanzania have expressed interest in how this indicator performs with respect to quality of data, acceptability to providers, and feasibility of incorporating it into the national HMIS.
- MCSP completed a preliminary review of the MNH-related data elements in national HMISs (including client cards, registers, and monthly summary reports) for 24 of 25 EPCMD countries. An analysis is also

in progress for child health; this HMIS review includes 23 EPCMD[2] countries. Both reviews are expected to advance global and country understanding of which of the new WHO-recommended routine RMNCH indicators EPCMD countries are currently able to calculate. A preliminary analysis of PPH-related data elements from the MNH HMIS review was shared at the meeting, "Bending the Curve on Postpartum Hemorrhage (PPH) Mortality: Taking Stock and Moving Forward," organized by MCSP (see Box 5). The meeting focused on implementation gains and outstanding needs for effective PPH programming in low-resource settings, including priorities for a PPH implementation-focused TWG.

Box 5. Summary results from preliminary analysis of PPH-related data elements from the MNH HMIS review

MCSP found variability in data capturing for active management of the third stage of labor, use of uterotonics to prevent PPH, PPH diagnosis and management, and PPH case fatality. MCSP found that in five countries, health facility maternity registers have a column to record data on provision of a uterotonic immediately after birth to prevent PPH. Country HMIS systems do not systematically capture PPH diagnosis and management, and of those with recorded diagnosis, forms do not capture PPH management in all countries. Only three country HMIS registers can report on maternal death due to PPH.

- MCSP took a national leadership role in working with MOHs to improve information system architecture and interoperability in Tanzania and Namibia. MCSP supported development of national digital HIS architecture and interoperability in both countries to increase the availability and timely use of routine maternal and child health data to improve the QoC and health outcomes. MCSP contributed to the development of a master facility registry in Namibia and helped outline requirements for interoperability and electronic registries in Tanzania, which were agreed upon by the MOH and partners.
- Health informatics support led to the creation of mobile versions of the KPC household data collection tools and QoC health facility assessment study tools for deployment in Tanzania and Nigeria, respectively. MCSP created tools in the user-friendly CommCare mobile application for use with smartphones and tablet computers, and now generic versions of the XML forms are being prepared for public distribution. These mobile applications, which enable built-in data quality control checks and real-time tracking of data collection, have already allowed for streamlined data collection and cleaning and have the potential to improve data quality. MCSP will revise and make available these country-specific mobile applications as part of the KPC and QoC assessment packages that are intended for use by other RMNCH stakeholders.
- MCSP made substantial progress across the program on action-oriented learning. Approximately 20% of learning activities have completed data collection and begun data analysis and/or dissemination of results. Refer to Annex C for a summary of progress on MCSP action-oriented learning. Additionally, preliminary results of learning activities and a description of how MCSP used results to inform programming are highlighted in the technical area and country summary sections of this report. As an example of one of the ways that learning is being disseminated and used, please see Box 6.

Box 6. Using learning results to strengthen local health systems in Tanzania

MCSP Tanzania conducted implementation research on how Comprehensive Council Health Plan planning and budgeting guidelines are applied for health programming in immunization. MCSP found that through the introduction and facilitated use of a REC microplanning tool, 100% of immunization funding needs were reflected in the intervention district's plan, while only 75% of the immunization funding needs were reflected in the comparison district's plan. Based on the dissemination and uptake plan for this learning activity, the MCSP team is working in PY 3 with MOH to use the tool in other councils in Kagera and adapt it for use in focus councils in Tabora, Simiyu, Tanga, and Mtwara. MCSP will disseminate findings and collaborate with stakeholders to develop concrete recommendations for improving the Comprehensive Council Health Plan process for immunization and for other high-impact RMNCH interventions.

[2] The team has excluded Yemen and South Sudan because of difficulties in getting the forms for review due to conflict. MCSP also has included two additional (non-EPCMD) countries–Guatemala and Namibia—in the review to inform MCSP's work in these countries.

HEALTH SYSTEMS STRENGTHENING

MCSP aims to help countries achieve and sustain equitable coverage of high-quality, evidence-based, high-impact RMNCH interventions by applying a health systems strengthening and equity (HSS/E) lens across MCSP's work. This approach includes developing methodologies and strategies to address HS challenges that affect delivery of priority interventions, documenting and promoting program design that reduces health inequities, and, where appropriate, conducting financial analysis to support planning and resource mobilization. MCSP ensures that HS considerations are part of MCSP country program approaches. MCSP also builds the capacity of district managers and MCSP staff to more effectively address HS issues that are barriers to improving services.

Accomplishments

- Building on application in Tanzania and Rwanda in PY 1, MCSP conducted the Rapid Health Systems Assessment (RHSA) tool in four regions of Guinea to gather key subnational data and identify key challenges on HS functioning. Data analysis and synthesis are complete and MCSP will present final RHSA results to the MOH and other partners in Q1 of PY 3. MOH stakeholders are eager to use RHSA results in regional-level Comprehensive Approach to health systems management workshops to facilitate the district health teams' planning process. Each district will 1) prioritize key HS challenges based on local needs and context, 2) develop action plans with M&E metrics, and 3) identify existing resources to support their HSS efforts. Districts will develop their own plans to strengthen implementation of priority activities, with MCSP support.
- The MCSP team completed a final review of Ghana's Community-Based Health Planning and Services (CHPS) cost data, developed cost and revenue estimates, and continued to improve the CHPS Planning Tool so districts can project investment and annual operating costs. MCSP presented results to key national and sub-national stakeholders at the National CHPS Forum in Ghana PY 2. The information was well received and has important implications for the work of national-level MOH strategic planning and district-level planning in PY 3. See Box 7.

Box 7. Realizing significant gains toward achieving universal health coverage—Ghana
MCSP is supported the Ghana Health Service (GHS) with cost estimates for Community-Based Health Planning and Services (CHPS) implementation to inform national scale-up. The GHS will include these cost estimates and information about the CHPS Planning Tool, which is supported by MCSP, in the National Implementation Guidelines. Training materials for the Planning Tool will also be developed, and regions will be trained to use the Planning Tool. CHPS is an important GHS health system reform that seeks to reduce maternal and child mortality by shifting health services from facility-based to community-based delivery.

- MCSP applied the Comprehensive Approach to Health Systems Management (abbreviated MTUMA from the original, *Mbinu Timilifu kwa Usimamizi wa Mifumo ya Afya*) in Tanzania. In April 2016, MCSP conducted participatory MTUMA workshops in Mara and Kagera regions to develop tailored, district-level plans for addressing HSS issues in four priority areas: 1) supply chain and reaching the "last mile" with RMNCH commodities, 2) safe blood supply for CEmONC services, 3) improving referrals from community to facilities, and 4) health financing, including increasing Community Health Fund enrollment. After the workshops, Council Health Management Teams implemented MTUMA plans with MCSP staff through the second half of PY 2 and will conclude by the end of December. Preliminary findings from two quarters of monitoring show that districts have seen the most consistent, measurable progress in the areas of blood supply and commodity procurement. MCSP with the CHMTs will conduct the MTUMA process assessment in PY 3, and document key results as a final case study.
- MCSP HSS/E HCD efforts focused on innovative, evidence-based approaches to individual and team learning, with the ultimate objective of maximizing delivery of high-impact RMNCH essential services.

Two key materials were completed to guide countries to improve local efforts: operational guidance for in-service clinical training and the cross-cutting technical brief for HCD. These tools reflect global evidence on HCD and practical experience from MCSP programs. For example, MCSP in Liberia used a facility-based integrated training approach to strengthen CEmONC and PPFP skills to address gaps identified by the use of QI standards. In Rwanda, MCSP used a facility-based mentoring approach to provide frequent RMNCH training of ENC/HBB skills. Refer to Objective 1 for more details on MCSP's work in HCD.

Gender

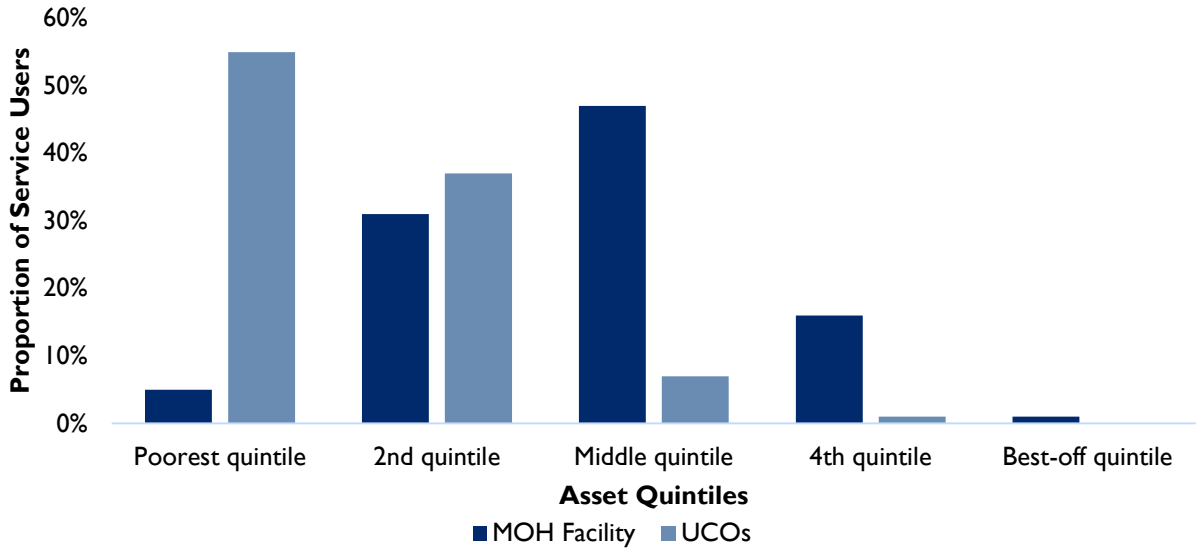
Overall, MCSP is addressing gender in 12 country programs and can report several achievements:

- MCSP launched the Gender Analysis Toolkit for Health System; developed a gender module for the KPC Survey currently being implemented in Mozambique and Tanzania; finalized and implemented the Gender Service Delivery Standards in Mozambique, Nigeria, Rwanda, and Tanzania; and implemented the Health Workers for Change curriculum on gender sensitivity and respectful care in Nigeria and Tanzania. Use of the Tanzania curriculum built the capacity of 868 CHWs, 23 MCSP staff, staff from 8 CSOs, and 21 midwifery mentors on basic/comprehensive emergency obstetric and newborn care to become champions on gender and RMC. In Nigeria, MCSP trained 85 service providers in Kogi and Ebonyi states on gender-sensitive service delivery, integrating gender into pre-service education quality assurance standards.
- MCSP worked to transform harmful gender norms that inhibit access to RMNCH information and services through community engagement, particularly with adolescents and men, in Mozambique, Pakistan, Rwanda, and Tanzania. In Rwanda, MCSP helped implement a subaward to a male engagement organization to address harmful gender norms, prevent gender-based violence (GBV), increase linkages to services, and engage couples. In Tanzania, MCSP built the capacity of CHWs on gender, who then formed 137 community dialogue groups in Mara and Kagera; 1,891 women and 1,517 men participated in the groups, with over half graduating. MCSP integrated gender SBCC messaging into the groups on FP, women's decision making, and male engagement in caregiving. There have been several positive outcomes: 91% of men who participated in gender dialogues are willing to educate others in community meetings and churches, and the number of men who accompany their wives for ANC in Mara and Kagera has increased substantially, as has the number of community members wishing to participate in the dialogues.
- MCSP adapted, refined, and began implementing GBV Quality Assurance Standards in Guinea, Haiti, Madagascar, and Rwanda to strengthen and ensure the quality of post-GBV services in health facilities. In Ghana, MCSP developed and featured a GBV E-Learning Module on the MOH's website. At the community level, MCSP supported GBV awareness raising, prevention, and linkages to care through dialogues with community groups, couples, and men in Guinea, Haiti, and Rwanda.

Equity

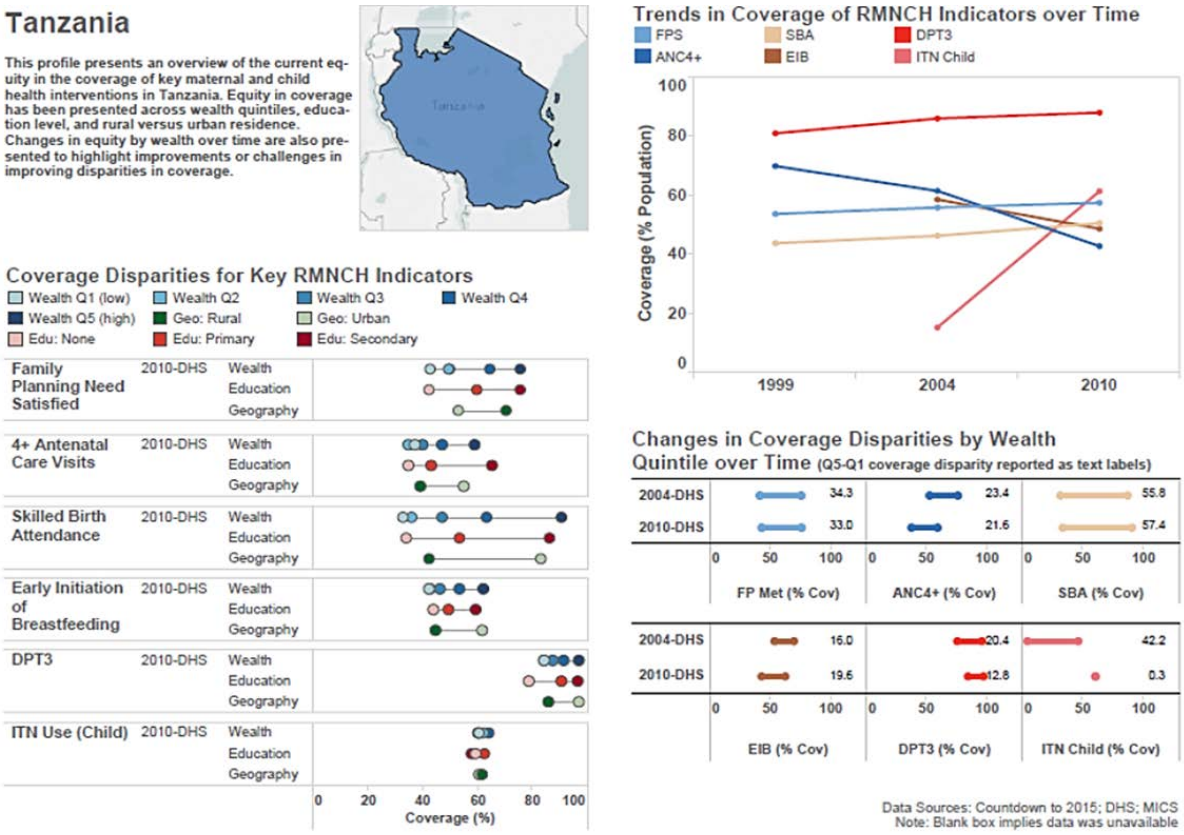
- MCSP prepared two case studies that document pro-equity program experiences in Honduras and Bangladesh to share approaches that led to improvements in equity of service utilization. MCSP country programs can incorporate some of these pro-equity strategies in their country-level programming to reach the most vulnerable populations. For example, in Uganda, MCSP is implementing community microplanning to identify the access barriers for hard-to-reach populations and actively monitoring to ensure that all communities are reached at least once per quarter with services, through RED/REC. The experience of ChildFund Honduras (funded through the USAID CSHGP) highlights how bringing high-quality, cost-effective interventions to rural, poverty-stricken populations increased access to MNCH services. The program established Community Health Units and, through an analysis with the socioeconomic status tool, determined that 55% of Community Health Unit clients were from the lowest socioeconomic quintile (see Figure 28 below).

Figure 28. ChildFund Honduras: Beneficiary wealth quintiles



- In Bangladesh, the MaMoni Health Systems Strengthening Project identified socioeconomic, geographic, and gender inequities as key challenges for utilization of RMNCH services. The MaMoni HSS case study highlighted local efforts such as community mapping, bringing services closer to the beneficiaries, and reducing financial costs associated with RMNCH services as innovative ways of improving health equity. Examples of pro-equity interventions implemented by MaMoni HSS include:
  - Reorganizing government satellite clinics and other counseling activities on Sundays and at the community level so that vulnerable populations could easily access services.
  - Training a private cadre of community-based skilled birth attendants and linking them to union councils to jointly determine how much private providers can charge for services and identify the poorest women who would receive free services.
  - Deploying water ambulances for emergency transport and referral.
  - Training women commodity sellers who sell contraceptives and linking them to supply chains for income generation.

Figure 29. Profile of the equity of key maternal and child health interventions in Tanzania



- MCSP completed an interactive dashboard that explores trends in the equity in coverage of key RMNCH interventions in MCSP countries across various parameters. The team presented a synthesis of broader trends in coverage disparities across MCSP countries. MCSP country teams used individual country profiles during the May 2016 technical meetings to develop strategies and activities that improve equity in the PY 3 workplans. MCSP is exploring how to make the outputs of this dashboard publicly available through the MCSP website.
- The MCSP team supported the Government of Burma to use 2014 Census data to create and share wealth indices and quintiles at various geographical levels on the government website. This enables implementers of MNCH activities in Burma to easily assess if their interventions are pro-poor. MCSP constructed a "simplified" version of the wealth index and will soon allow the use of the EquityTool, a mobile application that makes data collection and analysis of an individual's wealth quintile extremely user-friendly.
- Please also refer to Objective 1 for additional details on MCSP's work in health systems strengthening and equity.

COMMUNITY HEALTH

MCSP's mission is to promote the institutionalization of community health as a central component of country health systems by equipping national efforts with tools and strategies that support the development of viable and integrated community health platforms. The CHP is a central MCSP approach to institutionalizing community health, seeking to provide a common direction that also respects program differences. The intention of the MCSP approach is to offer all programs a progressive process built on what has already been achieved in each country.

This is consistent with USAID's Community Health Framework and contributes to progress in EPCMD. More specifically, MCSP aims to improve the balance of health promotion, prevention, and curative service delivery; support community health workforce linkages to communities and to health systems; cultivate stronger partnerships between government and civil society; and promote use of local information to inform learning and adaptation in response to implementation challenges.

Accomplishments

- MCSP has led and participated in global coalitions, networks, and conferences to advance community health and civil society engagement (CH/CSE):
    - During PY 2, MCSP contributed to three separate expert consultations convened by WHO related to CH/CSE: 1) CHW policy and planning challenges post Ebola; 2) research prioritization for Social, Behavioral and Community Engagement; and 3) country program reporting standards. MCSP worked with WHO to identify implementation principles for SBCE interventions to strengthen individual, household, and community capabilities. This activity is related to a body of work that WHO is doing to map evidence gaps and eventually provide formal guidance on SBCE interventions.
    - MCSP also contributed to two successful CORE Group Global Health Practitioner Conferences convened in October 2015 in Washington, and in May 2016 in Portland, Oregon. The conferences fostered relationships with key donors, community health network members, and other global stakeholders, and generated an improved understanding of the critical role for community health programming in the SDG era. The conferences provided opportunities for MCSP staff to actively participate in panel presentations and working groups while disseminating (and soliciting feedback on draft) tools and materials.
    - The CORE Group and its Community Health Network, partially supported by MCSP, worked with Partnership for Maternal, Newborn and Child Health to gather country-level data from CORE Group Members, starting with Mozambique, to increase the voice of civil society at the country level.
- MCSP has contributed to thought leadership by developing papers and briefs. MCSP drafted three papers that address macro-level barriers experienced by country programs to achieving EPCMD: 1) "Expanding Evidence Approaches," which presents a rationale for broadening the approaches and types of evidence used to improve and sustain implementation of community MNCH programs at scale; 2) MCSP's Cost Brief for Community Health, which helps policymakers and program managers consider the relative value of investing in community health with their limited resources; and 3) a manuscript, "Beyond the Building Blocks," which discusses how health systems must address community health to improve MNCH. MCSP will finalize and disseminate the documents in PY 3 to both internal and external audiences.
- MCSP has contributed to improving CSE and social accountability in several ways:
    - MCSP produced several written products to guide MCSP country programs with the aim of strengthening CSE in HS (a literature review and the MCSP Civil Society Engagement Strategy) and

improving social accountability specifically (Social Accountability Tools). MCSP has disseminated these products internally and externally with the CORE Group Community Health Network.

- In Malawi, MCSP has laid the groundwork in PY 2—including an in-depth field visit, meetings with key stakeholders, and identification of documents for literature review—to work in collaboration with the national social accountability task force led by UNICEF and USAID. The expected outcome is both an analytical report on social accountability implementation by CSOs in Malawi and guidance on social accountability monitoring, evaluation, and learning. The report will be shared with national stakeholders during a government-civil society forum in PY 3.

- In Ethiopia, MCSP completed implementation and assessment of a core-funded ENAP pilot project in April 2016, drafted a report, and conducted an in-country dissemination workshop during August. MCSP will finalize and share the final report and policy brief during Q 1 of PY 3. The report documents the potential for successfully promoting newborn health among a remote pastoralist population using an existing NGO immunization platform. The project demonstrated that such program integration is operationally feasible and efficient, and has high potential for rapid expansion, increasing ANC visits and facility-based delivery. More research is needed to improve methods to track the changing population size and location of pastoralist groups and to ensure these mobile populations are part of an equitable national health system.

- MCSP also convened a workshop with key global development partners engaged in Every Women Every Child (EWEC) in January 2016 to explore the possibility of building consensus around a common framework of action for civil society engagement. The outcome of this workshop was a report identifying core elements that serve to create a common taxonomy and draft model for CSE among EWEC partners.

- MCSP provided TA to strengthen the community-based workforce, improve the planning process at decentralized levels, and mobilize civil society to expand and scale up lifesaving interventions, including:

    - Improving the balance of health promotion, prevention, and curative service delivery: training of CHWs in RMNCH interventions pertaining to MH, newborn care, iCCM, and immunization (Ethiopia, Haiti, Malawi), and modeling of CHW workforce options using the CHW Capacity and Coverage (C3) Tool (Sierra Leone).

    - Supporting community health workforce linkages to communities and to HS: capacity-building of health facility staff to supervise CHWs (Tanzania, Rwanda, Zimbabwe).

    - Cultivating stronger partnerships between government and civil society: institutionalization and national scale-up of CHW program through national training guidance (Mozambique, Tanzania, Namibia) and policy advocacy and technical contribution to national CHW implementation guidelines (Ghana, Egypt, Kenya).

    - Promoting use of local information to inform learning and adaptation in response to implementation challenges: community mobilization and capacity-strengthening activities through various approaches, including the community action cycle (Bangladesh, Guinea, Haiti, Mozambique, Rwanda) and strengthening community systems for HISs, supply chain, and local financing (Kenya, Tanzania, Rwanda, Uganda).

    - Providing critical review through the CHP lens to strengthen three MCSP/MCHIP AA country community health programs (Mozambique, Rwanda, Zimbabwe).

SOCIAL AND BEHAVIORAL CHANGE

MCSP recognizes the importance of implementing strategic, contextualized, and evidence-based approaches to promote RMNCH social and behavior change across the continuum of care. Much of MCSP's social and behavior change (SBC)/SBCC work is driven by field program priorities and related funding. Core funds support staff with demonstrated expertise in SBCC to facilitate coordination, documentation and dissemination, capacity-building, and application of evidence-based practices across the program.

MCSP's cross-cutting SBCC work focuses on the following objectives: 1) implementing strategic, evidence-based SBCC activities at the country level; 2) documenting and sharing MCSP's SBC/SBCC efforts across the project; 3) contributing to the evidence base at country and global levels; and 4) coordinating and collaborating with SBCC partners globally and at the country level.

Accomplishments

- During PY 2, MCSP played a prominent role in facilitating inter-agency engagement, making substantial contributions to the development of global frameworks and documentation of learning in this area across immunization, child health, and FP. For example:
    - MCSP served on the advisory committee for the Communication & Community Engagement for Routine Immunization forum organized by UNICEF. MCSP staff drafted three of the five background papers for the meeting. The objectives of the meeting were to explore challenges, opportunities, and lessons learned in implementing demand-generation activities for immunization services; build on existing approaches and tools to enable countries to deliver results through communication and community engagement; and identify or enhance key performance indicators and tools for M&E of demand generation for immunization. The forum led to the development of a framework that can serve as a common basis for action and investment by various partners who support SBCC work for routine immunization.
    - MCSP participated actively in Gavi's working group on demand generation for immunization, including a high-level consultation in Geneva in January 2016 to advise Gavi on future areas for investment in this area.
    - MCSP facilitated meetings of the Demand Generation and Social Marketing sub-group of the iCCM Task Force, contributing to the preparation of case studies documenting lessons learned from Mali.
    - The SBCC Summit in Addis Ababa from February 8 to 10, 2016, presented an opportunity for MCSP staff to share MCHIP's and MCSP's work in SBCC (from South Sudan, Tanzania, Yemen). MCSP leveraged the SBCC summit to facilitate a workshop to build senior staff capacity on polio communication through the Communication Initiative. These efforts allow for information sharing to promote use of state-of-the-art and emerging evidence, tools, and approaches, and to facilitate interagency collaboration to advance SBC efforts across MCSP's programming.
    - MCSP has engaged closely with WHO on building, reporting, and assessing the evidence base for key MNCH social and behavioral science interventions, as well as in outlining implementation principles for SBCE interventions (see the Community/Civil Society Engagement section for more details).
- During PY 2, MCSP worked to transform harmful gender norms that inhibit access to RMNCAH information and services through community engagement, particularly with adolescents and men, in Mozambique, Pakistan, Rwanda, and Tanzania. In Rwanda, MCSP supported a male engagement organization to address harmful gender norms, prevent GBV, increase linkages to services, and engage couples. Please refer to the gender section with HSS for more details.

- MCSP is developing interpersonal counseling approaches and engaging community support groups to improve understanding of optimal IYCF and prevention of maternal anemia, and to increase uptake of nutrition practices and interventions, such as exclusive breastfeeding, optimal complementary feeding, and maternal IFA supplementation. In Kenya, collaboration with MOH and UNICEF led to the finalization of the Baby Friendly Community Initiative (BFCI) Implementation Guidelines, BFCI M&E tools, and the IYCF counseling package, which aid in guiding implementation of BFCI. In Malawi, in collaboration with MCSP and MOH, MCSP updated the WHO BFHI 20-hour course and existing behavior change communication materials, such as BFHI job aids and tools, to include the latest guidance on nutrition and HIV in partnership with BFHI master trainers.
- MCSP provided technical support for community mobilization activities in Guinea, Haiti, and Rwanda. In Guinea, MCSP facilitated development of a draft community mobilization strategy and convened a TOT for 26 participants at the national level and a basic training on community mobilization for 29 participants in the Boke region. In Haiti, MCSP facilitated development of a draft community mobilization strategy, supported two TOTs on community mobilization for 25 participants each, and provided support for rollout of community mobilization. In Rwanda, MCSP facilitated one TOT on community mobilization for 25 participants each and provided support for rollout of community mobilization. After this high-level training in Rwanda, each district involved will roll out the process so that each health catchment area and village in the targeted district will develop a collective action plan to address prioritized RMNCH issues. These activities are being actively monitored, and outcome level results will be available in PY 3. These results include number of women receiving ANC in the first trimester, number of women and newborns receiving a PNC visit within 48 hours following the delivery, number of functional health committees in a targeted health facility, and number of people reached by CHWs. These activities are advancing MCSP's objectives to enhance accountability at the community level and support countries to increase coverage and utilization of RMNCH interventions at the household, community, and health facility levels.
- MCSP completed phase 1 (formative research phase) of the study "Using social and behavior change communication (SBCC) to improve understanding and adoption of optimal nutrition and postpartum family planning practices in Lake Zone, Tanzania." Phase 1 findings have contributed to the knowledge base on current practices, barriers, and facilitators for optimal nutrition and FP practices in the Lake Zone, with a special focus on LAM. Findings are informing the development of a strategic approach for re-envisioning and revitalizing the promotion of LAM as a contraceptive option. Preliminary findings from phase 1 were shared at the CORE Group meeting on May 17. A short LAM "hackathon" that included MOH representatives from the Mara and Kagera regions of Tanzania resulted in innovative ideas for implementation. Some ideas from the hackathon had to be taken out of the proposed intervention due to the early closure of the MCSP Tanzania program. During PY 2, MCSP also finalized and disseminated "The Power of Counseling: Changing Maternal, Infant, and Young Child Nutrition and Family Planning Practices in Dhamar, Yemen" report. The report documents rich findings from the Yemen MIYCN-FP Trials of Improved Practices study conducted under the MCHIP award, includes a counseling guide focused on addressing key barriers for FP and nutrition, and highlights recommendations for future programming in this area.

DIGITAL HEALTH

Rapid advances in mobile technology and innovations provide tremendous opportunities to improve health outcomes. In PY 2, MCSP supported country programs to identify opportunities and integrate digital health interventions into existing programs. Additionally, MCSP provided global technical leadership in digital health by initiating the development of the digital health procurement guidance and scorecard toolkit and through participation in numerous digital health networks and conferences.

Accomplishments

- In line with priorities set by USAID's Global Health Bureau and Global Development Lab, MCSP initiated the development of the digital health procurement guidance and scorecard toolkit, which will be used to score digital health investments. As the next step, a workshop has been planned for December 8, 2016, to facilitate discussion and gain consensus for the tools among stakeholders. MCSP also shared key lessons and resources through the HDC and Global Digital Health Network. MCSP provided support to identify areas of possible collaboration and align digital health approaches and investments with partners and stakeholders at the Digital Health Knowledge Base meeting.
- MCSP developed a tablet-based survey to collect data on the technical information needs of providers from 16 countries with local Zika transmission at the first Latin America and Caribbean Conference to Reduce Inequalities in Sexual and Reproductive Health in September 2016 in Cartagena, Colombia. The survey results indicated that providers wish to receive more information about the convergence of SRH and Zika infection. They also demonstrated a desire to receive this information in a format or via a medium that can be carried on their person. MCSP will use these data to identify gaps in existing Zika resources and subsequently inform MCSP's strategic technical support.
- At the request of country programs and in response to interest expressed by USAID Missions, MCSP initiated a landscape assessment in Nigeria and began planning for landscape assessments in Haiti and Guatemala. Digital health helped the Burma country program identify possible areas of integration of digital health interventions to support malaria volunteers who provide child health services. MCSP continues to identify opportunities to incorporate ORB and other mPowering resources into country programs. ORB, which houses quality-assured, country-specific training content for various technical areas, can be a valuable training and learning tool for health workers in MCSP country programs. In PY 3, MCSP will continue to identify and integrate digital health into country programs to increase the effectiveness of program activities and improve data quality/utilization and expected outcomes.
- MCSP initiated planning and technical support for an MCSP Nigeria MNCH program activity that will pilot the use of a mobile data collection platform to allow patent and proprietary medicine providers to use smartphones for iCCM data collection, child health commodity stock management, and supportive supervision visits. The aim is to ultimately improve child health outcomes.

AFRICA BUREAU

Maternal and Newborn Health

MCSP's Africa Bureau MNH activities focused on strengthening the delivery and quality of high-impact ANC services, with an emphasis on the prevention and treatment of regionally relevant infectious diseases. The Africa Bureau-supported activities also focused on increasing MCSP's understanding of implementation of MPDSR systems in the region through a four-country assessment. In addition, MCSP supported the integration of MPDSR systems within QI strategies.

Accomplishments

- MCSP served as a core member of the WHO ANC expert review group, contributing to the development and review of the WHO ANC guidelines, released in November, 2016. MCSP contributed key implementation considerations for the new recommendations, informed by MCHIP and MCSP country program experience with provision of ANC services in low-resource settings. In PY 3, MCSP will co-develop briefs with WHO to summarize the updated ANC recommendations and incorporate them into country program ANC work as appropriate.

- MCSP participated in WHO's Global Maternal Death Surveillance and Response (MDSR) meeting to review the Global MDSR implementation survey and annual report. The report, published in August 2016, highlights implementation experiences primarily at the national level. Findings from this report will inform TA to MCSP country programs implementing MPDSR.
- MCSP efforts to strengthen country-level ANC programming in the Africa region included the development and field testing of a toolkit and job aid to improve early and sustained IPTp uptake through comprehensive ANC services. The toolkit provides guidance to determine GA for correct administration of the first dose of IPTp-SP at 13 weeks gestation. Field testing in Mozambique and Madagascar will inform revisions in early PY 3. The end result will be a resource that helps providers identify women eligible to receive IPTp-SP and other preventive services as early as 13 weeks of pregnancy and up to the time of delivery.
- MCSP developed a brief that summarizes MPDSR implementation principles and priorities to guide MCSP's global, regional, and country-level MPDSR activities. In addition to summarizing key MPDSR activities, the brief also outlines implementation principles to guide MCSP country programs implementing MPDSR activities. In PY 3, MCSP will update the brief based on findings from the multi-country MPDSR assessment.
- MCSP's maternal and newborn health teams began a multi-country assessment of MPDSR implementation status in four countries in Africa: Nigeria, Tanzania, Rwanda, and Zimbabwe. The assessment builds on the MDSR implementation survey conducted by WHO and published in 2016. Using in-depth interviews at the subnational level, MCSP's regional MPDSR assessment evaluates country implementation experiences and examines linkages with country QI processes, CRVS, and other national data and surveillance systems. (Zimbabwe was added as an assessment country after Mozambique withdrew support due to changes in priorities within the MOH.) Data collection began in Nigeria, where MCSP collaborated with SNL to complete the assessment in 10 health facilities in Ebonyi state. Preliminary findings showed that progress in implementing MPDSR varied across facilities in the state. All facilities were aware of the importance of conducting death reviews, but not all facilities are conducting them in non-punitive/no-blame environments. Linkages to community-level data collection and reporting on deaths occurring outside the facility were also lacking. MCSP identified and shared initial recommendations with health facilities and key stakeholders for strengthening MPDSR systems. MCSP will also complete an MPDSR assessment in Kogi State in PY 3 and will finalize a final report highlighting Nigeria findings and recommendations to share with country-level stakeholders for further action. Findings from the multi-country assessment will inform MCSP's ongoing technical support to MPDSR implementation in country programs in PY 3 and beyond.

Child Health

Sub-Saharan Africa continues to experience the world's highest rates of neonatal, infant, and under-5 mortality. While the annual rate of reduction in under-5 mortality improved from 1.6% in the 1990s to 4.1% from 2000 to 2015,[3] the region still has an unacceptably high number of child deaths: 1 out of 9 children dies before age 5, more than 16 times the average for developed regions (1 in 152). To address the areas with the largest inequities in child health service delivery, MCSP focuses the majority of program efforts in the sub-Saharan Africa region.

Accomplishments

To better understand the evolution of child health since 2000 and the networks of stakeholders and leaders involved, MCSP conducted a mapping of global leadership in child health, as discussed in previous sections. To glean insights from a sub-Saharan Africa regional perspective, the study team interviewed five stakeholders suggested by the USAID's Africa Bureau. With the introduction of the SDGs, the country level has become the main focus for intervention and coordination efforts, increasing the importance of country ownership and

[3] UN Inter-agency Group for Child Mortality (IGME), 2015 Report

leadership of child health programs. The recommendations from the report offer insight about how child health leadership in the region could be strengthened and repositioned to attain better outcomes under the SDGs.

Immunization

The Africa Bureau's work in immunization emphasizes cross-learning between African countries to facilitate knowledge dissemination, innovation, and collaboration.

Accomplishments

- For the groundbreaking Ministerial Conference on Immunization in Africa, in which all 54 African countries participated, MCSP and UNICEF co-led the development of the ministerial brief on community involvement, contributed to four other ministerial briefs, ensured diversity and strength of CSO involvement, and developed a social media toolkit. MCSP's efforts contributed substantially alongside WHO, the African Union, UNICEF, BMGF, and other partners to the passage of the Addis Declaration on Immunization, which 80% of African countries have now signed, thereby agreeing to make immunization services a national priority and a cornerstone of development.
- MCSP facilitated the participation of staff from eight countries and MOH officials from four countries in the EPI Managers Meeting for East and Southern Africa, where they contributed substantially to discussions on routine immunization coverage, equity, and new vaccine introduction, and participated in country side meetings. These opportunities help disseminate knowledge, generate ideas, and create linkages between immunization professionals that often lead to further communication and collaboration.

Reaching Every District/Community (RED/REC)

In June 2016, MCSP child health and immunization experts supported WHO AFRO's workshop in the Seychelles to review and adapt the RED guidelines. The workshop built on January's Cape Town meeting, during which participants from WHO and UNICEF, donors, MCSP, and MOHs from more than 20 African countries identified and exchanged experiences on best practices with the Reaching Every District/ Community (RED/REC) strategy, Equity and Integration of Child survival interventions. The aim was to update the current (2008 edition) RED WHO AFRO guidelines and strengthen the equity and integrated child survival approaches, as well as the planning and monitoring sections. MCSP provided child health expertise by contributing to inputs on integrated child survival components and to the component on monitoring and use of data for action. MCSP also contributed significant immunization TA on all parts of the documents, including micro-planning and management of resources, reaching target populations, monitoring and use of data for action, community engagement, supportive supervision, and linkages as well as integration.

Thirty participants from WHO, UNICEF, JSI, BMGF, MCSP, and USAID attended the Seychelles workshop and made presentations during plenary sessions, but primarily worked in small groups throughout the five-day meeting to address knowledge gaps and incorporate best practices into the five components of the RED strategy. A small cross-cutting group focused on integration with child health. Four new areas were identified for integration/strengthening the updated guide:

- Delivering in urban settings.
- Delivering across the life cycle (i.e., beyond just infancy).
- Making the most of opportunities to integrate delivery of other MNCH interventions.
- Using an equity-based approach to go beyond simple geographical prioritization to help identify and address the needs of individual communities (such as nomads, urban migrants, and ethnic minorities).

It is hoped the updated guidelines will provide the basis of the "how" to strengthen immunization systems in many AFRO countries and incorporate much of the new thinking highlighted in the Global Vaccine Action Plan (GVAP) to reach every community and undertake sound equity analyses. MCSP continues to play a major role in finalizing and adapting the guidelines in specific countries and supporting implementation in focal countries (beyond cascade training).

LATIN AMERICA AND CARIBBEAN BUREAU

Maternal Health

MCSP's Latin America and Caribbean (LAC) Bureau continues to contribute to regional and country-led efforts to reduce maternal and newborn mortality and morbidity in the region. The LAC Bureau's strategy is designed to achieve results though the utilization of and participation in regional platforms, including the Regional Maternal Mortality Reduction Task Force (GTR, acronym in Spanish), the LAC Neonatal Alliance, and the Caribbean Regional Midwifery Association (CRMA), as well as through midwifery education programming with the Guatemalan MOH.

Accomplishments

- During PY 2, MCSP has continued to provide leadership to the LAC Regional Maternal Mortality Reduction Task Force (GTR) and its Respectful Maternity Care (RMC) subcommittee. With MCSP's support, the GTR completed the Interagency Strategic Consensus for Latin America and the Caribbean Document, or DCEI. The DCEI is a direct result of the GTR's interagency efforts. The member agencies'[4] extensive collaborative review of existing global, regional, and country-level health-related documents has resulted in this singular comprehensive document. It is an invaluable tool that supports the synergy and efforts of governmental and intergovernmental organizations to identify the region's critical gaps and to use that information to revise and realign regional and national MH policies and priorities. Building off accumulated lessons learned over the past 18 years of experience, the DCEI serves as a road map for governments on the prioritization and adoption of updated MNH approaches and best practices within the LAC region. This document serves as a unified strategic agreement, a guide for interagency efforts to support the reduction of maternal mortality and morbidity in the context of the 2030 Agenda. In addition, the GTR completed the Maternal Mortality Surveillance Guide (English version). Dissemination is planned for PY 3.
- MCSP has continued to leverage its global MH technical, QoC, and RMC work alongside the regional work of the GTR to promote more equitable coverage of high-impact clinical and interpersonal care interventions in the LAC region linked to improved MH outcomes. These efforts align directly with the USAID LAC regional strategy, placing emphasis on the introduction and implementation of emerging WHO and other global technical standards.
- During PY 2, MCSP has continued to support the Caribbean Regional Midwifery Association (CRMA), focusing on curriculum strengthening, accreditation, and continuing professional development (CPD). Through MCSP guidance, the CRMA examined requirements and factors necessary to become a CPD provider, determining that the CRMA Education Committee will take the lead on this project and will first pilot a CPD offering in PY 3.
- MCSP spearheaded the development of the Government of Guatemala's first-ever standardized, competency-based midwifery curriculum and career path. To date, the Guatemalan MOH pledged to fully fund the first cadre of midwifery students and has worked with the national university, Universidad San Carlos (USAC), to begin preparing to incorporate the framework of a national curriculum into its current infrastructure. These efforts will continue in PY 3 under the MCSP Guatemala bilateral agreement.

[4] GTR member agencies include PAHO, UNFPA, UNICEF, IADB, World Bank, UNESCO, UNIFEM, UNOPS, USAID, Population Council, Family Care International, FLASOG, ICM, FIGO, and MCSP.

Newborn Health

Accomplishments

- MCSP continues to serve as co-chair for the LAC Neonatal Alliance, utilizing this platform to inform, advocate, and advance key newborn health strategies and initiatives. These include the Kangaroo Mother Care (KMC) acceleration group, Every Women Every Child, the ENAP, HBB, Essential Care for Every Baby, ECSB, and the UN Commission on Life-Saving Commodities, at the regional and global levels.
- MCSP continues to be seen as a respected technical leader in the area of Newborn Health within the region, consistently being invited to participate in regional events or conferences to increase the dissemination of newborn health best practices. During PY 2, PAHO/WHO invited MCSP to present at its annual meeting on the improving the quality of care in newborns and the current status and next steps in the response to the Zika epidemic. In addition, AAP invited MCSP to be a panelist during the United Nations General Assembly Leveraging Partnerships with Medical Professional Organizations, focusing mainly on the successful participation of professional societies in the LAC Neonatal Alliance.
- MCSP continues to implement new methods of information sharing such as the increased use of social media to disseminate information. Through MCSP, the LAC Alliance was able to facilitate intra-membership communication and promote information sharing on newborn health issues via the production and dissemination of electronic newsletters, using the LAC Alliance's Facebook page.
- MCSP continues to support the development of a regional standardized newborn death surveillance approach. Through the support of TWG meetings, regional surveillance specialists reviewed the current processes for recording perinatal/neonatal deaths and the surveillance systems by using open access computer platforms and the GTR Regional Perinatal Surveillance System Survey. Collaboration with the GTR is a key component of this work: The GTR provides technical inputs and resources to integrate perinatal and neonatal data collection within the MDSR activities in the LAC region.

In PY 2, MCSP provided support in the Asia Region to improve health worker capacity through mentorship in Laos. MCSP also laid the foundations for research studies on PNC and estimation of GA for implementation in India and Cambodia in PY3.

Accomplishments

Laos

- MCSP strengthened mentorship of providers as a means to improve the quality of maternal, newborn and child health services in MCSP-supported facilities. The second capacity-building workshop was held to train a cohort of eight mentors to be mentorship trainers. Since the first workshop, the first cohort of mentors has conducted mentoring visits in all MCSP-supported facilities on a quarterly basis to improve labor, delivery, and newborn care services with their coaching skills. In addition, the fourth mentors' planning meeting was held to assess mentor skills and elicit mentor feedback on work challenges and technical and logistical areas that need strengthening. The meeting was held in collaboration with provincial-level staff to share lessons learned. MCSP supported trained-mentors and staff at a facility in Viengkham to conduct a PNDA through an ad hoc mentoring visit that addressed gaps in delivery and postpartum newborn care and identified areas for mentorship skills strengthening.
- MCSP conducted a feasibility assessment with the Luang Prabang provincial hospital staff to assess the feasibility of introducing a QI initiative. Improving infection control in the delivery room was identified as a key QI need. WHO is supporting the MOH to develop a national QI initiative that MCSP aims to build upon to strengthen supportive supervision.

- MCSP promoted integration of mentoring as part of supervision during an Early Essential Newborn Care and Breastfeeding workshop in July, and also during a Maternal Death Surveillance and review process workshop. MCSP is now planning to integrate breastfeeding into its Early Essential Newborn Care capacity-building and mentoring activities.

PNC Study: India

- The study protocol was developed and approved by USAID in Q 4. The team also met with in-country stakeholders, including state-level officials in Uttarakhand and Odisha, to gain their buy-in and formal approval of the study. The engagement of in-country partners and MOHFW/NHM will facilitate study implementation as well as help ensure that the findings are considered for future PNC programming.
- The study aims to develop and implement a model for increased coverage of high-quality PNC services through an HSS and continuum-of-care approach in selected public health sites in India. This will be accomplished through two phases. The initial formative review phase (planned for three states: Uttarakhand, Odisha, and Karnataka) will gather information on how PNC services are delivered at public health facilities and through the home-based program (ASHAs), including the enablers of and barriers to effective coverage of PNC in the public sector. The results of the formative review will feed into a prioritization of strategies for improved coverage and quality of PNC services, which will be tested and evaluated during the implementation research phase of the study. The results will also be shared with national and state-level government stakeholders in India to inform scale-up of pre-discharge, facility-based PNC as well as post-discharge, home-based PNC, and to improve the linkages between the two.
- MCSP completed the desk review and secondary data analysis of PNC policies and programs in India. MCSP will further analyze the data together with the formative review findings in early PY 3, and together will inform the design of the model, which will be tested in the implementation research phase.
- The study team provided India-specific inputs to the WHO multi-country study of postnatal home visits (PNHV) to help inform global understanding of PNHV programs.

Gestational Age Study India and Cambodia

- The study protocol was approved by USAID and submitted to the Johns Hopkins Bloomberg School of Public Health IRB; final approval will follow local IRB approval in the study implementation countries of Cambodia and India. The PI conducted a study planning trip in Q 3 to both countries to meet with the USAID Missions, MOHs, candidates for local research partners, and other key stakeholders, to describe the study, its purpose, and applications of its potential findings. MCSP identified local research organizations in both countries to act as study partners. Study implementation will be completed in PY 3.
- The GA study is a mixed methods implementation research study to investigate the practice of GA estimation, documentation, and utilization for clinical care of pregnant women in both large and small facilities in Cambodia and India. The identification of optimal strategies to improve GA assessment in low-resource settings is a critical research gap with clinical relevance to MH and newborn survival. Furthermore, the unknowns around clinical documentation and use of GA data make it unclear to what extent the use of time-sensitive perinatal interventions could be optimized, even if the precision of GA estimation could be improved in low-resource settings. MCSP will assess practices to inform policy and operational recommendations with the potential to improve clinical practices, so that accurate GA estimation can be used to plan interventions targeted to specific time windows during pregnancy (e.g., antenatal corticosteroid administration).

ZIKA

Since June 2016, in response to the growing epidemic of the Zika virus (ZIKV), MCSP has focused on developing strategies to increase the capacity of health systems and providers caring for women of reproductive age, pregnant women, newborns, and families at risk of and affected by ZIKV infection in the Latin America and Caribbean (LAC) region. Through collaborations with PAHO, UNICEF, professional associations in the LAC region, and other partners, MCSP has been providing technical leadership in regional and global fora on issues related to quality care in pregnancy and care of newborns within the context of the ZIKV epidemic. MCSP has also supported the development, adaptation, and dissemination of updated guidelines and reference materials related to ZIKV at the global level and within the MCSP Haiti program.

Accomplishments

- In collaboration with USAID ASSIST and K4Health, MCSP conducted a rapid review of existing tools and materials related to ZIKV for providers and lower-level systems managers, including job aids, training materials, and resources for local health authorities across the continuum of pre-conception, pregnancy, birth, newborn health, and early childhood development. The findings of this analysis will be used to guide the adaptation of existing materials and development of new materials for providers and health facility managers related to ZIKV infection and prevention. The MCSP PNC Poster and Checklist have since been adapted to integrate ZIKV-related content (see Figure 30).

Figure 30: Sample resource for adaptation

- As co-chair of the LAC Neonatal Alliance, MCSP has provided technical leadership related to ZIKV through participation at global and regional events organized by USAID, PAHO, and partner organizations in Brazil, Colombia, the Dominican Republic, and Peru. Through these opportunities, MCSP has supported the development and dissemination of updated guidelines and reference materials related to ZIKV infection. This ensures that health care providers in ZIKV-endemic areas are receiving the most up-to-date information and guidance related to ZIKV prevention and care of newborns and families affected by ZIKV.
- In collaboration with ASSIST and PAHO, MCSP co-hosted a Spanish-language webinar related to Zika Congenital Syndrome in August 2016. The presentations and discussions focused on best practices related to prevention and screening of newborns for health care providers and HS managers in the LAC region. Participants included health care professionals and HS managers from throughout the LAC region.
- MCSP has supported mPowering to strengthen the ORB content platform (www.health-orb.org), identifying additional ZIKV-related content to expand the content library, and translating and adapting existing content related to ZIKV for frontline health workers and their communities on a variety of topics, including prevention of transmission and ANC. In total, seven Zika-specific sources have been uploaded to ORB, and 29 sources have been identified and approved and are pending updates or open licensing

before being shared on ORB. MCSP has identified an additional 10 sources that await content approval or open licensing verification before being uploaded onto the ORB portal.

- In partnership with ASSIST, the American Institute of Ultrasound in Medicine, and the Society for Maternal Fetal Medicine, MCSP conducted an initial design meeting related to a planned assessment of ultrasound equipment and provider capacity for the ZIKV response in five USAID priority countries: the Dominican Republic, El Salvador, Guatemala, Haiti, and Honduras. This meeting brought together USAID, members of professional associations, and experts in obstetrics, ultrasonography, and maternal fetal medicine, and achieved its goal of outlining the activity's principal objectives and expected results. The ultrasound assessment is intended to accomplish the following objectives: assess the capacity of ultrasound providers to detect features of Zika Congenital Syndrome, assess the capacity of ultrasound equipment used by providers included in the assessment, and inform referral pathways for pregnant women with suspected or confirmed ZIKV infection.

mPowering

mPowering Frontline Health Workers is an innovative public-private partnership designed to accelerate the use of mobile technology to improve the skills and performance of frontline health workers (FLHWs). mPowering is achieving this mission through its online training content platform, ORB, and by supporting an innovative content delivery process, Open Deliver. Through MCSP's global learning and advocacy work, mPowering is a catalyst for creating dynamic partnerships, ideas, and opportunities for collaborations within the global health sector. MCSP hosts mPowering's Secretariat and provides financial management, human resources, communications, and administrative support to mPowering, as well as technical partnership.

Accomplishments

- mPowering expanded and improved its ORB platform. This included adding new content in existing health areas, collecting content for a Zika health domain, and improving back-end functionality to allow translation and facilitate content review. By the end of PY 02, ORB had more than 6,000 unique users, and on average users accessed 10 resources per visit.
- mPowering's in-country training programs (in Nigeria, Uganda, Zambia, Ethiopia, and more) supported partners to integrate mobile technology into training. For example, programs in Nigeria and Uganda brought interactive training resources into rural health facilities as an on-demand source of refresher training. In Pakistan and Sierra Leone, mPowering supported partners to convene multi-stakeholder workshops to determine priorities for including digital health into training.
- mPowering's global learning work focused on sharing key lessons in digital health with the global health community and on facilitating collaboration in digital health. Through reports, advocacy pieces, and blog posts, mPowering documents and disseminates knowledge related to digital health, training, and the health workforce. By convening stakeholders at events such as the Wilton Park meeting (Unlocking the community health workforce potential, post-Ebola) in February 2016 and the Donor Coordination for Digital Health workshop in April 2016, mPowering events led to new collaborations and shared knowledge.

Saving Mothers, Giving Life (SMGL)

Started in 2012, Saving Mothers, Giving Life (SMGL) is a five-year initiative designed to rapidly reduce deaths related to pregnancy and childbirth through a coordinated approach that strengthens maternal and neonatal health services. SMGL seeks to address the three delays that prevent women from accessing MH services: delay in seeking services, delay in reaching services, and delay in receiving high-quality care. These

interventions are focused primarily on the critical period of labor, delivery, and the first 48 hours postpartum, when most maternal deaths and approximately half of newborn deaths occur.

In its third year, SMGL expanded into Cross River State, Nigeria, as well as additional districts in Uganda and Zambia. Each country has an SMGL Country Team responsible for coordination and oversight of SMGL program activities within their countries. SMGL Country Teams are guided by the SMGL M&E HQ team from USAID/Washington and CDC/Atlanta. Over the next year, a robust final evaluation will take place in Uganda and Zambia, while routine quarterly data gathering and analysis will continue in Nigeria.

Accomplishments

MCSP contributions to SMGL all involve M&E, and the SMGL USAID Advisor supports all three SMGL countries: Uganda, Zambia, and Nigeria. These include the following:

- Designing a data quality sheet for completion at the facility level for entry into an SMGL quarterly data collection tool for Zambia, to support ongoing capacity strengthening.
- Leading the process to review and clean the quarterly data for Zambia, followed by calculation of the SMGL 2015 M&E Indicators for Zambia and Uganda. Final indicators were presented to the SMGL Secretariat and shared with Rabin-Martin, the SMGL Communications partner, to publish country-specific bulletins.
- Working with Pathfinder Nigeria, the SMGL implementing partner, to finalize SMGL PIRS for USAID-supported facilities and for Merck for Mothers private facilities in Cross River State.
- With support from CDC/Atlanta and CDC/Zambia, finalizing GANTT charts with supporting Concept Notes and other documentation for the 2017 Summative Evaluation activities to be implemented in Zambia and Uganda.
- Supporting Cross River State's Health Facility Assessment (HFA) data review and report writing for USAID submission.

Survive & Thrive

In partnership across the three professional associations (AAP, ACNM, and ACOG), the GDA has accomplished many goals associated with Technical Packages/Module Development, Professional Association Strengthening, and the Helping 100,000 Babies Survive and Thrive initiative.

Accomplishments

- In this reporting period, the GDA completed the New Helping Mothers Survive modules that include Complicated Labor and Birth, Normal Labor and Birth, Professional Association Strengthening, Helping Babies Breathe 2nd Edition, and the Quality Improvement workbook.
- The GDA worked within several countries to build relationships with and help guide capacity-building across professional associations in India, Rwanda, Burma, and, soon, DRC.
- Under the auspices of the Helping 100,000 Babies Survive and Thrive (100KB) initiative, great strides were made in India, Nigeria, and Ethiopia in PY 2, including enhanced partnerships with professional associations, adapted newborn health national plans, master clinical trainings, cascade trainings, and incorporation of QI planning.

STRATEGIC COMMUNICATIONS

MCSP continued to build on efforts to embed a robust communications plan that leverages existing platforms within the global health community. The goals are to communicate the work of MCSP, highlight its impact, disseminate resources, collaborate with like-minded organizations, and share knowledge and lessons learned. During this reporting period, MCSP has harnessed a variety of communications tools, such as the MCSP website, e-communications, digital and social media, traditional news media, conferences, special events, and key MCSP informational products (see Box 8). The goal is to promote USAID's flagship MCSP to strategically interact with key audiences.

Box 8. MCSP communications dissemination platforms

- E-communications
- Website
- Digital media
- Traditional news media
- Events and conferences

MCSP also continued a monthly communications working group, which included representation from each of the implementing partner organizations in the MCSP consortium as well as USAID. The group will continue to strategically communicate MCSP's work and leverage the partnership to advocate and promote RMNCH messages. MCSP HQ communications has also mobilized a network of field-based communicators or focal points from each country program to promote better communication about and alignment of activities globally.

Dr. Ana Langer, of the Maternal Health Task Force, speaking at the Global Maternal Newborn Health Conference. Photo by Miguel Sanchez, Global Maternal Newborn Health Conference.

Program Website

MCSP maintained a dynamic website in this reporting period with over 200 pages of content, including a new resource section (housing 144 MCSP produced resources; see Annex G for full listing during this reporting period) and 46 blogs, success stories, and happenings (see Annex Db).

The MCSP website (in PY 2) has had 96,829 page views and 39,700 sessions (according to Google analytics). Visitors from 183 countries accessed the site; the top five countries were the United States, India, Rwanda, Kenya, and Nigeria.

Communications Capacity-Building, Program Materials, and Collateral

After establishing and disseminating essential communications collateral in PY 1, MCSP shifted its focus in PY 2 to create expanded guidance and templates that allow staff to independently create visually appealing, properly branded materials. MCSP updated the internal notification and support form platform and provided training to help staff learn how to request publications and event support from MCSP Communications. The team also disseminated USAID's updated graphic standards and branding guidelines and updated MCSP templates and existing collateral to be in compliance. Other key collateral, templates, and communications training documents and resources created include cross-cutting fact sheets, the MCSP style guide, a product dissemination email template, guidance for crafting blogs, presentation guidance, and a visual template, as well additional photo sets on MCSP's Flickr.

Trainers pose with the Mama-U, a training tool for teaching postpartum IUD insertion, at the 2016 International Conference on Family Planning. Photo by Pat Szybist, Jhpiego.

Given the size and complexity of the global Program, the team put particular focus on creating, storing, and sharing accessible resources for field-based communicators and staff. For example, the team held an "All About MCSP Communications" webinar with field communications staff, created document and report cover templates in international-standard A4 paper size, made a more visually appealing success story template that has been used by multiple country offices, and added a sample event photography shot list and a list of essential questions to ask before planning an event to the existing events toolkit.

MCSP's technical teams worked with communications on publications support **for nearly 50 technical products** (case studies, toolkits, manuals, briefs, etc.), as well as **nearly 30 articles published in peer-reviewed journals** (full listing in Annexes G and F, respectively). MCSP disseminated these products digitally via email and the website and on social media as well as at virtual and in-person meetings, events, and conferences held globally, regionally, or in-country.

Special Events

Messages and learning from MCSP were also widely shared at high-level events and conferences. MCSP hosted or co-hosted 26 events this year, including country launch events in Rwanda and Liberia, the GMNHC, the Lancet Maternal Health series event, the Madagascar FP Conference, several events on Capitol Hill, Women Deliver, ICFP, the Immunization Ministerial Conference, and more. Finally, a good deal of effort over the past year has been spent on the planning for the Institutionalizing Community Health Conference, with MCSP serving on the core communications and executive planning committee. MCSP staff made over 30 presentations at global meetings, conferences, and other events to include AMSTH, FIGO, AIDS 2016, ICT4D Conference, SBCC Summit, and the Global Vaccine & Immunization Research Forum. A full listing of all presentations and events can be found in Annexes E and Eb, respectively.

MCSP's Sheena Currie demonstrates an alternative birthing technique at the 2016 Women Deliver Conference. Photo by Liz Eddy, MCSP.

Online Engagement

MCSP employed several means via online engagement to increase visibility, including social media, online digital campaigns, external placement, and electronic communications to the mailing list.

External Coverage

MCSP's work garnered external attention at the local and global levels. By developing and maintaining strategic relationships with news outlets, partner blogs, and international media organizations, MCSP's **work was promoted by external outlets 154 times.** Outlets included the Huffington Post, Cosmopolitan Magazine, Redbook online, VOA, MSN, MCSP partner sites, the Department of State, the UN Foundation, Kaiser Family Foundation, and USAID (including the Bureau's Exposure site). As USAID's flagship EPCMD project, MCSP work was highlighted in eight USAID e-blasts (going out to a listserv of 81,000 subscribers).

Types of content promoted include Global Handwashing Day, International Women's Day, World Immunization Week, Mother's Day, Father's Day, World Contraception Day, and World Breastfeeding Week.

Participants watch a demonstration of the Mama-U at the 2016 *Conférence National sur la Planification* in Madagascar. Photo by MCSP.

Program Social Media

MCSP social media sites increased in influence over the past year, with **5,958 new followers** joining on Facebook and Twitter. The total number of Facebook fans increased by 46.4%, with a 38.4% increase in Twitter followers over the prior year. There were 22,213 "engagements" (replies, retweets, mentions, likes, and shares), and engagement was up on Twitter by 157.4% over the prior year. The top Facebook fans are from the following countries: United States, Pakistan, India, Kenya, and Nigeria. Over the last year, MCSP regularly participated in partner and donor campaigns for such key events as the Ministerial Conference on Immunization in Africa, World Immunization Week, World Malaria Day, and World Prematurity Day.

MCSP played a key role in organizing the GMNHC conference as discussed earlier in the report. MCSP live tweeted from the Lancet Stillbirth Series Launch, as well as from three advocacy events cohosted by MCSP on Capitol Hill. The team created a viral infographic and GIF for routine immunization and provided substantial live digital coverage of the Women Deliver Conference in Copenhagen. The MCSP photo-sharing account continued to grow on Flickr, with over 5,205 photos.

Program e-Communications

MCSP continues to use e-communications to share program work with **nearly 6,000 subscribers.** During this reporting period, MCSP disseminated eight e-blasts on conferences such as GMNHC and Women Deliver, as well as such thematic days as World Malaria Day. The team also launched a new monthly newsletter featuring MCSP work via blogs, photos, key technical resources, and more, but also curated content from others within the RMNCH community that showcases MCSP as a global thought leader and convener. All e-blasts had an average 21% open rate, which is very successful compared to industry standards.

MCSP leadership and panelists before MCSP's Achieving Impact at Scale event, which was held at the Human Rights Campaign in Washington, DC. Photo by Sruti Ramadugu, MCSP.

Opportunities and Challenges

Program Scope and Size: PY 2 continued to witness a growth in country programs, with the startup of seven new programs and continuation of 34 programs, while six programs were closed out. While presenting a tremendous opportunity to expand the MCSP footprint, the varying scopes and timelines of MCSP country programs can present challenges for achieving and measuring impact in country programs with a short life-span (e.g., less than 18 months) and for collectively defining results and success as one global program. For examples, plans for an endline KPC were terminated in Tanzania given the shortened project time period of the country program. MCSP's indicator testing plans have also been adversely affected by funding cuts and changes in Mission priorities in Tanzania and Rwanda, respectively. The assessment has been scaled back in Tanzania and eliminated in Rwanda. Missions expect a rapid response time; however, the simultaneous start-up on multiple programs can result in delays. MCSP continues to be recognized for timely and flexible technical support to country programs, including the strategic use of complementary core and country resources when appropriate and agreed upon by USAID.

Engagement in Global Leadership Fora: MCSP's strong country platforms and presence continue to provide an opportunity to leverage country learning and realities to inform global discourse and, in turn, bring global evidence to the country level to strengthen evidence-based programs. The child health global leadership mapping conducted in PY 2 showed an overall lack of global champions in child health, which poses a challenge for implementing partners to ensure that child health remains and gets attention within the RMNCH agenda.

In PY 3, MCSP also has an exciting opportunity to support USAID and partners UNICEF, WHO, and BMGF to convene the Institutionalizing Community Health Conference in Africa, the first of its kind. The conference has great promise to stimulate learning and coordinated action from countries around community health. MCSP also supported country teams to follow up on and, where appropriate, get involved in the ENAP tracking process to influence the discussion about data utilization for improved newborn health programming. While MCSP participation in these global fora is critical to ensure relevance for countries, the engagement of so many players often results in time delays for finalization of guidance and formal rollout and expansion at the country level.

Within this evolving landscape of the new SDG era, where accountability mechanisms remain unclear, the large number of indicators; the multiple players; and the multiple working groups such as HDC, EPMM, and ENAP present both opportunity and challenges for implementing programs such as MCSP. Also, as a program, MCSP—like many other implementing organizations and programs—is not being engaged in Global Financing Facility discussions, despite the fact that investment cases should influence and inform how MCSP performs in a particular country. There often remains a large disconnect between global dialogue and country implementation. While MCSP continues to bridge this divide, the span of the RMNCH platform and the large number of stakeholders with multiple messaging poses a challenge.

Country data realities: MCSP completed a preliminary review of the MNH-related data elements in national HMIS (including client cards, registers and monthly summary reports) for 24 of 25 EPCMD countries. MCSP is extending this review to the area of child health, which is being conducted in 23 EPCMD[5] countries. Both reviews are expected to advance global and country understanding of which of the new WHO-recommended routine RMNCH indicators are currently available in HMIS systems and provide a clear sense of the data realities that exist. Understanding these gaps enables MCSP to prioritize critical data elements for country programs and inform the global dialogue on metrics and measurement.

Building the evidence around equity: In response to renewed emphasis on addressing equity of health services highlighted by USAID's 2016 *Acting on the Call* Report, MCSP will intensify efforts to improve equity

[5] The team has excluded Yemen and South Sudan because of difficulties getting the forms for review due to conflict. MCSP also has included two addition (non-EPCMD) countries—Guatemala and Namibia—in the review to inform MCSP's work in these countries.

of institutional delivery. This will be an opportunity to gather additional data on the needs and perceptions of targeted underserved groups to design program innovations promoting safe delivery.

Coordination with partners: MCSP continues to work closely with the range of partners to minimize duplication of resources and complement efforts. For example, MCSP has been collaborating with a range of partners such as ASSIST, K4Health, PAHO, and CDC on the Zika response. These collaboration have enabled MCSP to focus efforts and resources in areas where it is best poised to make a difference, such as technical content and capacity development. In the area of nutrition, MCSP and the SPRING Project identified opportunities for both global projects to facilitate information sharing, dissemination of learnings, and leveraging of resources on anemia programming via the K4H toolkit, the Accelerated Reduction of Efforts on Anemia (AREA) COP, and e-blasts. MCSP and SPRING worked with USAID to revitalize the USAID Anemia Task Force by identifying key objectives, actions, and contributions to the global dialogue on the need for multisectoral anemia programming.

Annex A. Financial Summary

MCSP Cumulative Obligations, Costs, and Pipeline at September 30, 2016

	Total obligated funds to Sep 30, 2016 $ (000's)	Cumulative expense to-date to Sep 30, 2016 $ (000's)	Balance of pipeline at Sep 30, 2016 (excluding accruals) $ (000's)
CORE FUNDS			
MCH	$ [redacted]	$ [redacted]	$ [redacted]
WASH	$ [redacted]	$ [redacted]	$ [redacted]
Ebola	$ [redacted]	$ [redacted]	$ [redacted]
ZIKA	$ [redacted]	$ [redacted]	$ [redacted]
FP	$ [redacted]	$ [redacted]	$ [redacted]
HIV/AIDS	$ [redacted]	$ [redacted]	$ [redacted]
Nutrition	$ [redacted]	$ [redacted]	$ [redacted]
Malaria	$ [redacted]	$ [redacted]	$ [redacted]
DCOF(DCHA)	$ [redacted]	$ [redacted]	$ [redacted]
TOTAL CORE	$ [redacted]	$ [redacted]	$ [redacted]
BUREAU FUNDS			
AFR/SD	$ [redacted]	$ [redacted]	$ [redacted]
LAC	$ [redacted]	$ [redacted]	$ [redacted]
ASIA/SPO	$ [redacted]	$ [redacted]	$ [redacted]
TOTAL BUREAU	$ [redacted]	$ [redacted]	$ [redacted]
FIELD SUPPORT	$ [redacted]	$ [redacted]	$ [redacted]
TOTAL MCSP	$ [redacted]	$ [redacted]	$ [redacted]

Annex B: Performance Monitoring Plan

#	Indicator	Definition and disaggregation	Data source/ collection method	Frequency of data collection	FY 2014 data	FY 2015 data	FY 2016 data
Objective 1: Increase coverage and utilization of evidence-based, sustainable, high-quality RMNCH interventions at the household, community, and health facility levels							
Performance Indicators Collected through Routine Data Sources							
1	Couple-years of protection (CYP) in MCSP-supported areas*	CYP is the estimated protection provided by contraceptive methods during a one-year period, based on the volume of all contraceptives sold or distributed free of charge to clients during that period. CYP is calculated by multiplying the quantity of each method distributed to clients by a conversion factor to yield an estimate of the duration of contraceptive protection provided per unit of that method. The CYP for each method is then summed for all methods to obtain a total CYP figure. Disaggregated by country and method	HMIS/service statistics	Quarterly	Total: 2,171,470 Haiti: 68,294 Mali: 2,103,176	Total CYP: 833,154 Ethiopia – BEmONC: 1,643 Guinea – FP – MCH/ GBV: 12,248 Haiti – Social Marketing: 79,023 Kenya: 78,352 Mali: 460,612 Mozambique: 201,013 Nigeria – MNH: 805 Zambia: 1,504	Total CYP: 571,685 Ethiopia – BEmONC: 2,307 Guinea – MCH/GBV: 48, 949 Guinea – Restoration Services: 80,387 Haiti – SSQH: 93,184 Kenya: 211,961 Liberia – RHS: 15,373 Malawi: 11,998 Mozambique – EPCMD: 59,504 Nigeria – MNCH: 48,025

#	Indicator	Definition and disaggregation	Data source/ collection method	Frequency of data collection	FY 2014 data	FY 2015 data	FY 2016 data
2	Number/ Percent of women delivering in MCSP-supported health facilities who accept a method of family planning prior to discharge	Numerator: Number of women who delivered at MCSP-supported health facilities who accepted a method of FP prior to leaving the facility Denominator: All women who delivered in MCSP-supported facilities (over the reporting period) Disaggregate by country and FP method	HMIS	Quarterly	Mali (12,152/ 19,290): 63%	Ethiopia – BEmONC: 498/ 12,761 (4%) Guinea – FP – MCH/ GBV: 3,574/ 15,595 (23%) Mali: 41,370 (numerator only) Zambia: 56/ 10,460 (1%)	Ethiopia – BEmONC: 699/ 36,194 (2%) Guinea – MCH/ GBV: 16,849 (numerator only) Guinea – Restoration Services: 29,568/ 123,142 (24%) Mozambique – EPCMD: 21,708/ 41,869 (52%) Nigeria – MNCH: 1,893/ 35,952 (5%) Rwanda – EPCMD: 5,926/ 104,965 (6%) Tanzania: 6,232/ 42,737 (15%)
3	Number of countries where MCSP increased access to permanent family planning methods	Countries where MCSP supported introduction/re-introduction (after at least one year of no new acceptors) of new permanent FP methods. Disaggregated by country and methods	Program records	Annually	1: Mali	4: Ethiopia – BEmONC, Mozambique, Nigeria – MNH, Zambia	4: Kenya, Nigeria – MNCH, Rwanda – EPCMD, Tanzania
4	Number of countries where MCSP support includes training of service providers and/or promotion of permanent methods	Disaggregated by country and type of method(s)	Program records	Annually	None Reported	6: Ethiopia – BEmONC, Madagascar, Mozambique – Bridge, Nigeria – MNH, Tanzania, Zambia	4: Kenya, Nigeria – MNCH, Rwanda – EPCMD, Tanzania

#	Indicator	Definition and disaggregation	Data source/ collection method	Frequency of data collection	FY 2014 data	FY 2015 data	FY 2016 data
5	Number of clients attending essential MNCH services at MCSP-supported facilities who adopted a FP method during that visit	Essential MNCH services include ANC, postabortion care, postpartum care, well-baby/immunization services Disaggregated by point of service and by country	HMIS/service statistics	Quarterly	None Reported	Total: 330,574 Ethiopia – BEmONC: 498 Guinea – FP – MCH/ GBV: 35,446 Mozambique – Bridge: 291,824 Nigeria – MNH: 2,412 Zambia: 394	Total: 335,292 Ethiopia – BEmONC: 699 Guniea – MCH/GBV: 69,432 Guinea – Restoration Services: 114,859 Liberia – RHS: 7,230 Madagascar: 3,823 Nigeria – MNCH: 13,231 Rwanda – EPCMD: 126,018
6	Number of service delivery points that expanded the types of contraceptive methods available with MCSP support	This indicator counts the total number of facilities (~~public or private), vendors, or other service delivery points~~ that add a method to the contraceptives available for the first time (during the reporting period). Disaggregated by country and contraceptive method	HMIS/service statistics	Quarterly	Total: 281 Haiti – Social Marketing: 106 Mali: 175	Total: 69 Ethiopia – BEmONC: 18 Haiti – Social Marketing: 51	Total: 163 Ethiopia – BEmONC: 24 Madagascar: 64 Nigeria – MNCH: 6 Rwanda – EPCMD: 69

#	Indicator	Definition and disaggregation	Data source/ collection method	Frequency of data collection	FY 2014 data	FY 2015 data	FY 2016 data
7	Number/ Percentage of MCSP-supported facilities that offer delivery services with MgSO4 available in the delivery room	Numerator: Number of facilities that offer delivery services with MgSO4 available in the delivery room Denominator: Total number of facilities that offer delivery services Disaggregated by country	Supervision reports, logistic management information system, health facility survey	Annually	None Reported	Ethiopia – BEmONC: 18/ 22 (82%) Guinea – FP – MCH/ GBV: 234/ 234 (100%) Mozambique – Bridge: 127/ 127 (100%) Zambia: 17/ 91 (19%)	Guinea – MCH/ GBV: 234/ 234 (100%) Guinea – Restoration Services: 218/ 218 (100%) Kenya: 289/ 289 (100%) Liberia – RHS: 32/ 77 (42%) Mozambique – EPCMD: 1,211/ 1,211 (100%) Nigeria – MNCH: 34/ 120 (28%) Rwanda – EPCMD: 76/ 170 (45%)
8	Number of women provided with misoprostol in advance of delivery for prevention of postpartum hemorrhage in MCSP-supported areas	Disaggregated by country	HMIS/service statistics	Quarterly	None Reported	None Reported	Total: 1,343 Mozambique – EPCMD: 305 Nigeria – MNCH: 1,038

#	Indicator	Definition and disaggregation	Data source/ collection method	Frequency of data collection	FY 2014 data	FY 2015 data	FY 2016 data
9	Number/ Percentage of women receiving a uterotonic in the third stage of labor in MCSP-supported areas*	Numerator: Number of women receiving a prophylactic uterotonic in the third stage of labor (immediately after birth) Denominator: Total number of women giving birth Disaggregated by country and facility and home births	HMIS/service statistics	Quarterly	Mali: 17,221/ 19,290 (89%)	Ethiopia – BEmONC: 3,775/ 12,761 (30%) Guinea – FP – MCH/ GBV: 11,954/ 15,595 (77%) Mozambique – Bridge: 104,422/ 118,262 (88%) Nigeria – MNH: 926/ 2,212 (42%) Tanzania: 38,146/ 44,025 (87%) Zambia: 9,881/ 10,460 (94%)	Ethiopia – BEmONC: 15,838/ 22,892 (69%) Guinea – MCH/ GBV: 7,564/ 7,962 (54%) Guinea – Restoration Services: 79,986/ 90,686 (88%) Haiti – SSQH: 6,087/ 24,393 (25%) Madagascar: 29,030/ 29,822 (97%) Mozambique – EPCMD: 38,895/ 41,869 (93%) Nigeria – MNCH: 22,981/ 40,585 (57%) Rwanda – EPCMD: 94,158/ 104,965 (90%) Tanzania: 88,707/ 110,461 (80%)
10	Number of newborns admitted to facility-based KMC at MCSP-supported facilities	Disaggregated by birth weight	HMIS/service statistics or program records	Quarterly	Total: 1,026 Mali: 1,026	Total: 437 Mozambique: 437	Total: 5,254 Kenya: 55 Mozambique – EPCMD: 2,607 Nigeria – MNCH: 158 Rwanda – EPCMD: 1,869 Tanzania: 565

#	Indicator	Definition and disaggregation	Data source/ collection method	Frequency of data collection	FY 2014 data	FY 2015 data	FY 2016 data
11	Number/ Percentage of babies not breathing/crying at birth who were successfully resuscitated in MCSP-supported areas	Numerator: Number of babies not breathing/crying at birth born in MCSP-supported areas that were successfully resuscitated Denominator: Number of babies not breathing/crying at birth born in MCSP-supported areas Disaggregated by community-based and facility-based births and by country	HMIS/service statistics	Quarterly	Mali: 301/324 (93%)	Ethiopia – BEmONC: 13/ 83 (16%) Guinea – FP – MCH/ GBV: 355 (numerator only) Mozambique: 128/ 171 (75%) Zambia: 447/520 (86%)	Ethiopia – BEmONC: 272 (numerator only) Guinea – MCH/ GBV: 1,662 (numerator only) Guinea – Restoration Services: 4,095 (numerator only) Madagascar: 2,061/ 2,253 (92%) Mozambique – EPCMD: 565/ 668 (85%) Nigeria – MNCH: 105/ 105 (100%) Rwanda – EPCMD: 4,131/ 4,624 (89%)
12	Number/ Percentage of newborns with suspected severe bacterial infection who receive appropriate antibiotic therapy	Numerator: Number of newborns with suspected severe bacterial infection (infant reportedly stopped feeding well and/or stopped moving on its own) receiving antibiotics Denominator: Number of newborns with suspected severe bacterial infection. Disaggregated by country	HMIS, supplemental data collection form	Quarterly	None Reported	None Reported	None Reported
13	Number of countries in which interventions to address the unique RMNCH needs of young, first-time parents are initiated	Disaggregated by country	Program records	Annually	None Reported	1: Nigeria – MNH	1: Nigeria – MNCH

#	Indicator	Definition and disaggregation	Data source/ collection method	Frequency of data collection	FY 2014 data	FY 2015 data	FY 2016 data
14	Percentage of children age 2–59 months with fever during the reporting period (three months) for whom advice or treatment was sought from a CCM-trained CHW in MCSP-supported areas	Numerator: Number of children aged 2–59 months with fever during the reporting period (three months) for whom advice or treatment was sought from a CCM-trained CHW in MCSP-supported areas Denominator: Expected number of children aged 2–59 months with fever during the reporting period (three months) in MCSP-supported areas Disaggregated by country	HMIS, CHW records, community HIS, if available	Quarterly	Mali: 23,713/ 30,530 (78%)	None Reported	Rwanda – EPCMD: 89,457/ 972,916 (9%)
15	Percentage of children age 2–59 months with fast or difficult breathing during the reporting period (three months) for whom advice or treatment was sought from a CCM-trained CHW in MCSP-supported areas	Numerator: Number of children aged 2–59 months with fast or difficult breathing during the reporting period (three months) for whom advice or treatment was sought from a CCM-trained CHW Denominator: Expected number of children aged 2–59 months with fast or difficult breathing during the reporting period (three months) Disaggregated by country	HMIS, CHW records, community HIS, if available	Quarterly	Mali: 6,235/ 6,235 (100%)	None Reported	Rwanda – EPCMD: 32,821/ 1,444,968 (2.3%)

#	Indicator	Definition and disaggregation	Data source/ collection method	Frequency of data collection	FY 2014 data	FY 2015 data	FY 2016 data
16	Number of cases of child diarrhea treated in USAID-assisted (MCSP) programs*	Number of cases of child diarrhea treated through MCSP-supported programs with oral rehydration salt (ORS) AND zinc supplements Disaggregated by country, type of health worker (facility-based health worker or community health worker and if CHW is CCM-trained)	HMIS/service statistics, community HIS	Quarterly	Total: 6259 Mali: 6,259	Total: 7,180 Kenya: 6,811 Mali: 369	Total: 119,357 Guinea – MCH/ GBV: 454 Guinea – Restoration Services: 1,369 Kenya: 54,231 Liberia – RHS: 4,284 Mozambique – EPCMD: 3,232 Namibia: 451 Rwanda – EPCMD: 55,336
17	Number of cases of child pneumonia treated with antibiotics by trained facility or community health workers in USG (MCSP)-supported programs*	Disaggregated by country, type of health worker (facility-based health worker or community health worker and if CHW is CCM-trained)	HMIS/service statistics, community HIS	Quarterly	Total: 6,235 Mali: 6,235	Total: 3,732 Kenya: 2,998 Mali: 734	Total: 100,085 Guinea – MCH/ GBV: 697 Guinea – Restoration Services: 7,173 Kenya: 23,882 Liberia – RHS: 6,509 Mozambique – EPCMD: 2,680 Rwanda – EPCMD: 59,144

#	Indicator	Definition and disaggregation	Data source/ collection method	Frequency of data collection	FY 2014 data	FY 2015 data	FY 2016 data
18	Number/ Percentage of children aged <12 months who received DPT3/Penta3 vaccine in MCSP-supported areas	Numerator: Number of children aged <12 months receiving three doses of DPT/Penta3 vaccine in MCSP-supported areas Denominator: Total estimated number of children aged <12 months in the in MCSP-supported catchment area[1] Disaggregated by country	HMIS	Quarterly	Malawi: 397,503/ 440,194 (90%)	Kenya: 7,332 (numerator only) Malawi: 591,673/ 632,977 (93%) Uganda: 86,918/ 92,431 (94%)	Haiti – SSQH: 33,087/ 41,344 (80%) Kenya: 46,970/ 47,600 (98.7%) Liberia – RHS: 13,296/ 15,675 (85%) Malawi: 30,796/ 47,088 (65%) Mozambique – EPCMD: 31,084 (numerator only) Kenya: 70,135/ 97,368 (72%) Nigeria – Routine Immunization: 454,669/ 464,078 (98%) Tanzania: 278,050/ 283,104 (98%) Uganda – 40,022/ 46,452 (86%)
19	Number/ Percentage of target health facilities with appropriate handwashing supplies in the delivery room in MCSP-supported areas	Numerator: Number of target health facilities with appropriate handwashing supplies in the delivery room Denominator: total number of targeted health facilities Disaggregated by country	Health facility survey, program records	Annually	Mali: 175/ 175 (100%)	Guinea – FP – MCH/GBV: 74/ 234 (32%)	Guinea – FP – MCH/GBV: 74/ 234 (32%) Kenya: 289/ 289 (100%) Liberia – RHS: 77/ 77 (100%) Nigeria – MNCH: 97/ 120 (81%)
20	Number of children under 5 reached by ~~USG~~ MCSP-supported nutrition programs	Disaggregated by country, sex	Program records	Annually	Total: 5,879 Mali: 5,879	Total: 117,388 Kenya: 117,388	Total: 461,305 Haiti – SSQH: 105,348 Kenya: 355,957

[1] As countries varied between working in fixed areas and just running campaigns, the denominators for the various countries were calculated differently based upon their activities.

#	Indicator	Definition and disaggregation	Data source/ collection method	Frequency of data collection	FY 2014 data	FY 2015 data	FY 2016 data
21	Number of HIV-positive pregnant women who received antiretrovirals (ARV) to reduce the risk of mother-to-child transmission*	Disaggregate by treatment option	HMIS/service statistics	Quarterly	None Reported	Total: 17,884 Haiti – Social Marketing: 546 Mozambique: 16,602 Zambia: 736	Total: 689 Haiti – SSQH: 662 Liberia – RHS: 27
22	Number of MCSP-supported countries with pre-service education strengthened to improve RMNCH services with MCSP support	Disaggregated by type of technical area strengthened and cadre of provider	Program records	Annually	Total: 2 Malawi, Uganda	Total: 6	Total: 6 countries See Tables 1 and 2 for details related to this indicator
23	Number of people trained through USG-supported programs*	Disaggregated by technical or cross-cutting area, training topic, funding (any core funding used or only field support), sex, type of personnel, and country	Training information monitoring system, training participant registers	Quarterly	Total: 555	Total: 19,108	Total: 73,880 See Table 3 for details related to this indicator
24	Number of MCSP-supported health facilities actively implementing a QI approach	Number of MCSP-supported facilities that are actively implementing a QI approach, such as Standards-Based Management and Recognition (SBM-R® or RAPID) Disaggregated by country and type of facility and type of approach	Quality improvement assessment tool, tracer condition assessment, health facility survey, supervision visit reports	Annually	Total: 177	Total: 521[2]	Total: 1,367 See Table 4 for details related to this indicator

[2] In subsequent discussions with Ethiopia – CBNC, this number was decremented by 4,324 because it was determined that the support provided did not reach the level of support expected for this indicator

#	Indicator	Definition and disaggregation	Data source/ collection method	Frequency of data collection	FY 2014 data	FY 2015 data	FY 2016 data
26	Number of countries where MCSP has supported the scale-up of high-impact RMNCH interventions	Disaggregated by country and intervention	Program records	Annually	None Reported	Total: 9	Total: 16 See Table 5 for details related to this indicator
Objective 2: Close innovation gaps needed to improve health outcomes among high burden and vulnerable populations through engagement with a broad range of partners							
27	Number of people completing an intervention pertaining to gender norms that meets minimum criteria	This includes adults and children completing an intervention in the reporting period Disaggregated by country, sex	Program records	Annually	None Reported	None Reported	Total: 15,069 Ethiopia – BeMONC: 64 Haiti – EPCMD: 9 Haiti – SSQH: 2,817 Mozambique – EPCMD: 718 Nigeria – MNCH: 252 Rwanda – EPCMD: 574 Tanzania: 10,635
28	Number of countries where MCSP supported a gender analysis	Disaggregated by country	Program records	Annually	Mali: 1	Total: 2 Guinea – IPC, Nigeria – MNH	Total: 3 Guinea – MCH/ GBV, Nigeria -– MNCH, Tanzania
29	Number of countries that have integrated GBV screening into ANC services with MCSP support	Disaggregated by country	Program records	Annually	None Reported	Total: 2 Guinea – IPC, Madagascar	Total: 3 Guinea – MCH/GBV, Madagascar, Rwanda – EPCMD

#	Indicator	Definition and disaggregation	Data source/ collection method	Frequency of data collection	FY 2014 data	FY 2015 data	FY 2016 data
30	Number of countries that have introduced a health service innovation with MCSP support	An innovation is "an idea, practice, or object perceived as new by an individual or other unit of adoption Disaggregated by country	Program records	Annually	Mali: 1	Priority health innovations: Nigeria – MNH, Ethiopia – BEmONC Other country-level innovations: Madagascar	5 Priority innovations 8 Other innovations See Table 6 for details related to this indicator
31	Number of grants awarded to local non-governmental institutions to advance RMNCH services	Non-governmental institutions include professional societies, CSOs, academic or research institutions, faith-based organizations, etc. This may include grants to support service delivery or knowledge generation. Disaggregated by country	Program records	Annually	None Reported	Total: 5 Malawi: 1 Nigeria – MNH: 4	Total: 21 DRC: 1 Haiti – EPCMD: 3 Mozambique – EPCMD: 1 Namibia: 1 Nigeria – MNCH: 4 Rwanda – EPCMD: 3 Tanzania: 8
32	Number of local partners whose capacity MCSP has built	Local partners may include the MOH, non-governmental institutions, including professional societies, CSOs, academic or research institutions, faith-based organizations, etc. Disaggregated by country	Program records	Annually	None Reported	Total: 23 Burma: 1 Ethiopia – BEmONC: 11 Ghana: 3 Madagascar: 3 Malawi: 1 Nigeria – MNH: 4	Total: 60 Ethiopia – BeMONC: 2 Ghana – PSE/CHPS: 3 Liberia – RHS: 1 Madagascar: 3 Mozambique – EPCMD: 32 Myanmar (Burma): 4 Namibia: 1 Nigeria – MNCH: 4 Rwanda – EPCMD: 2 Tanzania: 8

#	Indicator	Definition and disaggregation	Data source/ collection method	Frequency of data collection	FY 2014 data	FY 2015 data	FY 2016 data
33	Number of countries that have used information and communication technologies (ICT) to improve the performance of health systems or support service delivery with MCSP support	ICT includes: mobile phones, text messages, electronic medical records, LMIS Excludes: radio, television campaigns, routine HMIS Disaggregated by country, equity, gender, incorporation into national or subnational e/mHealth strategy	Program records	Annually	Mali: 1	Total: 4 Ghana – PSE/CHPS, Guinea – IPC, Madagascar, Nigeria – MNH	Total: 8 Ghana – PSE/CHPS, Guinea – MCH/GBV, Madagascar, Namibia, Nigeria – MAMA, Nigeria – MNCH, Nigeria – Routine Immunization, Tanzania
34	Number of countries that have introduced new vaccines with MCSP support	This means a vaccine that is new to the target country. Disaggregated by country, vaccine type	Program records	Annually	None Reported	Total: 2 Malawi: 2 Tanzania: 1	Total: 8 See Table 7 for details related to this indicator
35	Number of countries where MCSP has used innovative approaches to strengthen referral systems	An innovative approach is "an idea, practice, or object perceived as new by an individual or other unit of adoption. Disaggregated by country	Program records	Annually	Total: 1 Mali	Total: 1 Guinea – IPC	Total: 5 Guinea – MCH/GBV, Haiti – EPCMD, Nigeria – MNH, Nigeria – Routine Immunization, Rwanda – EPCMD
36	Percentage of MCSP target districts that have engaged CSOs to develop community health strategies that include institutionalization of CSO involvement	Numerator: number of MCSP target districts that have engaged CSOs to develop community health strategies that include institutionalization of CSO involvement Denominator: total number of MCSP target districts Disaggregated by country	Program records	Annually	Mali: 11/13 (85%)	Guinea – FP – MCH/ GBV: 20/ 20 (100%), Guinea – IPC: 24/ 24 (100%) Malawi: 2/ 2 (100%) Mozambique – Bridge: 7/ 7 (100%)	Guinea – MCH/GBV: 20/ 20 (100%) Kenya: 11/ 29 (38%) Mozambique – EPCMD: 19/ 19 (100%) Nigeria – Routine Immunization: 43/ 43 (100%) Rwanda – EPCMD: 16/ 16 (100%) Tanzania: 13/ 16 (81%)

#	Indicator	Definition and disaggregation	Data source/ collection method	Frequency of data collection	FY 2014 data	FY 2015 data	FY 2016 data
Objective 3: Foster effective policy, program learning and accountability for strengthening RMNCH outcomes across the continuum of care							
37	Number of (national) policies drafted with USG (MCSP) support*	Disaggregated by country and technical area	Final policy document; program records	Annually	Total: 2 Mali, Uganda	Total: 8 Ethiopia – BEmONC, Guinea Guinea – FP – MCH/ GBV, Madagascar, Malawi, Mozambique - Bridge	Total: 34 See Table 8 for details related to this indicator
38	Number of studies completed	A study is completed when either the final study report, research brief or manuscript is completed. A list of study names will be provided. Disaggregated by country	Program records	Annually	Total: 2 Malawi: 1 Mali: 1	Total: 2 Madagascar: 1 Nigeria – MNH: 1	Total: 13 See Table 9 for details related to this indicator
39	Number of articles submitted for publication in peer reviewed journals	This includes all articles submitted for publication in a peer review journal that MCSP project staff have written or contributed to. Disaggregated by country	Program records	Annually	Malawi: 1	Total: 3 Guinea – FP – MCH/ GBV: 2 Madagascar: 1	Total: 3 Guinea – MCH/ GBV: 2 Madagascar: 1 For a list of published articles, refer to Annex G
40	Number of technical reports/papers, policy/research/ program briefs, and fact sheets produced and disseminated	This refers to any type of technical report, paper, policy brief, research brief, program brief, or fact sheet produced and disseminated about MCSP or written by MCSP staff. Dissemination can be electronic or in a public forum such as a national or international meeting or conference. Disaggregate by country and type of publication	Program records	Annually	Total: 1 Mali: 1	Total: 21 Ghana – PSE/ CHPS: 3 Guinea – FP – MCH/ GBV: 5 Guinea – IPC: 6 Madagascar: 2 Mozambique – Bridge: 1 Nigeria – MNH: 3 Uganda: 1	Total: 54 Guinea – MCH/GBV: 5 India – FP: 2 Liberia – RHS: 4 Madagascar: 2 Nigeria – MNCH: 3 Nigeria – Routine Immunization: 4 Rwanda – EPCMD: 5 Tanzania: 29 HQ: (Annex H)

#	Indicator	Definition and disaggregation	Data source/ collection method	Frequency of data collection	FY 2014 data	FY 2015 data	FY 2016 data
41	Number of MCSP-supported countries that have integrated new RMNCH indicators into the national HMIS	To be reported here, indicators must be institutionalized and incorporated into standard national HMIS recording and reporting formats. Disaggregated by country	Program records	Annually	None Reported	Total: 1 Mozambique – Bridge	Total: 3 Ghana – PSE/CHPS, Kenya, Nigeria – MNCH
42	Number of MCSP-supported countries pilot testing new RMNCH indicators	To be considered a pilot, the tools must be used for more than a month in at least one facility. Disaggregated by country	Program records	Annually	Total: 1 Mali	None Reported	Total: 3 Madagascar, Nigeria – MNCH, Tanzania
43	Percentage of MCSP target districts that have a systematic approach to track and display a priority set of RMNCH indicators	Numerator: Number of target districts (or counties/LGAs/*woredas*) that have a systematic approach to track and display a priority set of RMNCH indicators. This may include district scorecards/dashboards. Denominator: Total number of target districts Disaggregated by country	Program records	Annually	Mali: 13/ 13 (100%)	None Reported	Ghana – PSE/CHPS: 107/ 107 (100%) Kenya: 29/ 29 (100%) Madagascar: 56/ 74 (76%) Nigeria – Routine Immunization: 43/ 43 (100%) Rwanda – EPCMD: 16/ 16 (100%)
44	Percentage of MCSP target districts with regular feedback mechanisms supported by the program to share information on progress toward RMNCH health targets with community members and/or CSOs	Numerator: Number of target districts with regular feedback mechanisms to share information on progress toward health targets to community members and CSOs Denominator: Total number of target districts Disaggregated by country	Program records	Annually	Mali: 13/ 13 (100%)	Guinea – FP – MCH/ GBV: 2/ 20 (10%) Mozambique – Bridge: 7/ 7 (100%)	Kenya: 29/ 29 (100%) Nigeria – Routine Immunization: 43/ 43 (100%) Rwanda – EPCMD: 16/ 16 (100%) Tanzania: 13/ 16 (81%)

#	Indicator	Definition and disaggregation	Data source/ collection method	Frequency of data collection	FY 2014 data	FY 2015 data	FY 2016 data
45	Percentage of MCSP target districts that conducted a data quality assessment in the past year that included RMNCH indicators	Numerator: Number of target districts with one or more health facilities that conducted a data quality assessment in the past year that included reproductive health, maternal and newborn health, and child health indicators Denominator: Total number of target districts Disaggregated by country	Annual HIS review assessments	Annually	Mali: 7/ 13 (54%)	Guinea – IPC: 2/ 24 (8%) Nigeria – MNH: 34/ 34 (100%) Tanzania: 16/ 16 (100%)	Guinea – MCH/GBV: 2/ 20 (10%) Kenya: 29/ 29 (100%) Namibia: 12/ 34 (35.3%) Nigeria – MNCH: 34/ 34 (100%) Nigeria – Routine Immunization: 20/ 43 (46.5%) Rwanda – EPCMD: 12/ 16 (75%) Tanzania: 16/ 16 (100%) Uganda: 6/ 6 (100%)
46	Number of countries implementing a maternal and perinatal death surveillance and response system with MCSP support	This could cover the community and/or facility-based deaths and may include application of WHO's Maternal Death Surveillance and Response approach. Disaggregated by country	Supervision reports, health facility survey, surveillance reports	Annually	Total: 1 Mali	Total: 3 Guinea – FP – MCH/ GBV, Nigeria – MNH, Zambia	Total: 8 Guinea – MCH/GBV, Haiti – EPCMD, Kenya, Liberia – RHS, Mozambique – EPCMD, Nigeria – MNH, Rwanda – EPCMD, Tanzania

* USAID-required Operational Plan (OP) indicators

Table 1: Details on Indicator 22: Pre-service education strengthened, by cadre

Country	Doctor	Nurse	Midwives	CHWs
Burma			~~X~~	
Ghana – PSE/CHPS		X	X	X
Guinea – MCH/ GBV	X	X	X	
~~Kenya~~		~~X~~	~~X~~	
Haiti – EPCMD			X	
Liberia – HRH			X	
Madagascar			X	
~~Nigeria – MNCH~~				
Tanzania		X	X	X

Table 2: Details on Indicator 22: Pre-service education strengthened, by topic

Country	Maternal/ newborn health	Exclusive newborn health	FP/ RH	Immuni-zation	Malaria	WASH	HIV/ AIDS	Gender	Other
Ghana – PSE/CHPS	X	X			X	X		X	X
Guinea – MCH/ GBV	X	X	X		X				
Haiti – EPCMD	X	X				X			
~~Kenya~~				~~X~~					
Liberia – HRH	X	X	X	X	X		X		
Madagascar	X	X	X	X	X				
Tanzania	X	X	X	X					

Table 3: Details on Indicator 23: People trained

Row labels	Maternal/ newborn health	Exclusive newborn health	Child health & nutrition	FP\RH	Immunization	M&E	Malaria	WASH	HIV/ AIDS	Gender	Other
Burma	67										38
Ethiopia—BeMONC	111			129							
Ethiopia—CBNC		11602				35					
Ghana—IPC								151			
Guinea—IPC											854
Guinea—MCH/GBV						11				5	

Row labels	Maternal/ newborn health	Exclusive newborn health	Child health & nutrition	FP\RH	Immunization	M&E	Malaria	WASH	HIV/ AIDS	Gender	Other
Guinea—Restoration Services	529		105	885							
Haiti—EPCMD	516		97					63			
Haiti—SSQH	103		20			189		168	177	83	
India—FP				249							
Kenya	2,971		1,259	2,158	167	54	1,652	82	273		
Laos	10							4			1
Liberia—HRH								43			29
Liberia—RHS	18	18	95	42	185		18	398			439
Madagascar	1,309			697	698		971				
Malawi			437	200	264						
Mozambique—EPCMD	72	55	135	219		698	82	103		519	
Mozambique—Malaria			24				183				36
Namibia	135		135	135		30			91		162
Nigeria—MNH	432	441		216		555	77			252	
Nigeria—Routine Immunization			2,406		8,221	2,200					
Rwanda—EPCMD	5,089	356	429	5,076		992	2,570			1,026	417
Tanzania	266	39		385			231				
Uganda					8711						
	11,628	1,2511	5,142	1,0391	1,8246	4,764	5,784	1,012	541	1,885	1,976

Table 4: Details on Indicator 24: Facilities actively supporting quality improvement approaches

Country	Hospital	Health center	Clinic	Health post	Unknown
Ethiopia—BeMONC		110			
Ethiopia—CBNC		25			
Guinea—IPC	34	112	106	354	
Guinea—MCH/GBV	22	30			

Country	Hospital	Health center	Clinic	Health post	Unknown
Guinea—Restoration Services	40	116			
Haiti—SSQH	10	16			
India—FP	38	141			
Kenya	45	101	64	259	
Liberia—RHS	28	7	196		
Madagascar	16				
Malawi	6	120			
Mozambique—EPCMD					49
Nigeria—MNH	2	3			
Tanzania	92	377		351	62
Uganda		70			
Total	333	1,228	366	964	111

Table 5: Details for Indicator 26: High-impact interventions

Indicator	FY2015 data	Total countries covered to date
High-impact maternal health interventions		
ANC	Ethiopia – BeMONC, Guinea - Restoration Services, Haiti – SSQH, Kenya, Liberia – RHS, Mozambique – EPCMD, Nigeria – MNCH, Rwanda – EPCMD, Tanzania	9
CemONC	Guinea – Restoration Services, Haiti – SSQH, Kenya, Liberia – RHS, Mozambique – EPCMD, Nigeria – MNCH, Rwanda – EPCMD, Tanzania	8
Community-based services: PPH Prev	Kenya, Nigeria — MNCH	2
Facility-based services: PPH Prev	Ethiopia – BeMONC, Guinea – Restoration Services, Haiti – SSQH, Kenya, Liberia – RHS, Madagascar, Mozambique – EPCMD, Nigeria – MNCH, Rwanda – EPCMD, Tanzania	10
Infection (Dx/ Tx)	Ethiopia – BeMONC, Guinea – Restoration Services, Haiti – SSQH, Kenya, Liberia – RHS, Madagascar, Nigeria - MNCH	7
Labor monitoring and management (partograph)	Kenya, Liberia – RHS, Madagascar, Nigeria – MNCH, Rwanda - EPCMD	5
PE/E Mgmt (MgSO4 and/ or hypertensives)	Ethiopia – BeMONC, Guinea – Restoration Services, Haiti – SSQH, Kenya, Liberia – RHS, Madagascar, Mozambique – EPCMD, Nigeria – MNCH, Rwanda – EPCMD, Tanzania	10

Indicator	FY2015 data	Total countries covered to date
PPH Mgmt	Ethiopia – BeMONC, Guinea – Restoration Services, Haiti – EPCMD, Haiti – SSQH, Kenya, Liberia – RHS, Mozambique – EPCMD, Nigeria – MNCH, Rwanda – EPCMD, Tanzania	10
PTB (Mgmt)	Haiti – SSQH, Mozambique – EPCMD, Rwanda - EPCMD	3
RMC	Kenya, Laos, Mozambique - EPCMD	3
Routine MNH care	Ethiopia – BeMONC, Haiti – SSQH, Kenya, Laos, Liberia – RHS, Mozambique – EPCMD, Nigeria – MNCH, Rwanda – EPCMD, Tanzania	9
High-impact newborn health intervention		
Chlorhexidine (CHX)	Kenya, Mozambique – EPCMD, Nigeria - MNCH	3
Kangaroo mother care (KMC)	Ethiopia – BeMONC, Kenya, Liberia – RHS, Mozambique – EPCMD, Nigeria – MNCH, Rwanda – EPCMD, Tanzania	7
Newborn resuscitation (ENC, HBB)	Ethiopia – BeMONC, Haiti – EPCMD, Haiti – SSQH, Kenya, Laos, Liberia – RHS, Mozambique – EPCMD, Nigeria – MNCH, Rwanda – EPCMD, Tanzania	10
PSBI	Ethiopia – CBNC, Haiti – SSQH, Kenya, Liberia – RHS, Mozambique – EPCMD, Nigeria - MNCH	6
PTB (ACS)	Haiti – SSQH, Kenya, Mozambique – EPCMD, Rwanda - EPCMD	4
High-impact child health interventions		
Facility-based services: IMCI	Guinea – Restoration Services, Haiti – SSQH, Kenya, Liberia – RHS, Mozambique – EPCMD, Rwanda - EPCMD	6
iCCM	Kenya, Mozambique – EPCMD	2
High-impact FP interventions		
Community-based services: FP/PPFP	Guinea – Restoration Services, Haiti – SSQH, Kenya, Mozambique - EPCMD	4
Expanding Method Choice	Haiti – SSQH, India – FP, Kenya, Liberia – RHS, Mozambique – EPCMD, Nigeria – MNH, Rwanda – EPCMD, Tanzania	8
Facility-based services: LAM	Guinea – Restoration Services, Haiti – SSQH, Kenya, Liberia – RHS, Nigeria – MNH, Rwanda – EPCMD, Tanzania	7
Interval LARCs	Guinea – Restoration Services, Haiti – SSQH, Kenya, Liberia – RHS, Mozambique – EPCMD, Nigeria – MNCH, Rwanda - EPCMD	7
Perm. methods	Guinea – Restoration Services, Haiti – SSQH, India – FP, Kenya, Rwanda – EPCMD	5

Indicator	FY2015 data	Total countries covered to date
PP LARCs	Ethiopia – BeMONC, Guinea - Restoration Services, Haiti – SSQH, Kenya, Liberia – RHS, Madagascar, Nigeria – MNCH, Rwanda – EPCMD, Tanzania	9
High-impact immunization interventions		
Disease specific – measles	Haiti – SSQH, Kenya, Liberia – RHS	3
Disease specific – polio	Haiti – SSQH, Kenya, Liberia – RHS, Mozambique – EPCMD, Tanzania	5
Disease specific – tetanus	Haiti – SSQH, Kenya, Mozambique – EPCMD, Tanzania	4
New vaccine – IPV	Haiti – SSQH, Kenya, Uganda	3
New vaccine – meas – rub	Haiti – SSQH, Kenya, Tanzania	3
New vaccine – measles 2nd	Haiti – SSQH, Kenya, Tanzania	3
New vaccine – meningitis A	Haiti - SSQH	1
New vaccine – PCV	Tanzania	1
New vaccine – Rotavirus	Haiti – SSQH, Kenya, Liberia – RHS, Tanzania	4
High-impact malaria interventions		
Community-based services: Malaria case mgmt	Kenya, Mozambique - EPCMD	2
Community-based services: MiP	Kenya	1
Facility-based services: Malaria case mgmt	Kenya, Liberia – RHS, Mozambique - EPCMD	4
Facility-based services: MIP	Kenya	1
High-impact nutrition interventions		
Baby-friendly initiatives	Kenya	1
Early initiation of an exclusive breastfeeding	Haiti – SSQH, Kenya, Liberia – RHS, Madagascar	4
Maternal anemia/ IFA	Haiti – SSQH, Kenya, Mozambique - EPCMD	3
High-impact WASH interventions		
Facility	DRC, Guinea – Restoration Services, Haiti – SSQH, Kenya, Liberia – RHS, Mozambique - EPCMD	6
Household	Kenya, Mozambique - EPCMD	3

Table 6: Details on Indicator 30: Innovations

	The Reaching Every Community/ QI approach for immunization equity and coverage	PSBI treatment and antibiotic guidelines (feasible for community setting)	Gestational age assessment	First time and young parents	Bubble cPAP (newborn)	Uterine balloon tamponade (maternal)	Pneumonia diagnostic (child)	Other Innovation
Burma						~~1~~		1
Ethiopia		1						
Guinea - MCH/GBV								1
~~Kenya~~	~~1~~							
Laos						1		
Liberia						1		
Madagascar			1	1				2
Mozambique			1					
Namibia								1
Nigeria - MNH		1		1	1			
Nigeria - routine immunization								1
Rwanda - EPCMD								2
Uganda	1							

Table 7: Details on Indicator 34: Vaccines

	Rotavirus	Pneumococcal	Pentavalent	Measles	MenA	Other vaccine
Kenya	~~X~~			X		X
Liberia—RHS	X					
Malawi						X
Nigeria—routine immunization		X				X
Tanzania						X
Uganda						X

Table 8: Details on Indicator 37: Policies drafted

Country	# of policies	Titles
Burma	2	1. In-Service Training Day of Birth Modules 2. Learning Resource Package for MNH High Impact Interventions
DRC	3	1. IMCI guidelines and package 2. iCCM guidelines and package 3. Post-partum family planning guidelines and package
Ghana - PSE/CHPS	2	1. National CHN school curriculum revision by Nurses and Midwifery Council 2. Community Health-Based Planning Services (CHPS) National Implementation Guidelines.
Guinea - MCH/GBV	3	1. IPC policy and strategy 2. HMIS Indicator catalog for the new DHIS2 platform database under development 3. Guidance developed for the Hygiene and Sanitation Committees
Haiti - EPCMD	11	1-6. 6 protocols IMCI (Protocol for the Care of Infants and Children under 5 during Home Visits, Protocol for the Care of Infants and Children under 5 during Consultation at the Community Health Center (formerly dispensaries), Protocol for pre-consultation of Infants and Children under 5 at the Health Center, Protocol for consultation of Infants and Children under 5 by nurses at the Health Center, Protocol for consultation of Infants and Children under 5 during by doctors (general practitioners) at the Health Center, Protocol for additional care of Infants and Children under 5 during out-patient consultation at the Health Center) 7. Protocol on Prevention of anemia among pregnant and lactating women 8. CECAP Norms 9. MDSR guidelines 10. CPN and ANC guidelines 11. PPFP draft
Madagascar	3	1. La Feuille de route de la réduction de la mortalité maternelle et néonatale 2. Directives Techniques relatives aux nouvelles recommandations de TPI 3. updated RH strategic plans
Mozambique - EPCMD	3	1. Draft National Strategy for CECAP, 2016 – 2021 2. Draft National Strategy for Quality Improvement and Humanization, 2017-2023 3. Revised FP Clinical Manual
Nigeria – MNCH	2	1. National policy on Chlorhexidine and national policy on Malaria
Nigeria - routine immunization	3	1. cMYP 2016-2020 2. Basic Guide for Routine Immunization Service Providers 3. Guidelines on Strengthening RI Services
Tanzania	1	1. The National Road Map Strategic Plan to Improve Reproductive, Maternal, Newborn, Child & Adolescent Health in Tanzania (2016 - 2020) One Plan II
Uganda	1	1. Immunization in Practice Manual

Table 9: Details on Indicator 38: Studies completed

Country	# of studies	Title
Ethiopia - BeMONC	2	Assessment of respectful maternity care practice in public health facilities of Ethiopia The effectiveness of a blended learning approach for basic emergency obstetric and newborn care training in Ethiopia

Country	# of studies	Title
Madagascar	1	Status of MNH services delivery at public health facilities in 15 regions of Madagascar
Mali	2	Seasonal malaria chemo prevention intervention Introduce chlorhexidine for umbilical cord care
Mozambique – Bridge	1	Process documentation of the helping babies breathe approach and KMC needs assessment in Mozambique
Nigeria – MNCH	2	Facility assessment and quality of care study in Ebonyi and Kogi states
Nigeria – routine immunization	3	Sokoto - training needs assessment (technical report) RI diagnostic study Bauchi community partnership assessment
Rwanda – EPCMD	1	Health facility Baseline assessment
Tanzania	1	Knowledge, practice and coverage survey

Annex C: MCSP Action-Oriented Learning Agenda

MCSP action-oriented learning agenda													
Learning question	**Learning and implementation themes**								**Technical area(s)**	**Country/ countries**	**Stage†**	**Comments**
	Achieving sustainable impact at scale	Quality	Equity, including gender equity	HSS, including private sector	Community action for health	Innovations to address key gaps in coverage, quality, or equity	Measurement and data use for action and accountability	Technical- and/or country-specific				
† Stage: 1=Preparation; 2=Data collection; 3=Analysis/writing; 4=Dissemination; 5=Completed												
What is the country and global experience in resource mobilization for iCCM scale up?	X								Child Health	Ghana; Kenya; Uganda; Nigeria; Zambia	5	
What are the key components and characteristics (policy, incentives, scopes of work, and intervention packages) of government CHW programs in the EPCMD priority countries?					X				N/A	EPCMD priority countries	2	
Does policy in the EPCMD priority countries address health facility committees, village/local development committees, women's groups, and other similar types of community structures?					X				N/A	EPCMD priority countries	2	
What are effective mechanisms and models of PPFP implementation for integrating FP with MNCH services?				X					Child Health; Family Planning; Maternal Health; Newborn Health	Kenya; India	5	

MCSP action-oriented learning agenda												
Learning question	**Learning and implementation themes**								**Technical area(s)**	**Country/ countries**	**Stage†**	**Comments**
	Achieving sustainable impact at scale	Quality	Equity, including gender equity	HSS, including private sector	Community action for health	Innovations to address key gaps in coverage, quality, or equity	Measurement and data use for action and accountability	Technical- and/or country-specific				
† Stage: 1=Preparation; 2=Data collection; 3=Analysis/writing; 4=Dissemination; 5=Completed												
Assess how integration of FP and immunization services affects service provision, utilization, and quality in three or more MCSP countries.		X		X					Family Planning; Immunization	Liberia; Malawi; Tanzania	2	
Explore male care-seeking patterns and needs to design a model of male services that includes no-scalpel vasectomy alongside other desired services for men.								X	Family Planning	Kenya; Togo	1	
Introduce Levonorgestrel Intrauterine System (LNG-IUS) in the public sector, with a focus on postpartum women.								X	Family Planning	Kenya; Zambia	1	
Which process indicators are appropriate for providing real-time, reliable routine immunization system data that are on a pathway to uniformly high reliable routine immunization coverage that is sustainable over time?							X		Immunization	Kenya; Liberia; Madagascar; Malawi; Mozambique; Nigeria; Tanzania; Uganda	1	
What steps and processes are needed to improve the generation and active use of reliable routine immunization data?							X		Immunization	Kenya; Liberia; Madagascar; Malawi; Mozambique; Nigeria; Tanzania; Uganda	1	

MCSP action-oriented learning agenda												
Learning question	**Learning and implementation themes**								**Technical area(s)**	**Country/ countries**	**Stage†**	**Comments**
	Achieving sustainable impact at scale	Quality	Equity, including gender equity	HSS, including private sector	Community action for health	Innovations to address key gaps in coverage, quality, or equity	Measurement and data use for action and accountability	Technical- and/or country-specific				
† Stage: 1=Preparation; 2=Data collection; 3=Analysis/writing; 4=Dissemination; 5=Completed												
What are the in-country contextual factors that enable or restrict scale up of advance distribution of misoprostol for self-administration for prevention of PPH at home birth?	X				X				Maternal Health	Afghanistan; Mozambique	2	
Regional situational review of facility-based Maternal Death Surveillance and Response, Perinatal Death Surveillance and Response and/or combined MPDSR systems (when existent) in the Africa region to assess the status of implementation in select countries and to deepen understanding of operational barriers and generate recommendations for strengthening MPDSR systems at regional and country level.		X					X		Maternal Health; Newborn Health	Nigeria; Rwanda; Tanzania; Zimbabwe	2	
Through implementation of a systematic method for scaling up, can countries accelerate achievement of high effective coverage and institutionalization of high-impact RMNCH interventions?	X						X		Child Health; Family Planning, Maternal Health; Newborn Health	Afghanistan; Bangladesh; DRC; Liberia; Mozambique; Nigeria; Rwanda	2	

MCSP action-oriented learning agenda												
Learning question	**Learning and implementation themes**								**Technical area(s)**	**Country/ countries**	**Stage†**	**Comments**
	Achieving sustainable impact at scale	Quality	Equity, including gender equity	HSS, including private sector	Community action for health	Innovations to address key gaps in coverage, quality, or equity	Measurement and data use for action and accountability	Technical- and/or country-specific				
† Stage: 1=Preparation; 2=Data collection; 3=Analysis/writing; 4=Dissemination; 5=Completed												
HMIS review: Which key data elements related to MNCH indicators are present in routine health information systems in the EPCMD priority countries, and how are they managed?				X			X		Child Health; Maternal Health; Newborn Health	EPCMD priority countries	2/3	
KPC Survey: What is the health situation at a local level? Does intervention coverage vary across different vulnerable groups?			X				X		Child Health; Family Planning; Immunization; Malaria; Maternal Health; Newborn Health; Nutrition; WASH	Bangladesh; Ethiopia; Tanzania	5	DRC, Nigeria (child health) and Mozambique are under separate protocols; see below
What are the usefulness, feasibility, acceptability, and reliability of RMNCH indicators that may potentially be introduced into existing HMIS in low and middle income countries?		X					X		Child Health; Family Planning; Maternal Health; Newborn Health	DRC; Madagascar; Nigeria; Tanzania	2	

MCSP action-oriented learning agenda												
Learning question	**Learning and implementation themes**								**Technical area(s)**	**Country/ countries**	**Stage†**	**Comments**
	Achieving sustainable impact at scale	Quality	Equity, including gender equity	HSS, including private sector	Community action for health	Innovations to address key gaps in coverage, quality, or equity	Measurement and data use for action and accountability	Technical- and/or country-specific				
† Stage: 1=Preparation; 2=Data collection; 3=Analysis/writing; 4=Dissemination; 5=Completed												
Do training activities that integrate basic newborn care with basic emergency obstetric care (BEmOC) effectively ensure providers' competencies in basic newborn care in Ethiopia and Nepal?				X					Maternal Health; Newborn Health	Ethiopia; Nepal	1/2	Nepal to be confirmed
What innovative approaches are programs taking to address the major barriers to and also factors facilitating/motivating exclusive breastfeeding in the first six months?						X			Nutrition	EPCMD and Nutrition priority countries	4	
To what extent is the consumption of junk food by children younger than five years a nutrition problem in the EPCMD priority countries and what are the factors influencing the feeding of these foods to children?								X	Nutrition	EPCMD and nutrition priority countries	5	
What are the major barriers to adequate food intake during pregnancy and what are programs doing to address the problem in the EPCMD priority countries?								X	Nutrition	EPCMD and nutrition priority countries	4	
Is CBD of IFA supplements practiced in the EPCMD priority countries and what are the barriers in moving CBD of IFA supplementation forward?					X				Nutrition	EPCMD and nutrition priority countries	4	

MCSP action-oriented learning agenda												
Learning question	**Learning and implementation themes**								**Technical area(s)**	**Country/ countries**	**Stage†**	**Comments**
	Achieving sustainable impact at scale	Quality	Equity, including gender equity	HSS, including private sector	Community action for health	Innovations to address key gaps in coverage, quality, or equity	Measurement and data use for action and accountability	Technical- and/or country-specific				
† Stage: 1=Preparation; 2=Data collection; 3=Analysis/writing; 4=Dissemination; 5=Completed												
Examine the current state of gestational age estimation, analysis, documentation, and data utilization in antepartum and intrapartum settings						X			Maternal Health	Cambodia; India	1	
Does utilization of CHWs for delivery of IPTp in three districts in Burkina Faso increase coverage of three or more IPTp doses compared to IPTp delivery only at ANC clinics?					X				Malaria	Burkina Faso	1	
How is MIP included or not included in ANC services in Burma?								X	Malaria; Maternal Health	Burma	5	
Assess movement of women across public and private sectors along continuum of care and gaps in PPFP that may result.				X					Family planning	DRC	1	
Baseline assessments to determine KPC of target population (household survey) and the readiness of health facilities and CHWs to deliver quality services		X	X	X			X		Child health; family planning; nutrition; WASH	DRC	1	

MCSP action-oriented learning agenda												
Learning question	**Learning and implementation themes**								**Technical area(s)**	**Country/ countries**	**Stage†**	**Comments**
	Achieving sustainable impact at scale	Quality	Equity, including gender equity	HSS, including private sector	Community action for health	Innovations to address key gaps in coverage, quality, or equity	Measurement and data use for action and accountability	Technical- and/or country-specific				
† Stage: 1=Preparation; 2=Data collection; 3=Analysis/writing; 4=Dissemination; 5=Completed												
Through implementation and management of a systematic scale-up process, can countries accelerate achievement of high effective coverage and institutionalization of the iCCM to end preventable deaths of children under 5?	X	X			X		X		Child health	DRC	1	
What are the best approaches for integrating nutrition into iCCM to improve health and nutritional outcomes for children under 5? Can preventive and curative aspects of nutrition be integrated into the iCCM platform? Is this feasible and what are the gaps and opportunities to improve service delivery of nutrition counseling and iCCM?				X	X				Child health; nutrition	DRC	1	
What are feasible measures for tracking the additional coverage achieved from implementing iCCM? What are feasible measures for quality of iCCM programs using routine information systems?	X	X			X		X		Child health	DRC	1	

MCSP action-oriented learning agenda												
Learning question	**Learning and implementation themes**								**Technical area(s)**	**Country/ countries**	**Stage†**	**Comments**
	Achieving sustainable impact at scale	Quality	Equity, including gender equity	HSS, including private sector	Community action for health	Innovations to address key gaps in coverage, quality, or equity	Measurement and data use for action and accountability	Technical- and/or country-specific				
† Stage: 1=Preparation; 2=Data collection; 3=Analysis/writing; 4=Dissemination; 5=Completed												
Do caretakers of referred sick newborns with possible severe bacterial infection comply with referral and do they receive appropriate and adequate treatment at the health center? Who complies with referral and who doesn't, and why?					X	X			Newborn health	Ethiopia	1	
What is the care given to low birthweight babies? How is this care related to attitudes and care practices and quality of counselling by health extension workers?					X				Newborn health	Ethiopia	1	
What are key barriers to and facilitators for early pregnancy identification, birth notification, and early home PNC visits?					X				Maternal health; newborn health	Ethiopia	1	
Evaluation of blended approach for BEmONC: Are the gains of knowledge through the blended BEmONC training similar to or better than those gains through the conventional BEmONC training approach?				X					Maternal health; newborn health	Ethiopia	4	

MCSP action-oriented learning agenda												
Learning question	**Learning and implementation themes**								**Technical area(s)**	**Country/ countries**	**Stage†**	**Comments**
	Achieving sustainable impact at scale	Quality	Equity, including gender equity	HSS, including private sector	Community action for health	Innovations to address key gaps in coverage, quality, or equity	Measurement and data use for action and accountability	Technical- and/or country-specific				
† Stage: 1=Preparation; 2=Data collection; 3=Analysis/writing; 4=Dissemination; 5=Completed												
Among maternity care clients in health centers and hospitals in Amhara, Oromiya, and SNNPR regions in Ethiopia, what is the prevalence of self-reported disrespect and abuse and what are characteristics of desired respectful maternity care?		X							Maternal health	Ethiopia	4	
Does active audit feedback improve the quality of care through increased and appropriate use of MgSO4 and antihypertensive therapy among women in referral hospitals who develop severe PE/E, or those suffering hypertensive crises?		X							Maternal health	Ethiopia	2	Data extraction has been challenging due to in-country security situation; combined with approaching close-out date, the study is at risk.
Can the uterine balloon tamponade as a management approach for moderate to severe PPH be implemented under routine conditions in a safe, feasible, and acceptable manner in health centers and hospitals in Ethiopia?						X			Maternal health	Ethiopia	X	Cancelled as local IRB requested a full clinical trial

MCSP action-oriented learning agenda												
Learning question	**Learning and implementation themes**								**Technical area(s)**	**Country/ countries**	**Stage†**	**Comments**
	Achieving sustainable impact at scale	Quality	Equity, including gender equity	HSS, including private sector	Community action for health	Innovations to address key gaps in coverage, quality, or equity	Measurement and data use for action and accountability	Technical- and/or country-specific				
† Stage: 1=Preparation; 2=Data collection; 3=Analysis/writing; 4=Dissemination; 5=Completed												
How feasible and effective is it to track women through a reproductive continuum (inclusive of all methods in the extended postpartum period) and their receipt of key health services and uptake of key behaviors? Test and refine means to track intra-facility referrals and linkages for immunization and FP.				X					Family planning	Ethiopia	1	
What is an appropriate model for urban CHPS?					X				Child health; family planning; maternal health; newborn health	Ghana	1	
How does the current job description of CHOs compare to CHO-training and actual delivery of services? Does this vary between regions or rural versus urban areas?				X	X				Child health; family planning; maternal health; newborn health	Ghana	3	

MCSP action-oriented learning agenda												
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† Stage: 1=Preparation; 2=Data collection; 3=Analysis/writing; 4=Dissemination; 5=Completed												
Use of misoprostol for home births: Is it safe, feasible, and acceptable to distribute misoprostol at CHW home visits to pregnant women? Can a scalable model of misoprostol distribution be developed?					X				Maternal health	Haiti	1	
Model referral networks: Does referral and counter referral (RCR) completion rate improve when adequate transport, communication, and clinical protocols are in place? What are practical mechanism(s) for tracking referral completion? Is the community satisfied with the RCR system?				X					Child health; family planning; maternal health; newborn health	Haiti	1	
How effective is the intervention on improving perception of quality of FP services? Is there a change in client/provider's perspectives about quality of FP services provided?		X							Family planning	India	1	
Which FP quality indicators and data visualization and sharing approaches are useful for informing FP quality improvement efforts?		X					X		Family planning	India	1	

MCSP action-oriented learning agenda												
Learning question	**Learning and implementation themes**								**Technical area(s)**	**Country/ countries**	**Stage†**	**Comments**
	Achieving sustainable impact at scale	Quality	Equity, including gender equity	HSS, including private sector	Community action for health	Innovations to address key gaps in coverage, quality, or equity	Measurement and data use for action and accountability	Technical- and/or country-specific				
† Stage: 1=Preparation; 2=Data collection; 3=Analysis/writing; 4=Dissemination; 5=Completed												
Demonstration on progestin-only pills and centchroman in the public sector—what is the feasibility, acceptability, and program effectiveness of introducing new and approved modern contraceptive methods in the existing FP basket at government health facilities in five states?								X	Family planning	India	1	
Which are the major program platforms in India to reach mothers and newborns at home in the postnatal period with preventive services, including assessment, counseling, and referrals?	X				X				Maternal health; newborn health	India	1	
What is the change in perceptions, knowledge, and skills of graduates in EPI following implementation of the revised EPI content in pre-service curriculum?				X					Immunization	Kenya	1	
What are unintentional pregnancy rates among women using a contraceptive implant while taking efavirenz as a component of ART?								X	Family planning; HIV	Kenya	2	

MCSP action-oriented learning agenda												
Learning question	**Learning and implementation themes**								**Technical area(s)**	**Country/ countries**	**Stage†**	**Comments**
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† Stage: 1=Preparation; 2=Data collection; 3=Analysis/writing; 4=Dissemination; 5=Completed												
Are ORT corners functional in Igembe North and Bondo sub-counties in Kenya, and to what extent do they adhere to the intervention standards outlined in Kenya's National ORT Corner Operational Guidelines?								X	Child health; nutrition; WASH	Kenya	5	
What is the feasibility of implementing iCCM in Bondo, Kenya?	X				X				Child health	Kenya	5	
Assessment: status of maternal, newborn and family planning service delivery at health facilities in 15 regions of Madagascar		X							Family planning; maternal health; newborn health	Madagascar	4	
Do providers and supervisors find structured supportive supervision in MNH and FP clinical skills [post provider training] to be feasible and acceptable?		X		X					Family planning; maternal health; newborn health	Madagascar	1	
For first-time parents, what factors influence their intentions to seek services and to use ANC, MNC, and FP (including post-partum FP) services at relevant times in their reproductive life course?		X	X			X			Family planning	Madagascar	4	

MCSP action-oriented learning agenda												
Learning question	**Learning and implementation themes**								**Technical area(s)**	**Country/ countries**	**Stage†**	**Comments**
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† Stage: 1=Preparation; 2=Data collection; 3=Analysis/writing; 4=Dissemination; 5=Completed												
Care-seeking behavior for febrile illness in Madagascar.					X				Malaria	Madagascar	1	
What is the baseline EPI coverage in two MCSP-supported, low performing districts?								X	Immunization	Malawi	5	
Does involvement of village leaders in newborn tracking for vaccination using the My Village, My Home tool result in improved vaccination coverage and timeliness of vaccination?					X		X		Immunization	Malawi	2	
What are the changes in knowledge, attitudes, practices and coverage of key RMNCH areas, including malaria, FP, nutrition, WASH, and gender equity among the population in Nampula and Sofala provinces targeted by MCSP in Mozambique?	X		X				X		Child health; family planning; malaria; maternal health; newborn health; nutrition; WASH	Mozambique	2	
Does the referral network approach help reduce delays in receiving high-impact MNCH interventions and thereby contribute to fewer maternal, newborn, and child deaths?		X		X					Child health; maternal health; newborn health	Mozambique	1	

MCSP action-oriented learning agenda												
Learning question	**Learning and implementation themes**								**Technical area(s)**	**Country/ countries**	**Stage†**	**Comments**
	Achieving sustainable impact at scale	Quality	Equity, including gender equity	HSS, including private sector	Community action for health	Innovations to address key gaps in coverage, quality, or equity	Measurement and data use for action and accountability	Technical- and/or country-specific				
† Stage: 1=Preparation; 2=Data collection; 3=Analysis/writing; 4=Dissemination; 5=Completed												
Does male involvement in birth preparedness planning help reduce delays in receiving high-impact MNH interventions and thereby contribute to fewer maternal and newborn deaths?			X		X				Maternal health; newborn health	Mozambique	1	
Can systematic support for scale-up of advance distribution of misoprostol for self-administration according to Mozambique's National PPH Prevention Strategy accelerate achievement of sustainable impact at scale?	X				X				Maternal health	Mozambique	1	
Through implementation of a systematic method for piloting and scaling up, can the HEP reach effective coverage and institutionalization of CBHTC at the community level to identify and link HIV-positive clients to care?	X			X	X				HIV	Namibia	X	Removed from learning agenda as MOH opted for full scale-up instead of further testing and comparison of HTC methods
Does HIV/SRH integration in Namibian Planned Parenthood Association (NAPPA) facilities improve retention in care of adolescents living with HIV?				X					Family Planninyg; HIV	Namibia	X	Cancelled as Mission re-programmed funds

MCSP action-oriented learning agenda												
Learning question	**Learning and implementation themes**								**Technical area(s)**	**Country/ countries**	**Stage†**	**Comments**
	Achieving sustainable impact at scale	Quality	Equity, including gender equity	HSS, including private sector	Community action for health	Innovations to address key gaps in coverage, quality, or equity	Measurement and data use for action and accountability	Technical- and/or country-specific				
† Stage: 1=Preparation; 2=Data collection; 3=Analysis/writing; 4=Dissemination; 5=Completed												
Care of PSBI in private sector by non-physician providers (medicine shops): nationally representative survey.				X		X			Newborn health	Nepal	1	
Assess four sets of factors related to RMNCH quality of care: the national policy environment; facility readiness to provide care with respect to infrastructure, supplies, medications, and client-friendly services; health provider skills with respect to performance of evidence-based RMNCH and respectful care; and health provider knowledge of evidence-based practices.		X					X		Child health; family planning; maternal health; newborn health	Nigeria	5	
Baseline facility readiness assessment: essential maternal and newborn care services in Kogi and Ebonyi states.		X							Maternal health; newborn health	Nigeria	5	
What are the key determinants of strengthening of implementation of simplified antibiotic treatment for possible severe bacterial infection at PHC level in Kogi and Ebonyi States?				X		X			Newborn health	Nigeria	1	

MCSP action-oriented learning agenda												
Learning question	**Learning and implementation themes**								**Technical area(s)**	**Country/ countries**	**Stage†**	**Comments**
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How can positive behaviors related to appropriate cord care (chlorhexidine application or the practice of clean, dry cord care), delivery hygiene, and hand hygiene be strengthened during the period from the onset of labor through the first 2 days of life?		X			X				Newborn health; WASH	Nigeria	1	
Study on care-seeking during infancy and the post-partum period in Nigeria.					X				Maternal Health; newborn health	Nigeria	1	
Are low-dose, high-frequency site-based in-service trainings as effective or more effective than group-based offsite trainings for transferring knowledge and skills to the job?				X					Maternal health; newborn health	Nigeria	2	
From policy to implementation: introduction and expansion of CHX in Nigeria.	X								Newborn health	Nigeria	2	
Ultrasound study								X	Maternal health	Nigeria	1	
What is the feasibility of using age and stage-based interactive SMS and voice messaging to improve MNCH knowledge, uptake of services, and satisfaction in Cross River and Ebonyi states of Nigeria?				X	X				Digital health	Nigeria	1	

MCSP action-oriented learning agenda												
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† Stage: 1=Preparation; 2=Data collection; 3=Analysis/writing; 4=Dissemination; 5=Completed												
Can care for newborn infants with respiratory distress be improved with the introduction of bubble continuous positive airway pressure (bCPAP) in selected hospitals in Ebonyi and Kogi States, Nigeria?						X			Newborn health	Nigeria	2	
Does the use of age and lifestage specific counselling tools and techniques lead to improvement in the quality of services for adolescent girls/young mothers and increased FP utilization by this age group? Can an integrated package of services for young mothers/parents be feasibly implemented within the greater RMNCH health service platforms?		X	X			X			Family planning	Nigeria	2	
What are the KPCs for child health in households in the target LGAs?			X				X		Child health	Nigeria	1	
What are the barriers and facilitating factors (including gender-related factors) that influence families' practices related to seeking care for sick children under 5 in communities in Kogi and Ebonyi?			X		X				Child health	Nigeria	1	

MCSP action-oriented learning agenda												
Learning question	**Learning and implementation themes**								**Technical area(s)**	**Country/ countries**	**Stage†**	**Comments**
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Can engaging traditional barbers and other community resource persons to identify and refer newborns to routine vaccination sites increase the timeliness of vaccination and decrease children "left out" of routine immunization?					X		X		Immunization	Nigeria	1	
What are the key processes, achievements, challenges, and opportunities associated with the implementation of a quadripartite memorandum of understanding model for RI system strengthening in Bauchi and Sokoto states?				X			X		Immunization	Nigeria	1	
How can spatial tools be used to integrate multiple data sources for improved population estimates and PHC health facility catchment area maps that in turn lead to better targeting of RI services?				X			X		Immunization	Nigeria	1	
Understanding household factors affecting demand for polio vaccination and rates of missed children in northern Nigeria					X				Immunization	Nigeria	5	

MCSP action-oriented learning agenda												
Learning question	**Learning and implementation themes**								**Technical area(s)**	**Country/ countries**	**Stage†**	**Comments**
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† Stage: 1=Preparation; 2=Data collection; 3=Analysis/writing; 4=Dissemination; 5=Completed												
Have program interventions improved the readiness of public health facilities in MCSP-supported districts to provide comprehensive RMNCH services?		X							Child health; family planning; maternal health, newborn health	Rwanda	5	
Do "low-dose, high-frequency mentoring, and quality improvement" approaches for capacity building improve retention of providers' skills and performance in labor management and newborn resuscitation in Rwanda? And can this approach be scaled up successfully?	X	X		X					Newborn health	Rwanda	2	
Through systematic support for scaling up PPFP services focused on expanding PPLARCs in the immediate post-partum period, can integration of PPFP interventions contribute to the reduction of unmet need for FP in Rwanda?	X			X					Family planning	Rwanda	2	
What are the key factors to be considered for introducing and sustaining chlorhexidine use for umbilical cord care within existing health systems in Rwanda?	X			X	X				Newborn health	Rwanda	1	

MCSP action-oriented learning agenda												
Learning question	**Learning and implementation themes**								**Technical area(s)**	**Country/ countries**	**Stage†**	**Comments**
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† Stage: 1=Preparation; 2=Data collection; 3=Analysis/writing; 4=Dissemination; 5=Completed												
Assess the effectiveness of intermittent screening and treatment for preventing MIP in high-prevalence districts								X	Malaria	Rwanda	2	
Conduct household malaria control behavioral tracking survey (KAP)								X	Malaria	Rwanda	1	
Assess effectiveness of ACTs in treating simple malaria in Rwanda.								X	Malaria	Rwanda	1	
What lessons can be learned from the implementation of IMCI at community level that will strengthen community worker performance and further introduction of other interventions?					X				Child health; malaria	Rwanda	1	
Is integration of a GBV intervention, including counseling, screening, and referral, into ANC services feasible and effective and does it affect ANC service utilization among women screened?			X						Family planning; maternal health	Rwanda	X	Cancelled due to insufficient time remaining prior to program end date
Test new approaches for communicating about LAM and transition in context of optimal MIYCN practices; reformulation of PPFP-MIYCN SBCC strategy					X				Family planning; nutrition	Tanzania	2/3	

MCSP action-oriented learning agenda												
Learning question	**Learning and implementation themes**								**Technical area(s)**	**Country/ countries**	**Stage†**	**Comments**
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Can monitoring stillbirth and very early newborn death provide a valid indicator of quality of intrapartum care, and what is the appropriate scale of application of the indicator? Can an indicator to measure facility perinatal mortality be introduced to routine HMIS as a wider-scale quality-of-care indicator?		X					X		newborn health	Tanzania	2	
Conduct learning/operations research to understand how the CCHP PlanRep 3 guidelines are currently applied through an in-depth analysis to identify strengths, weaknesses, and gaps for health programming in immunization, as a technical content example.				X	X				Immunization	Tanzania	4	
What are the tangible results of the REC-QI approach and the principle enablers/drivers of change along the REC-QI continuum from "orient" to "sustain"?		X		X		X			Immunization	Uganda	1	
What are enabling and inhibiting factors for uptake and sustainability of the REC-QI practices by health facilities in Kapchorwa district?		X		X		X			Immunization	Uganda	1	

Annex D. Success Stories, Blogs, and Happenings

SUCCESS STORY

GHANA

Photo: MCSP/Cicely Thomas

NAME
Ghana's National Community-Based Health Planning and Services Forum

ROLE
Health Service

LOCATION
Accra, Ghana

SUMMARY
The Government of Ghana highlighted its commitment to and progress toward achieving universal health coverage by hosting the National Community-based Health Planning and Services (CHPS) Forum in September 2016. This Forum, led by the Ghana Health Service, brought national, sub-national, and community-level stakeholders together to present and review CHPS cost estimates, possible financing options, and a planning tool developed to support CHPS national scale-up.

Ghana Health Service Presents CHPS Cost Estimates and Implementation Guidelines, Realizing Significant Gains Toward Achieving Universal Health Coverage

Community-based Health Planning and Services (CHPS) is a strategy to improve the delivery of primary health care services by increasing community participation in health decision-making. The shift from facility-based to community-based health service delivery is an important health system reform by the Ghana Health Service (GHS) for reducing maternal and child mortality. However, efforts to scale-up CHPS in Ghana have been constrained by a lack of national implementation guidelines and costing information to plan for CHPS.

On September 29th, national and subnational CHPS stakeholders participated in a national forum focused on scaling up CHPS nationally in Ghana. Representatives from the GHS, Ministry of Health, National Health Insurance Authority, regional and district health providers, and community leaders gathered in Accra for the event.

In collaboration with the GHS, MCSP presented CHPS cost estimates, including the average per capita costs for investment and operations. The estimates were broken down by cost component, including community mobilization, building, medical and non-medical equipment, and staff salary. MCSP also presented a menu of potential sources of financing for CHPS investment and operating costs.

In addition, MCSP introduced the CHPS planning tool, an Excel-based tool that helps stakeholders interested in implementing CHPS to easily project investment and annual operating costs by inputting unit cost averages and quantities. The tool also allows stakeholders to compare their results against national benchmarks and data from other regions, as well as set currency conversions and adjust for inflation.

The GHS and Ministry of Health will use the cost estimates and identified financing sources to develop a strategic plan for CHPS scale-up, including plans for donor support and long-term sustainable government investment. At a sub-national level, the tool will help districts to identify and mobilize resources, informing decision-making and supporting sub-national implementation.

"Resource implications of CHPS can be quite daunting, which is the reason why the costing activity is so critical. The CHPS cost and revenue [financing] estimates and CHPS planning tool will allow districts to plan for sustainability, and identify resources and how to tap into them."

- Akua Kwateng-Addo,
Health Office Director, USAID/Ghana

National and sub-national stakeholders expressed that CHPS cost estimates, a menu of financing options, and the CHPS planning tool are critical for national scale-up of CHPS, and will be used by the Ministry of Health to inform its strategic plan. Participants also provided useful feedback that will be used to improve the tool, and expressed interest in piloting it to help them implement CHPS at district and community levels.

"The CHPS cost and revenue [financing] estimates help us to see that CHPS national scale-up is doable. When we identify, break-down and quantify the costs, we can see which costs can be matched with which resources. Using the CHPS planning tool, you can go in a region and create and cost a scenario of a CHPS compound you want to put in a village and you can use the output of the tool (the costed plan) to engage the partners to finance the CHPS."

- Dr. Koku Awoonor-Williams, Director PPMED, GHS

By: Daniela Gutierrez; Meley Woldeghebriel; Cicely Thomas

SUCCESS STORY

GHANA

Gifty Baidoo shows her third-year midwifery students how to insert a catheter on a model in the refurbished skills lab. Photo: MCSP

NAME
Gifty Baidoo

ROLE
Midwife Trainer

LOCATION
Accra, Ghana

SUMMARY
Because of the increasing number of students at midwifery and community health nurse training schools in Ghana, it is difficult for students to consistently practice in direct clinical settings. MCSP has been providing skills labs in training institutions and plans to reach all midwifery and community health nursing schools in the country by 2019. The skills labs are prototype clinical settings where students practice firsthand on models before they are presented with a similar situation in the health facility. Gifty Baidoo, a training tutor at Korle Bu Midwifery Training School in Acrra, supports this new training initiative, and credits the practice simulations with boosting students' confidence.

Skills Labs in Midwifery Schools Improve Confidence of Trainers and Students

Until the skills lab was refurbished a year ago, tutors at the Korle Bu Midwifery Training School in Accra, Ghana, delivered health care instructions using makeshift teaching aids and out-of-date materials. To overcome challenges posed by a large class size, Gifty Baidoo, Deputy Chief Health Tutor, had devised innovative instructional skills to ensure teaching was effective and students were able to ask questions.

To do this, she divided her classes – averaging 100 students – into two lecture groups. She then selected a particular student to attend each lecture session to take notes and prompted other students to raise relevant questions. With this approach, Gifty ensured lectures were standardized, allowing students to benefit from questions asked during each lecture and demonstration.

When she was a student, Gifty remembers, there were more opportunities to interact with tutors and practice skills in a clinical setting. "Now, with increasing student numbers, it is practically impossible," she admits.

Through the support of MCSP, all midwifery and community health nursing training schools throughout Ghana will be provided with fully equipped skills labs and linked into an eLearning platform to provide supplemental learning materials. The Program provides support to the Ministry of Health and Ghana Health Service to develop sustainable, cost-effective preservice education interventions to ensure that nurses and midwives who graduate from health training institutions are prepared and competent to deliver high-quality care.

In 2015, MCSP set up 12 skills labs in midwifery training institutions and plans to reach all midwifery and community health nursing schools in the country by 2019. The skills labs – prototype clinical settings populated with humanistic anatomical models – enable health tutors to demonstrate medical procedures and standards to student midwives and nurses. The eLearning program aims to address several challenges in the face of increasing student enrollment: infrastructure; limited number of tutors; far distances; and out-of-date learning materials.

Now, to overcome the challenge of space, Gifty and her tutor colleague at Korle Bu no longer need to use improvised teaching and learning aids or resort to dividing classes into groups. The skills lab provides students an opportunity for firsthand practice on models before they are presented with a similar situation in the health facility.

Gifty explains that these additional practice simulations boost the confidence of students and lecturers alike. "It gives the tutor the assurance that my students would not go out there [and] mess up," she says of the impact of the skills labs on her students, "because they know that the student has seen it before."

"[Practice simulations] gives the tutor the assurance that my students would not go out there [and] mess up, because they know that the student has seen it before."

- Gifty Baidoo

Gifty Baidoo demonstrates normal labor and delivery procedures to her midwifery students at Korle Bu.
Photo: MCSP

SUCCESS STORY

LIBERIA

Photo: MCSP

NAME
Ruth Flangar

ROLE
Nurse

LOCATION
Grand Bassa, Liberia

SUMMARY
Boeglay Clinic, located in rural Grand Bassa, provides services to more than 7,000 people. To better meet the needs of this population, the Clinic urgently needed to improve services and quality of care. MCSP conducted a series of trainings to strengthen clinical skills of MCSP-supported facilities, such as Boeglay Clinic. After attending the sessions, Ruth Flangar, a Clinic nurse, is more confident in her ability to provide maternal and newborn care. She credits the trainings and tools provided with helping her better meet the needs of her patients.

Trainings Improve Clinicians' Skills and Community Trust in Facility

In rural Grand Bassa, Liberia – 35 miles from the county capital – is Boeglay Clinic. The facility provides immunization, family planning, consultation, and maternal and child health (MCH) services to a population of more than 7,000. However, with a baseline assessment average score of 25.50% in 11 technical areas (ANC, ASRH, HIV, TB, Malaria, IMNCI, Comp, NLD, EPI, PP, & RHFP), and staffed by only two poorly-skilled clinicians, the facility urgently needed improved services.

MCSP, in its efforts to strengthen MCH services and infection prevention and control practices in Grand Bassa, conducted an Integrated Reproductive Maternal Newborn Child and Adolescent Health training and Safe and Quality Health Service training. During these trainings, clinicians from MCSP-supported facilities sharpened their skills through hands-on practice using various simulators, including the MamaNatalie birthing simulator.

"Today, I am a confident maternal and newborn health service provider because of MCSP," said Ruth Flangar, a nurse who serves as Boeglay Clinic's MCH supervisor. "The series of trainings that MCSP conducted for us in Buchanan and the tools they left with me during their supervisions are really helping me as guides to become efficient in meeting the needs of my patients."

These trainings have also built the trust of patients and the larger community in providers' skills. Facility-based deliveries at Boeglay Clinic have risen significantly – from an average of 7 per month to an average of 25 per month. (The Ministry of Health has a monthly target of 26 facility-based deliveries per month for the clinic.)

"My first two children, I deliver[ed] at home, but since this midwife came to this clinic, she [told us] to deliver here at the clinic, so I will come here to deliver by God grace," said Mary Tekpah, who was at the clinic for a routine antenatal care visit with her husband.

Thanks to routine mentoring visits and integrated outreach activities, the quality of services at the clinic is continuing to improve. MCSP monthly and quarterly intensive onsite supportive supervision, mentoring and coaching visits – along with a supply of essential drugs and provision of MCH materials – are contributing to the improved quality of services.

"Today, I am a confident maternal and newborn health service provider because of MCSP. The series of trainings that MCSP conducted for us in Buchanan and the tools they left with me during their supervisions are really helping me as guides to become efficient in meeting the needs of my patients."

- Ruth Flangar

By: T. Ruston Yarnko and Lauretta Nagbe Se

SUCCESS STORY

MALAWI

Amele Precious and her child visited an outreach clinic in Msanduliza to access FP services (Sept 12, 2016). Photo: Sheila Makoko/MCSP

NAME
Amele Precious

ROLE
Mother

LOCATION
Msanduliza, Malawi

SUMMARY
Long distances to health facilities prevent many women in rural Malawi from accessing family planning services and taking their children to clinics for vaccinations. MCSP worked with the Ministry of Health to integrate family planning and immunization services in outreach clinics to address these limitations. This resulted in an increase in the rate of women and children utilizing services. Young mother Amele Precious, pictured, visited an outreach clinic to access family planning services. Encouraged by the integration and associated training, one community formed a family planning group to educate community members on these newly available and integrated services and their importance.

Service Integration Reaps Increased Immunization and Family Planning Coverage

For Amele Precious, the 7 km (4 mile) journey to the nearest health center in Chinguluwe deterred her from accessing vital health services, including family planning. Precious is one of many women in the Msanduliza village of the Ntchisi District who were discouraged by this distance.

In Malawi, they are not alone: 80% of the population lives in rural villages far from health services. To address the issue of health service coverage, the District Health Management Team of the Ministry of Health partnered with MCSP to bring essential services closer to the community through outreach clinics.

The outreach in Msanduliza caters to a population of 990 people from 23 villages. Due to the current state of the health sector in Malawi, Msanduliza outreach clinic's services were previously limited to growth monitoring and immunization services for children under five. Women seeking family planning services were forced to trek the four miles to Chinguluwe Health Center, where family planning services were offered twice a week.

During the rainy season, this journey is nearly impossible due to poor road conditions. The limited frequency of service provision combined with the great distance to the health facility prevented women from accessing family planning services, which may have led to unplanned pregnancies.

To close this gap, MCSP partnered with the Ministry of Health to train facility-based health providers and community health workers, locally known as health surveillance assistants (HSAs), on service integration. As a result, health facility service providers have started offering immunization and family planning services as a package, providing both services during a single visit. MCSP also oriented community leaders on the value of integrated services and encouraged them to notify their communities about newly packaged services.

Frankson Chibwato, a HSA, noted a steep increase in the number of women accessing services at the outreach clinic since immunization and family planning services have been provided in an integrated fashion: "Since we started providing integrated service, attendance at the clinics has increased. Before the trainings, the clinics would serve 40 clients per session, but now they serve 120-140 clients per clinic session." In fact, 180 women lined up to access services on the first day of the integrated outreach clinic in Msanduliza.

Service integration not only resulted in improved coverage of service delivery for immunization and family planning services, but it also inspired community members to unite to promote these services through the formation of family planning groups. For example, the Chimwala group boasts 21 members, including men, women and community leaders. The group has reached 459 families in their community, promoting the benefits of practicing family planning and accessing lifesaving immunizations for children.

Training and increased promotion of integrated services has educated men on the importance of making informed decisions as a family. As a result, men have begun escorting their wives to the clinic to access these services, or visiting the clinic to pick up contraceptives when women are unable to attend. The immediate success of the integrated family planning and immunization service delivery can be attributed to the focus on community leadership and mobilization.

"Since we started providing integrated service, attendance at the clinics has increased. Before the trainings, the clinics would serve 40 clients per session, but now they serve 120-140 clients per clinic session."

- Frankson Chibwato, HSA

For Precious and the women of the Masunduliza village, the four mile journey no longer stands in their way. They can access family planning services more frequently, in the comfort of their own village, and with the growing support of their community.

The Chimwala family planning group meets to discuss their progress.
Photo: Sheila Makoko/MCSP

By: Sheila Makoko, Naomi Kalemba, and Kelsey Freeman

SUCCESS STORY

NAMIBIA

Photo: MCSP

NAME
Bernadine

ROLE
Health Extension Worker (HEW)

LOCATION
Engela District, Namibia

SUMMARY
In Namibia, HIV/AIDS is one of the leading causes of death. HIV testing is an important lifesaving intervention. MCSP is working to train health extension workers to deliver community-based HIV testing and counseling. Bernadine, one of the HEWs trained in northern Namibia, has tested more than 200 client and connected persons with HIV with counseling and care. Her success prompted a case study to learn more about how other health workers can be effective, efficient, and have a lasting impact on their communities.

Health Extension Worker's Success Testing Clients for HIV Serves as Basis for Case Study

Morbidities associated with immunosuppression make HIV/AIDS one of the leading causes of death in Namibia. Testing for HIV is thus an important and lifesaving intervention. However, a human resource crisis in the country coupled with the fact that many Namibians live in isolated, hard-to-reach communities has kept rates of routine HIV testing in the country low.

In response, MCSP is implementing a multi-faceted project to support the Ministry of Health and Social Services in delivering community-based HIV testing and counseling (HTC) through the national Health Extension Program (HEP). Beginning in July 2016, the HEP pilot program rolled out HIV rapid test training to 60 health extension workers (HEWs) at three clinics in the Engela district of northern Namibia.

Since training, Bernadine – a HEW stationed in Engela district – has tested almost 209 clients in her community for HIV. Of those tested, 11 tested positive for HIV antibodies. Of those who tested positive, nine were successfully linked to care and initiated on antiretroviral treatment (ART).

Moreover, she has tested more individuals and identified more people living with HIV (PLHIV) than other trained HEWs conducting community-based HTC. To better understand how Bernadine's successes in the field might be applied to other field sites and adopted by other HEWs, a case study was conducted.

At the time of the interview (October 2016), 38-year-old Bernadine lived in Oshikango village. Her work covered three locations and was responsible for the health of people in 93 households.

Her passion for helping others began long before her career as a HEW: as a young girl in school, Bernadine dreamed of becoming a nurse; at home, she was often the caretaker. From 2009 to 2013, she volunteered with the elderly and with PLHIV to help them with personal projects. After studying health at Good Samaritan College, she began her work as a HEW in December 2014.

"When I saw the advert [to become a HEW], I knew this was my job because I had the heart to do it," she said.

Bernadine had never conducted HIV rapid testing prior to the HTC training, but integrating HTC into her established role as a HEW made her job easier, she said. In the past, when she screened and referred clients to the clinic for tuberculosis, some returned with a negative tuberculosis result, but a persistent cough. Now, Bernadine can test her clients for HIV, as well, putting her in a better position to serve their needs.

"When I saw the advert [to become a health extension worker], I knew this was my job because I had the heart to do it."

- Bernadine

"Now I can be more helpful, [I can] help the people in my community more," she said.

Bernadine found that community members were very accepting of HTC. By listening to them and providing information about HTC and treatment, she found initial fear of testing dissipated among her clients. Many were scared of testing because they did not know their status, she said, and had never been tested before. Misconceptions and stigma—especially surrounding taking medication—were pervasive. Bernadine worked hard to counsel her clients about these fears before testing.

Index client testing also posed a challenge in the field. Testing the children and partners of clients who tested positive was difficult, because many contacts lived far away. Tracing these contacts was difficult, as many clients regularly crossed the border into Angola.

Bernadine encountered one couple when one partner was infected by HIV and the other was not. Both clients decided to test individually, and only told Bernadine of their relationship after they had both been tested for HIV. She counselled the two clients individually, and referred the HIV positive client for ART.

"Positive or negative, they feel free. They accept their results," she said of her clients.

In the field, she encountered only one refusal. The man who did not want to get tested was a part of a couple; his wife did want to be tested. Bernadine was able to test all of their children for HIV, but the wife did not want to get tested without her husband.

The majority of her tested clients were in their 20s and 30s, and did not have a high perceived personal risk for HIV. After counseling, many changed their minds and wanted to get tested

"Now I can be more helpful, [I can] help the people in my community more."

- Bernadine

Bernadine said providing accurate information is very important to proper HTC, as is counseling men. She found men generally needed more time to decide about HIV testing than women. In her pre-testing counseling, she always explained the implications of a positive test, preparing her client for either result.

None of her clients who tested positive were visibly sad or depressed by their results, she said. Bernadine counseled them and supported them with important information about how and where to access ART services, how to visit the hospital, and the importance of safe sex.

Bernadine is a highly motivated HEW, who is trusted and well-known in the communities she serves. Her successes could be attributed her strong work ethic as well as the higher prevalence of HIV in her coverage area.

Others conducting community-based HTC could learn from Bernadine's patience with her clients and her pre-test counseling, which ensures that clients are prepared for their results and successfully linked to care. She also counsels her clients on HIV testing even if she does not have adequate supplies for rapid testing. That way, the next time she visits, they have had time to consider HIV testing. She then provides additional counseling if they choose to test.

SUCCESS STORY

NIGERIA

Nurse-midwife Mariam Habib holds Dorcas Bakare's baby. Photo: Olusoga Adebambo

NAME
Mariam Habib

ROLE
Nurse-Midwife

LOCATION
Kabba, Nigeria

SUMMARY
Not all healthcare workers in Nigeria are adequately skilled to provide needed services. Recognizing this challenge in Ebonyi and Kogi States, MCSP empowered more than 700 healthcare workers with skills in essential and basic emergency obstetric and newborn care. One of the beneficiaries, Mariam Habib, used these new skills to save a newborn who failed to breathe at birth.

Skilled Healthcare Workers are Helping to End Needless Maternal and Newborn Deaths

Healthcare workers are an essential workforce in developing countries like Nigeria, where 1 of every 16 women dies during childbirth and 70 newborns die for every 1,000 live births. In such a context, skilled birth attendants like Mariam Habib are critical to ending the preventable deaths of mothers and newborns.

Habib, 35, is a nurse-midwife at Zonal Hospital Kabba in north-central Nigeria. Her work – including the successful revival of a newborn – justifies the investments made to empower frontline healthcare workers with lifesaving skills. It also justifies the need for the constant presence of skilled workers in every health facility to provide high-quality maternal, newborn and child health services to patients as needed.

In Nigeria, however, healthcare workers are often nonexistent or not skilled enough to provide required services in many health facilities. Added to these shortcomings is the poor state of many facilities, further challenging the delivery of high-quality health care. The country's poor indices in deliveries by skilled birth attendants (38%) and deliveries at health facilities (36%) are effects of the challenges in the link between frontline health workers (and health facilities) and high-quality service delivery.

Recognizing these and other related challenges in the Nigerian health system, MCSP has been working with the federal government of Nigeria and governments of Ebonyi and Kogi States, health ministries, departments and agencies, public and private healthcare providers, professional associations, and other stakeholders to build the capacity of healthcare workers to provide high-quality maternal and newborn health services in both states. Focusing on ending the preventable deaths of mothers and children, the Program has empowered more than 700 healthcare workers from 120 facilities in these states to provide basic emergency obstetric and newborn care and essential newborn care.

Habib was one of the frontline health workers who benefitted from the trainings, using her new skills to save the life of a newborn only weeks later. When 38-year-old Dorcas Bakare – in prolonged and painful labor – was rushed to her hospital from a traditional birth attendant's house, Habib was on duty. Dorcas delivered a baby that failed to breathe at birth, and the mother feared her newborn would not survive.

"If not for God and the nurse, my baby would have died."

- Dorcas Bakare

Confidently, Mariam dried the baby thoroughly and used a bag and mask to ventilate him for a few minutes – a procedure she learned at the second essential newborn care training organized by MCSP in collaboration with the Kogi State Ministry of Health. The training helped 22 health workers, including Mariam, gain skills in Helping Babies Breathe, Essential Care for Every Baby, and Essential Care for Small Babies.

"I am proud of my achievement. I knew what to do because of MCSP's training."

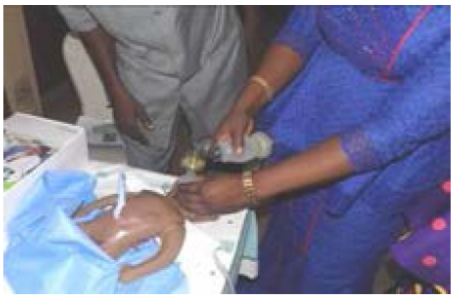
- Mariam Habib

At the training, Mariam handled a bag and mask for the first time – on an anatomical model. Soon after, with Dorcas' lifeless baby, she used the bag and mask on her first human patient. After ventilating him for about five minutes, the baby began to breathe and cry. She stabilized the newborn and provided other essential care to the delight of his relieved mother.

"If not for God and the nurse, my baby would have died," Dorcas said.

For Mariam, it was a moment of pride and gratitude: "I am proud of my achievement," she said. "I knew what to do because of MCSP's training."

She also thanked MCSP for donating the bag and mask to her hospital. The Program donated the lifesaving equipment and materials to 48 health facilities to complement the training of their workers and to set up newborn resuscitation corners in the hospitals. While targeting to set up newborn corners in 60 facilities, MCSP is also advocating to the governments of Ebonyi and Kogi States and hospital boards in the states to provide critical equipment and lifesaving commodities in all facilities across these states.



A healthcare worker practices newborn resuscitation with a bag and mask on a model at a training organized by MCSP. Photo: MCSP

Mariam extols the ethos of the MCSP's leadership in Nigeria: if a patient is brought alive to a facility, they should leave alive. With births by skilled attendants in both Ebonyi and Kogi States increasing from 9,899 to 13,650 in two years, more skilled birth attendants like Mariam will make the difference between life and death in Nigeria.

By: Tolulope Soyannwo, Tolase Olatinwo and Oniyire Adetiloye

SUCCESS STORY

UGANDA

Photo: Milly Namaalwa/MCSP

NAME

Village Health Teams (VHTs)

ROLE

Community mobilizers

LOCATION

Uganda

SUMMARY

MCSP is working to strengthen local village health teams (VHTs). These community mobilizers play a key role providing supportive health education, counseling, answering questions, and more. VHTs play a are also helping educate families about the importance of routine immunization, utilizing civil society organizations – like local churches – to share immunization schedules with parishioners. These trained VHTs have contributed greatly to their communities by increasing turnout during immunization campaigns and connecting citizens to other health services.

Community Mobilizers are Key to Reaching Every Child

MCSP trains village health teams (VHTs) in routine immunization (RI) to encourage parents and health workers to collaborate when reviewing and planning for RI. Staff at lower health facilities, which are the most distant and ill-equipped, applaud the VHT engagement for yielding positive results in their communities.

Evelyn Katusiime, a nurse at Karangara Health Facility, reported a marked increase in the number of child caretakers turning up for RI at the health facility since the start of MCSP's support. "There is a big difference seen among mothers turning up for RI services, both at static and outreach sessions," she said. "MCSP support and training given to the VHTs has had a positive impact on our community in taking up RI services. The VHTs in my catchment area are empowered – they know what to communicate to caretakers and this motivates them to bring their children for RI."

VHTs are also encouraging an open-minded approach to these health services. All VHTs provide counseling and health education to mothers during their home visits before conducting RI.

MCSP trainings are effective in both clearly explaining VHT roles, and motivating VHTs to be linked to the health facility. In the past, community members were not aware of VHT members training and, therefore, less apt to trust their advice. Now, the community listens and VHTs feel empowered to provide basic key messages to caretakers. Moreover, trained VHTs act as resource persons within their communities, helping to drive demand for health services in rural settings.

Despite a lack of regular remuneration, social recognition of their work plays an important role in motivating VHTs to continue serving. "[They] are happy, because they are recognized by the nurses and known by the community as people who have been trained by Government," Evelyn said.

During training, VHTs agree to share RI program details and announcements during church services the Sunday before a RI session. This has contributed to a significant increase in caretaker turnout as evidenced in the average number of vaccinations conducted per month, which has increased by 231% in one health facility alone (MOG/UNEPI DHIS 2).

"The problem was lack of regular and adequate health education on RI. Neither us, the health workers, nor the VHTs were prioritizing health education on RI," said Bahati Provia, a nursing assistant. "We had always focused on talking about and educating on other health programs – such as malaria prevention and good nutrition – but hadn't considered the benefits behind talking to mothers about their schedules and the impact RI visits with the health facility would have. Our action point was to integrate RI messages into every health education session conducted. This has yielded very good turn out and we now provide both group and individual health education."

Provia and Hamlet Arineitwe, a clinical support worker, are the staff on duty at Byumba Health Center non-governmental organization in Kanungu district, southwestern Uganda. Dressed in their uniforms, they attend to clients seeking out services, including RI. They work once a week at this facility, serving five villages in their catchment area.

Without a refrigerator, health workers pick up vaccines from Kayonza Health Center, which is 7kms (4.3 miles) away over rough terrain. This requires a great amount of staff planning and commitment and, unfortunately, the health facility was challenged with high dropout rates. For a patient's initial vaccination, health workers experienced high client turn out; however, with subsequent doses, they were not doing as well.

"We send messages to churches in our catchment area and we have a local club for residents dubbed as Batakakwelinda ('residents helping themselves'). Some of these clubs sit at the outreach sites and convene every month. Both men and women who are the caretakers are targeted for RI."

- Lucia, VHT from Kanungu District

MCSP has provided an understanding of the process of identifying problems and drafting local solutions. They have used the VHTs in defaulter tracing. They have an improvised register where they record those children immunized per session; this information is then transfer to the Ministry of Health's child register. Every two weeks, to identify those left out or not completing their immunizations, information from the improvised register on defaulters is compared with VHTs' estimated number of target children in the village.

Photo: Milly Namaalwa/MCSP

Photo: Milly Namaalwa/MCSP

By: Milly Namaalwa, Possy Mugyeny, Timothy Kiyemba

Annex Db: List of Success Stories, Blogs and Happenings

	Title	Link	Success Story/ Blog/Happening	Date	Country/ Region	Intervention Area(s)
1	Men in Mozambique Step Up to Help their Spouses Prepare for Birth	http://bit.ly/2eea1Fj	Blog	9/20/2016	Mozambique	Gender/maternal health
2	In Nigeria, More Women are Choosing a Modern Method to Safely Plan their Families	http://bit.ly/2cHksQN	Blog	9/16/2016	Nigeria	Family planning
3	Better-Designed Health Information Systems Make for Better Health Outcomes	http://bit.ly/2dPQEV7	Blog	8/19/2016	Global	Health systems strengthening/M&E
4	The breast and beyond: Improving feeding practices in Kenya	http://bit.ly/2awBge8	Blog	7/29/2016	Kenya	Newborn health/nutrition
5	Thinking Broadly about Reducing Missed Opportunities	http://bit.ly/2dhDI9G	Blog	7/8/2016	Liberia	Immunization/family planning
6	"Gone are the days when all family health affairs were left to women alone": A Ugandan father Speaks	http://bit.ly/2eaTKq4	Blog	6/16/2016	Uganda	Gender
7	Spotlight on Madagascar: Growing the Postpartum Family Planning Movement	http://bit.ly/2dhjif5	Blog	5/23/2016	Madagascar	Family planning
8	Meeting the Sustainable Development Goals through Postpartum Family Planning	http://bit.ly/27yF5qz	Blog	5/10/2016	Kenya	Family planning
9	Midwives and the Things They Carry	http://bit.ly/2dTaouD	Blog	5/5/2016	Global	Maternal health
10	Data for Decision-Making: Empowering Local Data Use	http://bit.ly/2dT9374	Blog	4/29/2016	Africa Region	Immunization/M&E
11	As the World Focuses on Zika Virus, Malaria Continues its Deadly Toll	http://bit.ly/2dPW7w3	Blog	4/22/2016	Global	Malaria

	Title	Link	Success Story/ Blog/Happening	Date	Country/ Region	Intervention Area(s)
12	Pre-elimination Activities are Saving Lives from Malaria in Rwanda	http://bit.ly/2dPV7a2	Blog	4/19/2016	Rwanda	Malaria
13	Respect During Childbirth is a Right, Not a Luxury	http://bit.ly/1WijXQe	Blog	4/7/2016	Global	Maternal health
14	Community Health Workers are Key to Universal Health Coverage	http://bit.ly/1MhngoA	Blog	4/5/2016	Global	Community
15	Walking the Talk: Three Keys to Ending Vaccine-preventable Deaths	http://bit.ly/2dPWmGa	Blog	2/22/2016	Africa Region	Immunization
16	"Where are Mothers and Newborns in the Post-2015 Era?"	http://bit.ly/2eb0JyY	Blog	2/5/2016	Global	Maternal health/newborn health
17	From Chiang Mai to Mexico City to Nusa Dua: Family Planning is Key to Saving Lives	http://bit.ly/2dC6UXZ	Blog	1/11/2016	Global	Family planning
18	If we know how to save preterm babies, why are they still dying?	http://bit.ly/1N96lob	Blog	11/12/2015	Global	Newborn health
19	Introducing USAID'S New Community Health Framework	http://bit.ly/2dPYL55	Blog	11/11/2015	Global	Community
20	Beyond creature comforts: Respectful maternity care saves lives	http://bit.ly/1jD5eQG	Blog	10/20/2015	Global	Maternal health
21	Investing in Marginalized Populations to Improve Newborn Survival in Latin America & the Caribbean	http://bit.ly/2dPXObA	Blog	10/16/2015	LAC	Newborn health
22	Want to save 3 billion lives? Improve quality of care at birth	http://bit.ly/2dCa7GQ	Blog	10/16/2015	Global	Maternal health
23	Scaling up Malaria in Pregnancy Interventions to Improve Maternal and Child Health	http://bit.ly/2e3VJuv	Blog	10/16/2015	Global	Maternal/malaria/child health
24	Buying Condoms? Contraceptive Questions? Ask Your Hairdresser	http://bit.ly/2dCcbyO	Success Story	9/26/2016	Guinea	Family planning

	Title	Link	Success Story/ Blog/Happening	Date	Country/ Region	Intervention Area(s)
25	Mock Scenarios and Hands-on Trainings Lead to Big Improvements at Liberian Hospital	http://bit.ly/2cyiTsZ	Success Story	8/29/2016	Liberia	Maternal health/family planning
26	Tanzania Reduces Infant Mortality with Lifesaving Vaccines	http://bit.ly/2dCc2Lt	Success Story	8/25/2016	Tanzania	Immunization
27	Integrated community case management of childhood illness is happening in Bondo, western Kenya	http://bit.ly/2dPZulL	Success Story	8/5/2016	Kenya	Child health
28	Hope comes knocking: Preventing malaria in pregnancy in Kenya	http://bit.ly/2dPYLRj	Success Story	4/20/2016	Kenya	Malaria/maternal health
29	In Tanzania, First Responders are Stopping Malaria at the Community Level	http://bit.ly/2dZSl2I	Success Story	4/18/2016	Tanzania	Malaria
30	In Ethiopia, Respectful Maternity Care is Increasing Facility Births	http://bit.ly/2dpECSM	Success Story	3/21/2016	Ethiopia	Maternal health
31	Extended Health Services Vital to Remote Communities in Namibia	http://bit.ly/2e42L0j	Success Story	2/29/2016	Namibia	Community
32	In Mozambique, Strong Community and Facility Linkages Improve Antenatal Care and Delivery Services	http://bit.ly/2dQ0nKU	Success Story	1/14/2016	Mozambique	Maternal health
33	Bringing Newborn Care Closer to Communities in Ethiopia	http://bit.ly/2dCfeXA	Success Story	1/8/2016	Ethiopia	Newborn health
34	Celebrating the Clean Household Approach	http://bit.ly/2dCdxJE	Success Story	10/15/2015	Global	WASH
35	MCSP's Dr. Kavle speaks with Voice of America about World Breastfeeding Week	http://bit.ly/2fD6khT	Happening	8/3/2016	Global	Nutrition
36	Building Political Will for Gender Equity to Achieve MNC Survival Goals	http://bit.ly/2fLTcGs	Happening	5/26/2016	Global	Gender

	Title	Link	Success Story/ Blog/Happening	Date	Country/ Region	Intervention Area(s)
37	Achieving Impact at Scale, May 25th	http://bit.ly/2fD6KVl	Happening	5/11/2016	Global	Scale
38	Join MCSP at Women Deliver in Denmark!	http://bit.ly/1OfT0WO	Happening	5/4/2016	Global	RMNCH
39	April 13th Event: After Mexico City and Before Copenhagen – Keeping Our Promise to Mothers and Newborns	http://bit.ly/2e7DdyD	Happening	4/4/2016	Global	Maternal health/newborn health
40	What works: Equitable access to routine immunization and integrated child survival interventions	http://bit.ly/2e7BYzh	Happening	2/4/2016	Africa Region	Immunization
41	Global Commitments, Local Actions: Postpartum Family Planning Champions Deliver	http://bit.ly/1Pzy4cJ	Happening	1/25/2016	Global	Family planning
42	January 21st event: Strong Health Systems Support Healthy Families	http://bit.ly/2dCfbLi	Happening	1/12/2016	Global	Health systems strengthening
43	Restoring Confidence in Challenged Health System: MCSP in Liberia	http://bit.ly/2dQ4d7Y	Happening	12/2/2015	Liberia	Health systems strengthening/Ebola
44	USAID Celebrates Progress on Maternal and Child Survival in Rwanda	http://bit.ly/2dQ7xjC	Happening	11/24/2015	Rwanda	Maternal health/child health
45	Celebrate World Prematurity Day with MCSP on November 17th	http://bit.ly/2dpIZx3	Happening	11/9/2015	Global	Newborn health
46	Global Maternal Newborn Health Conference Begins in Mexico City	http://bit.ly/2dcC0sM	Happening	10/19/2015	Mexico	Maternal health/newborn health

Annex E: Presentations at International Conferences

#	Month, Year	Name of Conference	Presenter(s)	Presentation or Poster	Technical Area
1	September 2016	Partnerships for the Future: Could Medical Professional Organizations Be the Key to Closing Gaps in the Health SDGs?	Dr. Goldy Mazia	Fireside Chat #2: Leveraging Partnerships with Medical Professional Organizations	Newborn
2	August 2016	Infectious Diseases Society for Obstetrics and Gynecology Annual Meeting	Lisa Noguchi	Scientific Oral Presentation: Session One	Maternal health
3	August 2016	USAID Breastfeeding Symposium	Justine Kavle, Sarah Straubinger	Baby-Friendly Community Initiative: National Guidelines and Implementation Experience from Kenya	Nutrition
4	August 2016	Regional Forum on Permanent Methods of Contraception	Lynn Kanyuuru	Sustainable Preservice and In-Service Training Approaches and Strategies for Overcoming Access Barriers	Family planning
5	July 2016	Cracking the Nut Health: The Role of Communities in Building Resilient Health Systems	Vikas Dwivedi, Dyness Kasungami	Building Strong Community Health Information Systems: Interaction of Health Systems, Communities and Technology	Health systems strengthening
6	July 2016	AIDS 2016	Lisa Noguchi	Pre-Exposure Prophylaxis in Pregnancy: Time to Deliver?	HIV/AIDS
7	June 2016	Launch of IPPF Zika Response Program	Lisa Noguchi	MCSP Zika Response Program	Zika
8	June 2016	Reunion Regional de la Iniciativa IBP – America Latina y el Caribe	Lisa Noguchi	Access to LARCs	Family planning
9	May 2016	Global Health Practitioner Conference Spring 2016	Justine Kavle	Re-Envisioning Approaches to Improve Postpartum Family Planning (PPFP) and Maternal, Infant and Young Child Nutrition (MIYCN) in Tanzania	Nutrition
10	May 2016	ICT4D Conference	Alpha Nsaghurwe	Strengthening Health Systems Using the Enterprise Architecture Approach in Tanzania	Health systems strengthening
11	May 2016	Midwifery Symposium, Young Midwives in the Lead Program	Sheena Currie	Painting a Global Portrait: Major Programmes and Initiatives on Midwifery	Health systems strengthening/maternal health

#	Month, Year	Name of Conference	Presenter(s)	Presentation or Poster	Technical Area
12	March 2016	Global Vaccine & Immunization Research Forum (GVIRF)	Rebecca Fields	Immunization in the Second Year of Life	Immunization
13	March 2016	Global Health Mini-University	Rebecca Fields	Immunization: What's New, What Works, and What's in It for You	Immunization
14	February 2016	Health Equity Initiative	Tanvi Monga	Health Equity/Community Health Workers	Community health/civil society engagement
15	February 2016	WHO Planning Meeting of the Strategic Global Assessment of IMCI	Michel Pacque	Child Health Leadership Mapping	Child health
16	February 2016	UNICEF-Convened Regional Meeting on Scaling Up ICCM	Dyness Kasungami	Sessions on iCCM implementation, Planning, and M&E	Community health/civil society engagement
17	February 2016	International SBCC Summit 2016	Raphael Nshunju	Importance of SBCC in immunization and the Experience of using REC and CHWs in Tanzania	Social and Behavior Change Communication/Immunization
18	February 2016	International SBCC Summit 2016	Chelsea Cooper	FP-Nutrition Study in Tanzania and TIPs in Yemen	Social and Behavior Change Communication/immunization
19	February 2016	Society of Maternal Fetal Medicine Annual Conference	Mark Hathaway	PPIUD/FP	Maternal health
20	January 2016	International Conference on Family Planning	Chelsea Cooper	SMART in Egypt and FP-Nutrition Study in Tanzania	Family planning
21	January 2016	International Conference on Family Planning	Devon Mackenzie	One Stop Shop, or Service Silos? A Cross-Sectional Analysis of Postpartum Family Planning (PPFP) Integration with Maternal, Newborn and Child Health Services Using a Client Flow Assessment Tool	Family planning
22	January 2016	International Conference on Family Planning	Rae Galloway	The Power of Counseling for Changing Practices in Family Planning & Maternal, Infant, and Young Child Nutrition in Dhamar, Yemen	Family planning/nutrition
23	December 2015	Ouagadougou Partnership 4th Annual Meeting	Anne Pfitzer	Postpartum Family Planning	Family planning
24	November 2015	Global mHealth Forum	Carolyn Moore	mPowering Frontline Health Workers ORB Content Platform	Health systems strengthening
25	October 2015	American Society of Tropical Medicine and Hygiene	Elaine Roman	Prioritizing Malaria in Pregnancy as Malaria Transmission Declines	Malaria
26	October 2015	Fall 2015 Global Health Practitioner Conference	Justine Kavle	Factors Associated with Growth in the First 1,000 Days and Implications for Programming	Newborn health

#	Month, Year	Name of Conference	Presenter(s)	Presentation or Poster	Technical Area
27	October 2015	FIGO World Conference of Gynecology and Obstetrics	Patricia Gomez	mMentoring: Supporting Post-Training Knowledge Retention, Building Confidence and Increasing Performance in Midwifery Tutors and Preceptors	Health systems strengthening

Annex Eb: List of Communications Events

#	Month, Year	Name of Event	Location	MCSP Activity	Other Co-Sponsors	Hyperlink
	September 2016	Madagascar National Family Planning Conference	Madagascar	Supported social media, organized all logistics and led in-country partner engagement; supported media, presentations and collateral; advised on branding	• Government of Madagascar • Ministry of Health • UNFPA • World Health Organization • PSI	http://www.cnpfmada2016.org/
	September 2016	LAC Ultrasound Capacity Assessment Design Meeting	Washington, DC	Finalized the design of a five-country ultrasound capacity assessment	• American Institute of Ultrasound in Medicine • Society for Maternal-Fetal Medicine	N/A
	September 2016	Zika Response Team Ultrasound Assessment Design Meeting	Washington, DC	Meeting to plan for the USAID-funded collaboration on ultrasound capacity and Zika response in Latin America and the Caribbean; discussions addressed design, implementation and logistics of the assessment efforts	ASSIST	N/A
	September 2016	*The Lancet* Maternal Health Series, 2016	Washington, DC	Report launch at MCSP; invited maternal health leads from USAID to present on findings from series	London School of Hygiene & Tropical Medicine	http://www.thelancet.com/series/maternal-health-2016
	September 2016	The Case for Male Engagement in Reproductive, Maternal and Child Health	Washington, DC	Presented MCSP work and evidence behind male engagement in RMNCH	• Jhpiego • Interagency Gender Working Group • Promundo • Family Included	N/A
	August 2016	World Breastfeeding Week 2016	Washington, DC	USAID symposium in which MCSP participated in two roundtable dialogue circuits		N/A

#	Month, Year	Name of Event	Location	MCSP Activity	Other Co-Sponsors	Hyperlink
	July 2016	USAID 2016 Saving Lives at Birth DevelopmentXChange	Washington, DC	MCSP director presented at opening plenary session, "Looking Forward: The Future of MNCH Innovation"; MCSP had a booth and was a co-sponsor of the event	N/A	https://www.surveygizmo.com/s3/2727482/2016-Saving-Lives-at-Birth-DevelopmentXChange-General-Registration
	July 2016	Cracking the Nut Conference	Washington, DC	MCSP had a booth and several presentations; sponsored	N/A	http://www.crackingthenutconference.com/2016.html
	July 2016	Roll Back Malaria-Malaria in Pregnancy Working Group 2016 Meeting	Geneva, Switzerland	Introduced MCSP Malaria Game	Global Fund	http://rbm.acw-server1.co.uk/organizational-structure/working-groups/mipwg
	June 2016	Capitol Hill Briefing: Building Political Will for Gender Equity to Achieve Maternal, Newborn and Child Survival Goals	Washington, DC	Co-hosted event with Myra Betron representing MCSP on the topic of gender-based violence	• Jhpiego • Management Sciences for Health • Save the Children • Action Network	http://www.mcsprogram.org/featured/june-1st-building-political-will-gender-equity-achieve-mnc-survival-goals/
	June 2016	Care of the Small, Sick Newborn Forum	Washington, DC	Hosted presentations and panel discussions from seven field-based health professionals on how to best move forward to care for small, sick newborns	• Every Preemie—SCALE Scale • Save the Children's HNN	http://www.healthynewbornnetwork.org/event/care-small-sick-newborn/

#	Month, Year	Name of Event	Location	MCSP Activity	Other Co-Sponsors	Hyperlink
	May 2016	Women Deliver Conference	Copenhagen	• Helped execute sessions hosted by Population Council/MCSP, WHO and ICM, including social media and logistical support • Facilitated GMNHC event through advertising, social media, dissemination of materials and logistical support • Managed MCSP booth and staffed six "pop-up" demonstration sessions • Posted conference updates through the MCSP website • Created collateral, blog and graphics for Daily Digest and MCSP social media, and created a Flickr album highlighting our efforts at Women Deliver • Managed shipping of MCSP resources	• Population Council • International Confederation of Midwives • World Health Organization • Global Maternal Newborn Health Conference • Maternal Health Task Force	http://wd2016.org/ http://www.mcsprogram.org/featured/join-mcsp-women-deliver-denmark/
	May 2016	Scaling Up High-Impact Interventions	Washington, DC	Hosted meeting with representatives from four countries; moderated by John Borrazzo with remarks by Nahed Matta	N/A	http://www.mcsprogram.org/featured/youre-invited-achieving-impact-scale-may-25th/
	May 2016	Field staff visits to U.S. State Department and Capitol Hill	Washington, DC	Six congressional visits, including four to the Senate and two to the House, and one visit with the State Department; topics included gender-based violence, restoring health services after Ebola, maternal and child health and improving the functionality of health systems	N/A	N/A
	May 2016	Core Group Global Health Practitioner Spring Conference	Portland, OR	Cosponsored and supported MCSP's booth and several presentations	CORE Group	http://www.coregroup.org/meeting-reports-n/553-spring-2016-global-health-practitioner-conference-resources

#	Month, Year	Name of Event	Location	MCSP Activity	Other Co-Sponsors	Hyperlink
	April 2016	Woodrow Wilson Center Maternal Health Initiative— Event – GMNHC Follow-Up Event: "After Mexico City and Before Copenhagen: Keeping Our Promise to Mothers and Newborns	Washington, DC	Served on planning committee with leads from SNewborn Lives and Maternal Health Task Force; prepped MCSP speakers; disseminated key learning on social media and elsewhere; assisted on press outreach and key resources	• Saving Newborn Lives • Maternal Health Task Force • PATH	https://www.wilsoncenter.org/event/after-mexico-city-and-copenhagen-keeping-our-promise-to-mothers-and-newborns
	April 2016	Capitol Hill Reception & Learning Expo: Racing to Close the Immunization Gap	Washington, DC	Joined Capitol Hill reception with PATH and other partners to commemorate World Immunization Week; staffed booths to inform Hill staff about key immunization issues	• PATH • American Academy of Pediatrics • American Red Cross • GAVI • The Global Poverty Project • International AIDS Vaccine Iniative • International Vaccine Access Center • JSI • RESULTS • Save the Children • Shot@Life • UNICEF	http://globalhealth.org/event/racing-to-close-the-immunization-gap/
	March 2016	USAID's Global Health Mini-University	Washington, DC	Several MCSP presentations; provided communications support on site and social media	N/A	http://globalhealth.org/event/2016-global-health-mini-university/ http://mini-university.org/

#	Month, Year	Name of Event	Location	MCSP Activity	Other Co-Sponsors	Hyperlink
	February 2016	Ministerial Conference on Immunization in Africa (MCIA)	Addis Ababa, Ethiopia	Supported publication of Huffington Post blog and the creation of "Anything But Routine" infographic; helped author and created dissemination toolkit for the Civil Society Advocacy declaration; MCSP/CSO side event	N/A	http://immunizationinafrica2016.org/civilsocietydeclaration/
	January 2016	International Conference on Family Planning (ICFP)	Denpasar, Indonesia	Supported MCSP co-sponsored booth, microblogging, social media coverage and side events	N/A	http://fpconference.org/2016/
	January 2016	Postpartum Family Planning Follow-Up Workshop at International Conference on Family Planning (ICFP)	Denpasar, Indonesia	Dissiminated materials (giveaways, fact sheets, brochures); supported social media coverage, photos and video	• FP2020 • Bill & Melinda Gates Foundation • UNFPA • World Health Organization	http://fpconference.org/2016/
	January 2016	International Summit on Social Behavior Change Communications (SBCC) Summit	Addis Ababa, Ethiopia	MCSP booth; Chelsea Cooper presented poster	N/A	http://sbccsummit.org/
	November 2015	Rwanda MCSP Launch	Rwanda	Social media, press release, event support	N/A	N/A
	November 2015	Liberia MCSP Launch	Liberia	Social media, press release, event support	N/A	N/A

#	Month, Year	Name of Event	Location	MCSP Activity	Other Co-Sponsors	Hyperlink
	November 2015	Global Maternal Newborn Health Conference (GMNHC)	Mexico City, Mexico	• MCSP co-hosted: GMNHC activities included conference organization and planning, co-leading all communications, coordinating multiple MCSP presentations and providing on-site conference support • Supported MCSP booth and side events, such as the PPFP round table, etc. • Event support included materials such as handouts, giveaways, fact sheets, brochures and printed programs	• Maternal Health Task Force • Save the Children's Saving Newborn Lives	https://www.globalmnh2015.org/
	October 2015	International Federation of Gynecology and Obstetrics (FIGO)	Vancouver, Canada	Booth; social media coverage	N/A	http://figo2015.org/
	October 2015	Core Group Global Health Practitioners' Fall Conference	Washington, DC	Co-sponsored conference, with booth and multiple MCSP presentations	N/A	http://www.coregroup.org/component/events/event/139

Annex F: List of Peer-Reviewed Manuscripts Published

#	Month, year	Name of article	Journal name	Authors	Hyperlink	Technical area
1	October 2015	Evaluation of the availability of qualified personnel in maternal and neonatal health in Madagascar	*African Evaluation Journal*	Sandrine Andriantsimietry, Jean Pierre Rakotovao, Eliane Ramiandrison, Haja Andriamiharisoa, Eric Razakariasy, Rachel Favero, Eva Bazant, Patricia Gomez, Blami Dao	http://www.aejonline.org/index.php/aej/article/view/156/224	Maternal health; newborn health
2	December 2015	Case study: Primary healthcare clinical placements during nursing and midwifery education in Lesotho	*World Health and Population*	Alice Christensen, Semakaleng Phafoli, Johannah Butler, Isabel Nyangu, Laura Skolnik, Stacie C. Stender	http://www.longwoods.com/content/24493	Health systems strengthening
3	December 2015	Approaches to postpartum family planning	*International Perspectives on Sexual and Reproductive Health*	Anne Pfitzer, Clifton Kenon, Holly Blanchard	http://www.ncbi.nlm.nih.gov/pubmed/27295722	Family planning
4	December 2015	Increasing access to prevention of postpartum hemorrhage interventions for births in health facilities and at home in four districts of Rwanda	*African Journal of Reproductive Health*	Blami Dao, Fidele Ngabo, Jeremie Zoungrana, Barbara Rawlins, Beata Mukarugwiro, Pascal Musoni, Rachel Favero, Juliet MacDowell, Kanyamanza Eugene	http://www.ncbi.nlm.nih.gov/pubmed/27337854	Maternal health
5	December 2015	Case study: Experience applying and tracking a quality improvement approach for maternal and newborn health services in Sub-Saharan Africa	*World Health and Population*	Barbara Rawlins, Young-Mi Kim, Jaime Haver, Aleisha Rozario, Adrienne Kols, Hillary Chiguvare, Matias Anjos, Emmanuel Otolorin, Jacqueline Aribot	http://www.longwoods.com/content/24495	Maternal health; newborn health
6	December 2015	Small nations, large impact: The Caribbean Regional Midwives Association	*International Journal of Childbirth*	Debrah Lewis, Marcia Rollock, Margaret Marshall, Catherine Carr, Judith Fullerton	http://www.ingentaconnect.com/content/springer/ijc/2015/00000005/00000004/art00002	Maternal health; newborn health; health systems strengthening
7	December 2015	Overview of a multi-stakeholder dialogue around shared services for health: the digital health opportunity in Bangladesh	*Health Research Policy and Systems*	Sania Ashraf, Carolyn Moore, Vaibhav Gupta, Anir Chowdhury, Abdul K. Azad, Neelu Singh, David Hagan, Alain Labrique	http://health-policy-systems.biomedcentral.com/articles/10.1186/s12961-015-0063-2	eHealth

#	Month, year	Name of article	Journal name	Authors	Hyperlink	Technical area
8	January 2016	Monitoring iCCM: a feasibility study of the indicator guide for monitoring and evaluating integrated community case management	*Health Policy and Planning*	Timothy Roberton, Dyness Kasungami, Tanya Guenther, Elizabeth Hazel	http://heapol.oxfordjournals.org/content/31/6/759	Child Health; MMEL
9	January 2016	The three waves in implementation of facility-based kangaroo mother care: a multi-country case study from Asia	*BMC International Health and Human Rights*	Anne-Marie Bergh, Joseph de Graft-Johnson, Neena Khadka, Alyssa Om'Iniabohs, Rekha Udani, Hadi Protomo, Socorro De Leon-Mendoza	http://www.ncbi.nlm.nih.gov/pubmed/26818943	Newborn health
10	February 2016	A literature review of quantitative indicators to measure the quality of labor and delivery care	*International Journal of Gynecology and Obstetrics*	Vandana Tripathi	http://www.ijgo.org/article/S0020-7292(15)00652-9/abstract	Maternal health; newborn health; MMEL
11	March 2016	Promoting healthy behaviors among Egyptian mothers: A quasi-experimental study of a health communication package delivered by community organizations	*PLOS One*	Angie Brasington, Ali Abdelmegeid, Adrienne Kols, Vikas Dwivedi, Young-Mi Kim, Barbara Rawlins, Neena Khadka, Anita Gibson	http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0151783	Community health; SBCC
12	March 2016	Measurement of health program equity made easier: Validation of a simplified asset index using program data from Honduras and Senegal	*Global Health: Science and Practice*	Alex Ergo, Julie Ritter, Davidson R Gwatkin, Nancy Binkin	http://www.ncbi.nlm.nih.gov/pubmed/27016551	Equity
13	April 2016	Looking back and planning ahead: Examining global best practices in communication for inactivated polio vaccination introduction in Rwanda	*Global Health Communication*	Suruchi Sood, Ann Klassen, Carmen Cronin, Philip Massey, Corinne Shefner-Rogers	http://tandfonline.com/doi/full/10.1080/23762004.2016.1161418	Immunization

#	Month, year	Name of article	Journal name	Authors	Hyperlink	Technical area
14	April 2016	Polio immunization social norms in Kano State, Nigeria: Implications for designing polio immunization information and communication programs for routine immunization services	*Global Health Communication*	Abdullahi I. Musa	http://tandfonline.com/doi/full/10.1080/23762004.2016.1161419	Immunization
15	April 2016	Redefining immunization: Not just a shot in the arm	*Global Health Communication*	Nancy Anderson, Nana Wilson, Tamica Moon, Natalia Kanem, Amad Diop & Erick Gbodossou	http://tandfonline.com/doi/full/10.1080/23762004.2016.1161416	Immunization
16	May 2016	Polio Eradication and Health Systems in Karachi: Vaccine Refusals in Context	*Global Health Communication*	Svea Closser, Rashid Jooma, Emma Varley, Naina Qayyum, Sonia Rodrigues, Akasha Sarwar, Patricia Omidian	http://tandfonline.com/doi/full/10.1080/23762004.2016.1178563	Immunization
17	May 2016	Exploratory study of the role of knowledge brokers in translating knowledge to action following global maternal and newborn health technical meetings	*Public Health*	Theresa Norton, Catherine Howell, Charlene Reynolds	http://www.publichealthjrnl.com/article/S0033-3506(16)30048-8/abstract	Communications; knowledge management
18	June 2016	Vaccination coverage and timely vaccination with valid doses in Malawi	*Vaccine Reports*	Asnakew Tsega, Hannah Hausi, Geofrey Chriwa, Robert Steinglass, Dasha Smith, Musa Valle	http://www.sciencedirect.com/science/article/pii/S1879437816300158	Immunization
19	June 2016	Uncivil and skewed language on civil society?	*The Lancet*	Eric Gilles Sarriot, Karen LeBan, Emma Sacks, Christine Sow, Craig Burgess	http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(16)30731-0.pdf	Community health
20	July 2016	Evidence-based engagement of the Somali pastoralists of the Horn of Africa in polio immunization: Overview of tracking, cross-border, operations, and communication strategies	*Global Health Communication*	Rustam Haydarov, Saumya Anand, Bram Frouws, Brigitte Toure, Sam Okiror, Bal Ram Bhui	http://tandfonline.com/doi/full/10.1080/23762004.2016.1205890	Immunization

#	Month, year	Name of article	Journal name	Authors	Hyperlink	Technical area
21	July 2016	Community engagement, routine immunization, and the polio legacy in Northern Nigeria	*Global Health Communication*	Anne McArthur-Lloyd, Andrew McKenzie, Sally E. Findley, Cathy Green, Fatima Adamu	http://tandfonline.com/doi/full/10.1080/23762004.2016.1205887	Immunization
22	July 2016	Variations in the uptake of routine immunization in Nigeria: Examining determinants of inequitable access	*Global Health Communication*	Comfort Z. Olorunsaiye, Hannah Degge	http://tandfonline.com/doi/full/10.1080/23762004.2016.1206780	Immunization
23	July 2016	Association of volunteer communication mobilizers' polio-related knowledge and job-related characteristics with health message delivery performance in Kano District of Nigeria	*Global Health Communication*	Rabia Sadat, Abu Mohd Naser	http://tandfonline.com/doi/full/10.1080/23762004.2016.1199939	Immunization
24	August 2016	Coverage, compliance, acceptability and feasibility of a program to prevent pre-eclampsia and eclampsia through calcium supplementation for pregnant women: an operations research study in one district of Nepal	*BMC Pregnancy and Childbirth*	Kusum Thapa, Harshad Sanghvi, Barbara Rawlins, Yagya B. Karki, Kiran Regmi, Shilu Aryal, Yeshoda Aryal, Peter Murakami, Jona Bhattarai, Stephanie Suhowatsky	https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-016-1033-6	Maternal health
25	August 2016	A common monitoring framework for ending preventable maternal mortality, 2015–2030: phase I of a multi-step process	*BMC Pregnancy and Childbirth*	Allisyn C. Moran, R. Rima Jolivet, Doris Chou, Sarah L. Dalglish, Kathleen Hill, Kate Ramsey, Barbara Rawlins, Lale Say	http://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-016-1035-4	Maternal health; MMEL
26	September 2016	Providing antenatal corticosteroids for preterm birth: a quality improvement initiative in Cambodia and the Philippines	*International Journal for Quality in Health Care*	Jeffrey Michael Smith, Shivam Gupta, Emma Williams, Kate Brickson, Keth Lysotha, Navuth Tep, Anthony Calibo, Mary Christine Castro, Bernabe Marinduque, Mark Hathaway	http://www.ncbi.nlm.nih.gov/pubmed/27614015	Maternal health; newborn health

#	Month, year	Name of article	Journal name	Authors	Hyperlink	Technical area
27	September 2016	Postpartum family planning during sociopolitical transition: Findings from an Integrated community-based program in Egypt	*International Perspectives on Sexual and Reproductive Health*	Chelsea M. Cooper, Elaine Charurat, Issam El-Adawi, Young-Mi Kim, Mark R. Emerson, Wael Zaki, Anne Schuster	http://www.jstor.org/stable/10.1363/42e1216	Family planning
28	September 2016	Service availability and readiness assessment of maternal, newborn and child health services at public health facilities in Madagascar	*African Journal of Reproductive Health*	Sandrine H. Andriantsimietry, Raymond Rakotomanga, Jean Pierre Rakotovao, Eliane Ramiandrison, Marc Eric R. Razakariasy, Rachel Favero, Patricia Gomez, Blami Dao, Eva Bazant	http://www.ajrh.info/home/abstract.php?abstractTitle=Service Availability and Readiness Assessment of Maternal, Newborn and Child Health Services at Public Health Facilities in Madagascar&id=237	Maternal health; newborn health; child health
Previously unreported – peer-reviewed journal article below published in PY 1						
29	October 2014	Sociocultural factors perpetuating the practices of early marriage and childbirth in Sylhet District, Bangladesh	*International Health*	Elizabeth G. Henry, Nicholas B. Lehnertz, Ashraful Alam, Nabeel Ashraf Ali, Emma K. Williams, Syed Moshfiqur Rahman, Salahuddin Ahmed, Shams El Arifeen, Abdullah H. Baqui, Peter J. Winch	https://www.ncbi.nlm.nih.gov/pubmed/25294844	Family planning

Annex G: List of Tools and Materials Developed

#	Month, Year	Publication Name	Hyperlink	Country/Region	Technical Area
1	September 2016	Report on MCSP Support for the Polio Switch in April 2016	http://bit.ly/2f1sWH0	Global	Immunization
2	September 2016	Strengthening Human Capacity Development to Improve RMNCH Outcomes	http://bit.ly/2fhSooD	Global	HSS/equity
3	September 2016	Maternal and Child Survival Program Equity Toolkit	http://bit.ly/2dChZbr	Global	HSS/equity
4	August 2016	Prevention and Control of Pneumonia and Diarrhea: Technical Reference Materials	http://bit.ly/2fcUreU	Global	Child/CSHGP
5	August 2016	Rwanda Health Facility Assessment Core Questionnaire Adapted from SARA and SPA tools	http://bit.ly/2e40QLg	Rwanda	HSS/equity
6	August 2016	Alternative Birth Positions Training Materials	http://bit.ly/2eb7TU0	Global	Maternal
7	August 2016	Making Every Baby Count: Audit and Review of Stillbirths and Neonatal Deaths	http://bit.ly/2dQchWt	Global	Newborn
8	August 2016	MCSP Fact Sheet	http://bit.ly/2eb8Cor	Global	N/A
9	August 2016	Reaching Every Community Using Quality Improvement (REC-QI): Mapping to support routine immunization microplanning in Uganda	http://bit.ly/2dcC77W	Uganda	Immunization
10	July 2016	Operational Guidance for Maternal and Child Survival Country Programs: In-Service Clinical Training	http://bit.ly/2fhS5u5	Global	HSS/equity
11	July 2016	MCSP Innovations Fact Sheet	http://bit.ly/2e44WTz	Global	Innovations
12	July 2016	MCSP Nutrition Brief	http://bit.ly/2dhwosC	Global	Nutrition
13	June 2016	Mini-Laparotomy for Tubal Ligation Under Local Anesthesia Video	http://bit.ly/2e7KazJ	Global	Family planning
14	June 2016	Overview of MCSP Year One Results Summary	http://bit.ly/2eb9bhN	Global	N/A
15	June 2016	MCSP Social and Behavior Change Communication Fact Sheet	http://bit.ly/2e446q4	Global	SBCC
16	June 2016	MCSP Health Systems Strengthening Fact Sheet	http://bit.ly/2dpNMid	Global	HSS/equity
17	June 2016	MCSP Gender Fact Sheet	http://bit.ly/2e7KbDJ	Global	Gender
18	June 2016	Strengthening the Routine Immunization System through a Reaching Every Child-Quality Improvement Approach in Uganda	http://bit.ly/2dClfUm	Uganda	Immunization

#	Month, Year	Publication Name	Hyperlink	Country/Region	Technical Area
19	June 2016	Health Management Information Systems (HMIS) Review	http://bit.ly/2dpKPOy	Global	MMEL
20	May 2016	Review of Newborn Indicators in Maternal and Child Survival Program-Supported Countries	http://bit.ly/2e46X02	Global	Newborn
21	May 2016	Maternal and Child Survival Program: Zambia	http://bit.ly/2ebapK7	Zambia	N/A
22	April 2016	Mapping Global Leadership in Child Health	http://bit.ly/2dTm5l0	Global	Child
23	April 2016	Investing in Malaria in Pregnancy in Sub-Saharan Africa: Saving Women's and Children's Lives	http://bit.ly/2dCojQc	Sub-Saharan Africa	Malaria
24	April 2016	A Rapid Assessment of Oral Rehydration Therapy Corners in Bondo, Igembe North, and Igembe Central Subcounties, Kenya	http://bit.ly/2dcxXwF	Kenya	Child
25	April 2016	The Integrated Community Case Management (iCCM) of Childhood Illness Task Force: Fact Sheet	http://bit.ly/2dQfi9k	Global	Child
26	April 2016	Literature Review: Civil Society Engagement to Strengthen National Health Systems to End Preventable Child and Maternal Death	http://bit.ly/1TWKbJ9	Global	CH/CSE
27	March 2016	Civil Society Engagement Strategy: 2016–2019	http://bit.ly/1YbGzmy	Global	CH/CSE
28	March 2016	Focused Review of Successful Quality Improvement Initiatives Aimed at Compliance With Evidence-Based Practice Guidelines for Child Illness Care	http://bit.ly/2dCn4Al	Global	Child
29	March 2016	Comprehensive Approach to Health Systems Management Resource Compendium	http://bit.ly/2dhxR1X	Global	HSS
30	February 2016	MCSP Annual Report: Year One	http://bit.ly/2e7JlXt	Global	MMEL
31	February 2016	The Power of Counseling: Changing Maternal, Infant, and Young Child Nutrition and Family Planning Practices in Dhamar, Yemen	http://bit.ly/2eppqHQ	Yemen	Nutrition; family planning
32	January 2016	Haiti Fact Sheet	http://bit.ly/2ebbFXH	Haiti	N/A
33	December 2015	Case Study: Experience Applying and Tracking a Quality Improvement Approach for Maternal and Newborn Health Services in Sub-Saharan Africa	http://bit.ly/2ebeldE	Sub-Saharan Africa	HSS
34	December 2015	Case Study: Primary Healthcare Clinical Placements during Nursing and Midwifery Education in Lesotho	http://bit.ly/2e4oyVH	Lesotho	Maternal

#	Month, Year	Publication Name	Hyperlink	Country/Region	Technical Area
35	November 2015	The Global Fund New Funding Model: Lessons from Zambia on the Addition of Integrated Community Case managed (iCCM)	http://bit.ly/2dpP5hc	Zambia	Child
36	November 2015	The Global Fund New Funding Model: Lessons from Nigeria on Negotiating the Inclusion of Integrated Community Case Management (iCCM) of Childhood Illness	http://bit.ly/2e05WqF	Nigeria	Child
37	November 2015	The Global Fund New Funding Model: Lessons from Uganda on Integrating the Integrated Community Case Management Model (iCCM)	http://bit.ly/2ezNXpe	Uganda	Child
38	November 2015	The Global Fund New Funding Model: Lessons from Ghana on Negotiating the Inclusion of Integrated Community Case Management (iCCM) of Childhood Illness	http://bit.ly/2eecoHS	Ghana	Child
39	November 2015	Family Planning Needs during the First Two Years Postpartum in Uganda	http://bit.ly/2dTxj8U	Uganda	Family planning
40	October 2015	Technical Consultation on Reporting and Mapping Maternal Deaths in Countries with High Maternal Mortality	http://bit.ly/2egiqcs	Global	Maternal
41	October 2015	Feasibility Study of the Implementation of Integrated Community Case Management in Bondo: Leveraging Existing Systems	http://bit.ly/2dcMUPy	Kenya	Child
53	September 2015	Article I. The Global Fund New Funding Model: Lessons from Kenya on iCCM integration into the Malaria Concept Note	http://bit.ly/2ePiO1c	Kenya	Child
48	June 2015	Identification of a Short Quality of Care Index to Measure the Quality of Facility Routine Labor and Delivery Care in Sub-Saharan Africa	http://bit.ly/2fURMK3	Sub-Saharan Africa	Maternal
49	June 2015	Piloting a Streamlined Index for Assessment of Quality of Labor and Delivery Care in Tanzania— Findings and Recommendations	http://bit.ly/2ex9he9	Tanzania	Maternal
52	May 2015	Article II. Leveraging the Global Fund New Funding Model for integrated community case management: A synthesis of lessons from five countries	http://bit.ly/2fUWis1	Ghana; Kenya; Nigeria; Uganda; Zambia	Child

#	Month, Year	Publication Name	Hyperlink	Country/Region	Technical Area
51	April 2015	Postnatal Care for Mothers and Newborns: Highlights from the World Health Organization 2013 Guidelines	http://bit.ly/2ftdr96	Global	Maternal; newborn
54	February 2015	Article III. Case study: improving quality of care and outcomes for child health using the standards-based management and recognition approach in Zimbabwe	http://bit.ly/2fhXe63	Zimbabwe	Child
56	February 2015	Article IV. SBM-R for child health, a synthesis of initial experiences in Guinea and Zimbabwe	http://bit.ly/2fi0WMZ	Zimbabwe	Child
42	January 2015	Article V. Family planning needs during the first two years postpartum in Madagascar	http://bit.ly/1TtrETN	Madagascar	Family planning
43	January 2015	Article VI. Family planning needs during the first two years postpartum in Mozambique	http://bit.ly/1UTcNBh	Mozambique	Family planning
44	January 2015	Article VII. Family planning needs during the first two years postpartum in Nigeria	http://bit.ly/1QEdGe0	Nigeria	Family planning
45	January 2015	Article VIII. Family planning needs during the first two years postpartum in Tanzania	http://bit.ly/28ZftPm	Tanzania	Family planning
50	January 2015	Article IX. Scaling up high-impact health interventions in complex adaptive systems: Lessons from MCHIP	http://bit.ly/1U3zvHp	Global	MMEL
46	January 2015	Article X. Family planning needs during the first two years postpartum in Burkina Faso	http://bit.ly/1TtrUC5	Burkina Faso	Family planning
47	January 2015	Article XI. Family planning needs during the first two years postpartum in Ghana	http://bit.ly/1M79Gyr	Ghana	Family planning
57	September 2014	Article XII. Evaluation of the Helping Babies Breathe (HBB) initiative scale-up in Malawi	http://bit.ly/2fwsJMC	Malawi	MMEL
55	April 2014	Article XIII. Preliminary lessons learned: Integration of IMNCI standards in three health centers in Guinea	http://bit.ly/2ftf4DJ	Guinea	Child
58	April 2014	Article XIV. Mali: Qualitative study of the low utilization of Essential Community Care	http://bit.ly/2fyFOBE	Mali	Child

Annex H: Selected High-Impact Interventions

Technical area	Target condition	High impact intervention (HII)
	Pre-eclampsia/eclampsia, malaria in pregnancy, and other maternal conditions	ANC (includes various HII)
	Sepsis	Infection diagnosis and treatment
	Pre-eclampsia/eclampsia	PE/E management (MgSO4 and/or hypertensives)
	Postpartum hemorrhage	Facility-based PPH prevention
		Community-based PPH prevention
		PPH management
	Obstructed labor	Respectful maternity care
	All maternal and newborn mortality conditions	Comprehensive emergency obstetric and newborn care (includes various HII)
	Obstructed labor, sepsis	Routine MNH care (labor management)
	Prematurity	Preterm birth management
	Sepsis	Chlorhexidine
	Prematurity	Kangaroo mother care
	Asphyxia	Newborn resuscitation
	Sepsis	Antibiotic treatment for possibly serious bacterial infection
	Malaria, pneumonia, diarrhea	IMCI
		iCCM
		Demand generation and promotion of appropriate family practices
	Vaccine preventable diseases	Routine immunization (measles, polio, tetanus)
		New vaccine (IPV, measles 2nd, measles-rubella, meningitis A, PCV, rota)
	High total fertility rate and inadequate birth spacing	Expanding method choice
		Community-based FP/PPFP
		Interval LARCs
		FP permanent methods
		PPFP (LAM, LARCs)

Technical area	Target condition	High impact intervention (HII)
	Malnutrition	Infant and young child feeding (immediate breastfeeding, exclusive breastfeeding, complementary feeding)
	Malnutrition, diarrhea	Household actions (handwashing, point of use water treatment)
	Malaria	Facility-based MiP
		Facility-based malaria case management
		Community-based MiP
		Community-based malaria case management