USAID
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Report to Congress

WORKING TOWARD THE GOAL OF REDUCING MATERNAL AND CHILD MORTALITY: USAID PROGRAMMING AND RESPONSE TO FY08 APPROPRIATIONS

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Overview: A Strategic Approach for USAID Maternal and Child Health (MCH) Programming

Background

For more than two decades, the U.S. Congress has represented the American people's support for the U.S. Agency for International Development's (USAID) Child Survival and Maternal Health programs. USAID, in turn, has worked to turn this support into real progress in saving the lives and improving the health of mothers and children in many of the world's poorest countries. The Agency has contributed to global progress in maternal and child health by:

• Supporting the development and introduction of cost-effective, evidence-based interventions that can save lives in developing countries, from oral rehydration therapy and vitamin A supplementation in the 1980s and 1990s to management of postpartum hemorrhage and essential newborn care;

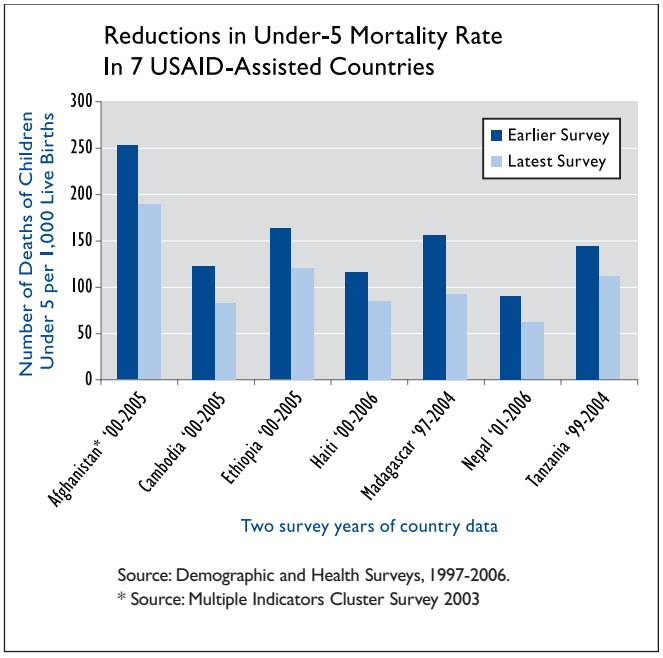
• Providing leadership to keep the attention of developing country governments and global leaders on the need to address the basic health and nutrition needs of the most vulnerable women, children, and families; and

• Supporting country-level programs that deliver high-impact interventions, measure results, and contribute to building countries' health systems and human capacity.

With this sustained U.S. leadership, efforts to improve the survival and health of mothers and children have delivered unprecedented public health success at global scale. When USAID and UNICEF, with Congressional support, launched the global "Child Survival Revolution" in the early 1980s, the number of children dying each year was estimated at 15 million. If no action had been taken, with increased numbers of children in the world, that number would now be more than 17 million. Instead, in 2007, UNICEF announced that – for the first time since systematic measurement began – the estimated number of under-5 child deaths was below 10 million. This means that more than 7 million children's lives are being saved each year.

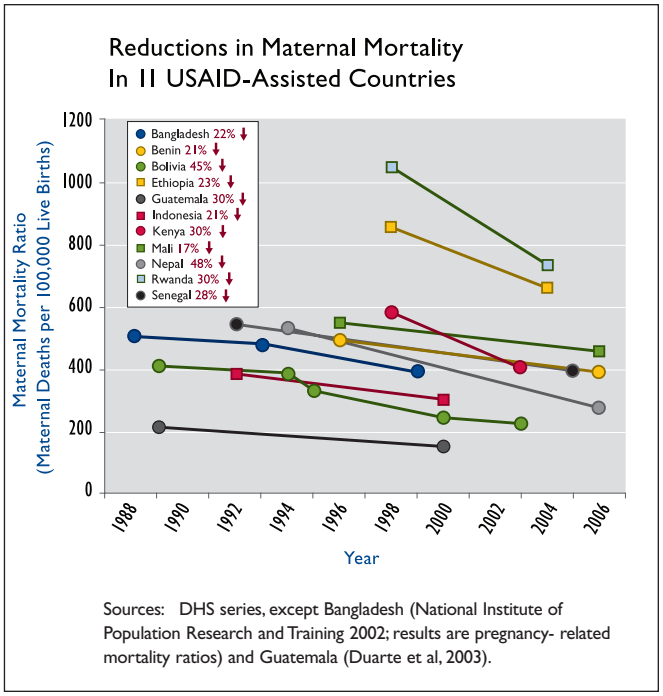
As illustrated in figure 1, a number of USAID-assisted countries – including some of the world's poorest and most challenging, such as Afghanistan, Cambodia, Ethiopia, Haiti, Madagascar, Nepal, and Tanzania – have shown that the survival of children can be improved by

FIGURE 1



Source: Demographic and Health Surveys, 1997-2006.
* Source: Multiple Indicators Cluster Survey 2003

FIGURE 2



Sources: DHS series, except Bangladesh (National Institute of Population Research and Training 2002; results are pregnancy- related mortality ratios) and Guatemala (Duarte et al, 2003).

20 to 30 percent or more in just 5 to 7 years. Likewise, countries with USAID support have made significant reductions in maternal mortality, as well. As shown in figure 2, over the course of a decade, declines of 17 to 48 percent have been documented in 11 countries.

These successes show what can be done with host government commitment, sustained support, and effective programs that deliver vital maternal and child heath services. They are the foundation for USAID's continued and expanded MCH efforts.

The unmet need for those efforts is clearly apparent in the 9.7 million remaining child deaths and half a million maternal deaths – most of them preventable – that still occur every year, almost all of them in the developing world. These deaths, and the lives deprived of productivity and prosperity by disease and hunger, represent a significant "unfinished agenda" in the decades-long effort to protect and improve the survival, health, and nutrition of mothers and children in developing countries. Global attention to this agenda has sharpened in recent years, with heightened interest in accelerating progress toward the 2015 Millennium Development Goals (MDGs). Achieving these goals will require the most effective and strategic use of resources by the global health community of multilateral and bilateral donors, host-country governments, civil society organizations, and private sector partners.

Recognizing this need to continue and accelerate progress, the 2008 foreign assistance appropriation, enacted in December 2007, provided USAID with a 25 percent increase in funding for its maternal and child health programs. With that appropriation came a mandate to report on "how its child survival programs are working toward the goal of reducing child mortality by two-thirds" and "to provide specific information about how the funding supports country efforts to reduce child mortality as well as how USAID funding complements the work of other private and public donors." The legislation requires USAID to submit a report at the completion of the first 6 months following enactment.

This report responds to these requirements and identifies USAID's initial steps to achieve greatest impact with this increased support for maternal and child health. As described in the report, these steps have included the strategic allocation to countries of FY08 MCH funding and identification of a set of "MCH priority countries," defined in terms of need (maternal and child mortality) as well as the presence of USAID Missions in countries and the capacity of those Missions and the countries themselves to implement expanded MCH programming. During the first 6 months of 2008, technical staff from GH and Regional Bureaus provided assistance to Missions in many of the priority countries to help them achieve the greatest possible program effectiveness and in-country leverage from their MCH funding; this process will continue throughout the year. This report also provides details on the MCH programs and funding levels of these priority countries.

The challenge

Despite significant progress over the past two decades, nearly 20 children under 5 still die every minute – almost 10 million each year – from causes that could be prevented from proven MCH interventions. Four million of these are newborn infants who die within their first month of life. In addition, 500,000 women die each year from complications of pregnancy and childbirth that likewise could be prevented.

USAID's goals

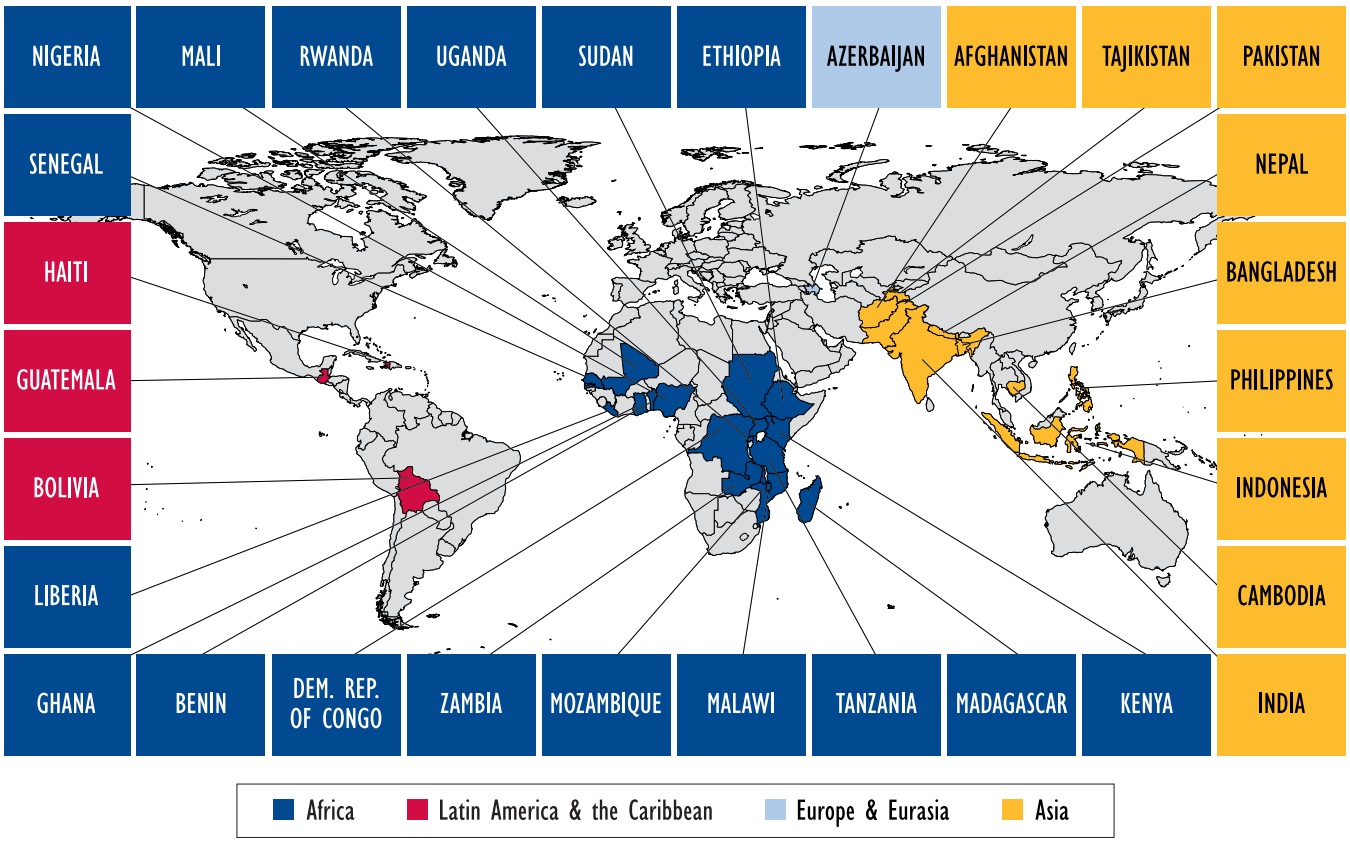
By 2013, USAID will support achievement of:

- Average reductions of both under-5 mortality rate (U5MR) and maternal mortality ratio (MMR) by 25 percent in 30 high mortality-burden countries
- Average reductions of child malnutrition by 15 percent in at least 10 of these countries
- Addressing the human resources crisis by increasing by at least 100,000 the number of functional (trained, equipped, and supervised) community health workers and volunteers serving at primary care and community levels

The keys to achieving these goals are:

- Delivering high-impact interventions that prevent or treat the major causes of maternal and child mortality and malnutrition, such as antenatal care and skilled birth attendance; postnatal and newborn care; breastfeeding, appropriate child feeding, and management of acute severe malnutrition; immunization; vitamin A and zinc supplementation; and prevention and treatment of diarrhea and pneumonia
- Strengthening essential elements of health systems, including human resources, pharmaceutical management and logistics, financing, quality assurance, governance, and information systems

MCH PRIORITY COUNTRIES AS OF MARCH 2008



Achieving the goals: Targeting countries

USAID will focus the majority of its maternal and child health resources from the Global Health and Child Survival account in 30 priority countries that account for at least 50 percent of infant, child, and maternal deaths worldwide. These countries are characterized by both high magnitude (i.e., numbers) and severity (rates) of maternal and child deaths. They also meet other criteria:

- Their governments have demonstrated a commitment to working with partners and civil society to achieve accelerated reductions in maternal and under-5 mortality.
- The country and the USAID Mission have the capacity to manage and program the required maternal and child health resources.
- There are opportunities to interact with other U.S. Government (USG) resources, such as Title II food aid, the President's Malaria Initiative, the U.S. President's Emergency Plan for AIDS Relief, family planning and reproductive health activities, and the Office of U.S. Foreign Disaster Assistance programs.
- There are also opportunities for effective leveraging of USAID resources against those of the host country as well as other international partners such as multilateral agencies and other bilateral donors; and global funding mechanisms, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the GAVI Alliance.

Achieving the goals: Strategic programming

USAID will aim to achieve and sustain the greatest possible reduction of maternal and child mortality and malnutrition through programs that:

- Focus on maternal, newborn, and child mortality reduction as a clear goal;
- Identify and scale up high-impact interventions most relevant to the country, using country-specific epidemiology as the basis for identifying priorities and interventions;
- Specifically aim for impact at scale, while linking increased coverage of key interventions to measured change in inputs and outputs;

- Strengthen health systems and human capacity to support and sustain improved maternal and child health outcomes;

- Support the most effective approaches to deliver key interventions to families and communities that need them by identifying the best mix of system strengthening, demand creation, and community and public-private approaches;

- Introduce approaches that link water and sanitation investments to improved women's and children's health; and

- Complement other USG, donor, and host country resources.

In addition, in priority countries that are recovering from conflict, USAID will implement tailored programs that extend basic services as quickly as possible while rebuilding the foundations of health systems.

The focus is on approaches that are evidence-based, replicable, and scalable, and that contribute to building systems and capacities to support countries in moving to the next stage of transformational development.

Achieving the goals: Partnerships

Effective partnerships will be critical for achieving the MCH goals. USAID's principal partners are the governments of host countries, guided by those countries' national strategies and plans.

USAID will pursue innovative working relationships with private-sector partners at the global, regional, and country levels to enhance health services in priority countries, recognizing that USAID Administrator Fore has set a target of tripling the number of such partnerships during 2008.

USAID will also strategically position its MCH program support to complement the resources of international partners (such as GAVI Health Systems Strengthening funding), other donors, multilateral organizations, and nongovernmental organizations (NGOs) operating in priority countries.

Interventions and Measuring Impact

High-impact MCH interventions

Based on more than 20 years of USAID leadership in maternal and child health programming, the foundation of USAID MCH programming is the development and implementation of evidence-based, high-impact interventions that can be feasibly delivered at low cost to women and children who need them. USAID has taken a systematic approach to this process, which involves:

- Identifying the specific diseases and conditions responsible for large shares of maternal or child illness and death
- Identifying potential interventions that prevent or treat these conditions and that can be used in low-resource settings
- Systematically testing these interventions, first in controlled settings and then in actual field conditions
- Introducing interventions deemed promising in demonstration areas of "early use" countries and evaluating their effectiveness
- Expanding implementation to national scale
- Integrating the interventions into comprehensive programs
- Supporting these interventions and programs in multiple countries

At the ground level, the MCH strategic approach will employ these evidence-based interventions, documented in the recent *Lancet* series on maternal, newborn, and child survival, in program approaches that have proven effective and cost-efficient, and have the potential for scaled-up national implementation.

With USAID support, countries as diverse as Nepal, Cambodia, Ethiopia, Madagascar, Nepal, Tanzania, and Afghanistan have already used this approach and demonstrated the possibility of reducing U5MR in high-mortality countries by 25 percent in 5 to 7 years. Comparable reductions have also been achieved for maternal mortality in such countries as Indonesia, Bangladesh, Egypt, Bolivia, and Guatemala.

Strengthening the community health workforce for MCH

There is convincing evidence that many of the MCH needs in high-burden countries can be met by nonprofessional health workers at the community level. Low-income countries have a long tradition of providing some elements of health care through nonprofessionals with only limited training. These community health workers (CHWs) cost much less than even low-level health professionals, and often work as unsalaried volunteers. CHWs are typically long-time residents of the community where they serve and are unlikely to move away.

Since the 1978 Declaration of Alma-Ata, the World Health Organization has promoted wider use of CHWs to provide selected types of MCH care and to promote health-related behaviors. Technical advances have allowed a wider range of high-impact interventions to be suitable for delivery by a provider with limited training. Examples include a simple package of services for the newborn and protocols for community treatment of malaria, pneumonia, and diarrhea.

CHW programs have traditionally focused on training volunteers to perform certain well-defined activities. Several countries have trained large numbers of CHWs and other volunteers, and are committed to training more. This large, ongoing investment provides an opportunity to foster complementary cost-effective approaches to further developing the skills of CHWs. USAID experience suggests that job aids, self-evaluation tools, incentive systems, and other approaches to CHW performance merit more attention.

Even with excellent training, CHWs are unlikely to achieve their maximum impact on health without the effective support of the organized health system. Based on USAID experience with health systems strengthening, this initiative will include a broad effort to monitor and improve the support provided to CHWs, including supervision, information systems, logistics, human resources management, and modern quality improvement. USAID will also address the role of the community itself, selection criteria for CHWs, and cultural factors. By 2013, USAID plans to expand the current supply of well-performing CHWs by 100,000 in MCH priority countries. USAID will build upon exist-

KEY MCH INTERVENTIONS	DESCRIPTION
Antenatal care	Depending on epidemiology and health system capacity, interventions focus on providing pregnant women with iron folate supplements, deworming, intermittent preventive malaria treatment, insecticide-treated mosquito nets, HIV and syphilis control, and counseling to use a skilled birth attendant and to seek timely emergency care in the event of a pregnancy or birth complication.
Skilled care at birth	Basic essential obstetric care that includes use of partogram, infection prevention, active management of the third stage of labor, essential newborn care, and recognition, initial treatment, and referral for hemorrhage, infection, hypertensive disorder, prolonged labor, newborn asphyxia, and postabortion complications.
Emergency obstetric care	Includes treatment of life-threatening complications, such as medical management of hypertensive disorder, blood transfusion, cesarean section, hysterectomy, and resuscitation.
Active management of the third stage of labor	Requires provision of a uterotonic drug immediately after birth, delivery of the placenta by controlled cord traction, and external uterine massage by a skilled birth attendant for prevention of postpartum hemorrhage. In the absence of a skilled birth attendant, a uterotonic alone may be administered.
Treatment of postpartum hemorrhage	Includes assessment of the cause and, if uterine atony, provision of a uterotonic; removal of the placenta or fragments as necessary; emptying the bladder; external or bimanual uterine compression; and recognition of severe hemorrhage that requires referral.
Essential newborn care	Focus is on immediate warming and drying, clean cord care, and early initiation of breatstfeeding.
Treatment of severe newborn infection	Includes assessment of symptoms and treatment with antibiotics and additional respiratory, nutritional, and fluid support, as feasible and needed.
Prevention of diarrhea	Focus is on point-of-use (typically household or school) water treatment to ensure the safety of drinking water, coupled with associated improvements in key hygiene behaviors, such as correct water handling and storage, effective hand washing, and safe feces disposal.
Treatment of diarrhea	Focus is on home-based treatment with oral rehydration therapy (use of oral rehydration solution, increased fluids, continued feeding) to prevent severe dehydration and treatment with zinc to reduce severity and duration of diarrhea.
Treatment of pneumonia	Focus is on community-based treatment of pneumonia with antibiotics and effective recognition of severe illness with appropriate referral.
Treatment of severe childhood illness	Includes assessment of symptoms, treatment with antibiotics and antimalarials, and provision of respiratory, fluid, and nutritional support as needed.
Immunizations	Focus is on full immunization for children (defined as three doses of diphtheria/pertussis/tetanus vaccine and immunization against measles and polio before age 1) and introduction of new vaccines in countries with high routine immunization coverage.
Vitamin A	Focus is on provision of vitamin A capsules to children 6 to 59 months twice annually.
Infant and young child feeding	Includes breastfeeding from immediately after birth, exclusive breastfeeding for the first 6 months of life, and addition of soft/semisolid foods. Community-based growth promotion and community-based management of acute malnutrition with ready-to-use therapeutic foods.

ing successful country-level CHW models, such as those deployed in Nepal and Bangladesh, as well as more recently developed efforts, such as the Health Extension Program in Ethiopia or the Accredited Social Health Activist cadre in India. USAID will provide support in both deepening current country efforts, as well as introducing effective CHW approaches in countries that currently do not have them.

Monitoring

No special reporting will be required of countries beyond routine annual Operational Plans and results reporting. Indicators and baseline measurements on key indicators (such as U5MR and MMR) are established with this report using existing national Demographic and Health Surveys. These indicators will be updated as additional national population-based surveys (Demographic and Health Surveys, Multiple Indicator Cluster Surveys) are carried out. They will include impact, outcome, and output indicators. Each year, USAID will aggregate and report on these key indicators for each priority country to allow tracking of progress toward MCH goals.

A core set of output indicators (such as the number of antenatal care visits by skilled providers from U.S. Government-assisted facilities or the number of people trained in child health and nutrition through U.S. Government-supported health area programs) has been identified by USAID Missions for annual reporting of maternal/child health and related health systems interventions. Baseline measurements of these output indicators will start with fiscal year 2008, with further refinement of reporting over the next fiscal year.

In addition, USAID will report on outcome indicators (such as use of antenatal care and skilled birth attendants [SBAs], immunization and micronutrient coverage, feeding practices, and use of appropriate treatment for child illness) as data are made available through the routine annual Operational Plans.

Individual Missions and country programs will use indicators and qualitative results to revise programs on an ongoing basis. All monitoring and measurement activities will be carried out in ways that contribute to strengthening host countries' national and local information systems and capacities.

FY08 Global Health and Child Survival Budget Allocation for Child Survival and Maternal Health

MCH Priority Country Status and Funding						
	Annual births (thousands)	**MMR (per 100,000 live births)**	**Annual Maternal Deaths+ (thousands)**	**U5MR (per 1,000 live births)**	**Annual Under-5 Deaths+ (thousands)**	**CSMH Total (thousands in USD)**
Africa Region						**123,635**
Benin	306	397	1.2	125	38	4,116
DR Congo	2,761	1,289*	35.6	148**	409	12,093
Ethiopia	2,820	673	19.0	123	347	13,371
Ghana	686	560***	3.8	111*	76	4,462
Kenya	1,331	560***	7.5	115	153	3,470
Liberia	140	994**	1.4	111**	16	5,158
Madagascar	698	469	3.3	94	66	6,695
Malawi	546	984	5.4	133	73	4,955
Mali	582	464	2.7	191	111	6,443
Mozambique	790	408	3.2	153	121	6,938
Nigeria	5,045	1,100***	59.0	201	1,014	15,860
Rwanda	379	750	2.8	103**	58	4,459
Senegal	464	401	1.9	121	56	4,640
Sudan	1,225*	2,037*	25.0	135*	165	12,399
Tanzania	1,418	578	8.2	112	159	5,693
Uganda	1,404	435	6.1	137	192	5,447
Zambia	450	729	3.3	119	54	7,435
Asia Region						**112,896**
Afghanistan	1,285	1,600******	20.6	191*	245	38,074
Bangladesh	4,417	322*****	14.2	65**	287	13,333
Cambodia	340	472	1.6	83	28	8,555
India	25,852	450***	117.0	74	1,920	14,978
Indonesia	4,742	307	14.6	45**	213	12,196
Nepal	876	281	2.5	61	53	7,432
Pakistan	4,543	276	12.5	94	427	13,864
Philippines	2,225	230***	4.6	40	89	3,720
Tajikistan	171	97*	0.2	79	14	744
Europe & Eurasia Region						**744**
Azerbaijan	129	82***	0.1	50**	6.5	744
Latin America and the Caribbean Region						**20,486**
Bolivia	219	229	0.5	75	16	6,510
Guatemala	366	153*******	0.6	53****	19	4,660
Haiti	300	630	1.9	86	26	9,316
TOTAL 30 PRIORITY COUNTRIES						**257,761**

Annual births: Census International Database; **MMR, U5MR:** Demographic and Health Surveys (DHS), 1997-2007

* Multiple Indicators Cluster Survey ** Preliminary Demographic and Health Survey *** WHO Maternal Mortality Report 2007 **** Reproductive Health Survey ***** Bangladesh: National Institute of Population Research and Training (NIPORT), ORC Macro, Johns Hopkins University and ICDDR,B. 2003. Bangladesh Maternal Health Services and Maternal Mortality Survey 2001. Dhaka, Bangladesh and Calverton, Maryland (USA): NIPORT, ORC Macro, Johns Hopkins University, and ICDDR,B. ****** Afghanistan: Bartlett, L. et al. 2002. "Maternal mortality in Afghanistan : magnitude, causes, risk factors and preventability." Afghan Ministry of Public Health, US Centers for Disease Control and Prevention, UNICEF, 2002. *******Guatemala: Duarte et al. 2003. "Linea Basal de Mortalidad Materna para El Año 2000" Mott, Guatemala, 2003

+ The annual number of maternal and under-five deaths are calculated from the mortality rate and the number of live births for each country.

ALL OTHER COUNTRIES RECEIVING CSMH FUNDS	
	CSMH Total (thousands in USD)
Angola	1,339
Burundi	2,559
Djibouti	248
Guinea	3,174
Somalia	748
Yemen	2,883
Dominican Republic	2,119
Ecuador	2,000
El Salvador	3,859
Honduras	3,535
Nicaragua	2,976
Peru	5,760
All Other Countries	**31,200**

CSMH FUNDING FOR REGIONAL BUREAUS AND MISSIONS	
	CSMH Total (thousands in USD)
Africa Regional Bureau	10,740
East Africa Regional Mission	1,488
West Africa Regional Mission	992
Asia Regional Bureau	2,182
Latin America and the Caribbean Regional Bureau	2,227
Regional Bureaus and Missions	**17,629**

SUMMARY CSMH FUNDING	
	CSMH Total (thousands in USD)
MCH Priority Countries	257,761
All Other Countries	31,200
Regional Bureaus and Missions	17,629
Bureau for Global Health (including Research and the Child Survival and Health Grants Program)	66,021
International Organizations (GAVI and Iodine Deficiency Disease)	73,897
GRAND TOTAL CSMH FUNDING	**446,808**

NOTES: CSH MCH funding for fistula is additive to CHS Population funds for fistula.
REDSO/ESA funding includes polio funding for Djibouti ($248,000) and Somalia ($248,000) and water funding for Somalia ($500,000).

Maternal and Child Health Strategic Approach – Africa

Objectives

By 2013, USAID will work with national governments and national and international partners in sub-Saharan Africa to implement sustainable approaches in MCH priority countries that will:

- Decrease U5MR by 25 percent
- Decrease MMR by 25 percent
- Decrease malnutrition by 15 percent
- Increase use of SBAs by 15 percent

MCH Priority Countries	
BENIN	MOZAMBIQUE
DR CONGO	NIGERIA
ETHIOPIA	RWANDA
GHANA	SENEGAL
KENYA	SUDAN
LIBERIA	TANZANIA
MADAGASCAR	UGANDA
MALAWI	ZAMBIA
MALI	

Problem statement

Mortality rates for mothers and children under 5 years of age remain alarmingly high in sub-Saharan Africa, where nearly 250,000 women die annually from pregnancy and childbirth-related conditions, and where less than half of all births are attended by a SBA. Adolescent pregnancy, low contraceptive prevalence (13 percent), and high fertility (estimated at 5.6 children per woman) increase the lifetime risk of maternal death. An African woman's lifetime risk of dying from pregnancy and childbirth-related conditions is 1 in 22, compared with 1 in 8,000 in industrialized countries. These regional figures mask considerable differences between and within countries. For example, the maternal mortality ratio (MMR) – maternal deaths per 100,000 live births – is estimated to be 560 in Ghana and 2,037 in Southern Sudan.

The overall U5MR in sub-Saharan Africa has improved, dropping from 187 per 1,000 live births in 1990 to 160 in 2006. However, this represents an average annual rate of decline in child mortality of only 1.0 percent over the past 16 years. This rate must increase to 10.5 percent for the period of 2007 to 2015 in order to achieve the MDG 4 target. The decrease in child mortality in sub-Saharan Africa also lags badly relative to other developing regions. Over the past 6 years, the percentage decline in child mortality was 14 percent for South Asia, 23 percent for Latin America, and 28 percent for East Asia and the Pacific, but only 6 percent for sub-Saharan Africa. The challenge for Africa is to reduce child and maternal mortality within a resource-constrained environment, with weak health systems, a workforce crisis, and an HIV/AIDS epidemic. The need to move beyond the current reach of the health system is evident in the fact that almost 80 percent of the children dying in Africa die at home without seeing a health care provider. On the present course, by 2010, sub-Saharan Africa will account for more than half of all child mortality worldwide.

What has been accomplished to date

USAID and partners have achieved significant successes where sufficient funds, strong national leadership, and effective implementation strategies have come together. U5MR rates have declined by 15 percent to 35 percent in Ethiopia, Malawi, Madagascar, Mozambique, Rwanda, Tanzania, and Zambia over the previous 5 years.

*Child Survival in Sub-Saharan Africa –Taking Stock**, an evaluation of USAID's Africa child survival programs, found that countries that achieved the greatest impact on mortality reduction had clear national objectives to reduce U5MR; programmed at scale to achieve population coverage; implemented a number of key interventions with high impact to achieve adequate program scope; developed operational partnerships with

* Marx M. Child Survival in Sub-Saharan Africa – Taking Stock. Washington, D.C., Academy for Educational Development [AED], Support for Analysis and Research in Africa [SARA], [2005]. [290] p. (USAID Contract No. AOT-C-00-99-00237-00)

other donors, NGOs, and the government that supported mutual program objectives; and designed effective programs based on national and local epidemiological and cultural factors.

Challenges

Major challenges for expanding and accelerating progress in the Africa region include:

- Weak health systems that have led to commodity disruptions, inadequate management, poor availability and use of information, and lack of supervision and oversight
- A health manpower crisis that affects all levels of the health sector
- An HIV/AIDS epidemic that erodes human capacity, diverts scarce resources, degrades organizational capacity, and fragments social and economic networks
- High comorbidity of malaria and HIV/AIDS
- Natural disasters, epidemics, and civil unrest, in all of which women and children suffer disproportionately
- High prevalence of malnutrition due to food insecurity and poor nutritional practices
- Frequent use of informal providers, including traditional healers and drug sellers, who rarely manage childhood illness correctly

Strategies

USAID's approach to improving maternal, child, and newborn health in sub-Saharan Africa will:

- Program at scale a sufficient number and range of priority health interventions to achieve high impact
- Support a mix of focused interventions for high impact and systems improvements for sustainability
- Improve the quality of delivery of health services in both public and private health
- Utilize the private sector and effective community outreach and mobilization strategies to improve management of childhood illnesses at the household and community levels
- Support innovative health financing approaches to mobilize resources and extend coverage
- Support strategies to address critical health workforce issues that have an impact on MCH services
- Establish strategic partnerships with government, other donors, and country stakeholders
- Maximize linkages with investments in HIV/AIDS and malaria prevention and treatment

Benin MCH Program Description

Overall MCH and health sector situation

Benin has a population of approximately 8 million, 44 percent of whom are below the age of 15. Benin ranks 163 out of 177 countries on the United Nations Human Development Index. The per capita annual income is about $510. With an annual growth rate of almost 3 percent, Benin's population will double in the next 24 years. The burgeoning population exerts a huge influence on demands for social services, including health and water. In these areas, Benin faces particular challenges due to entrenched poverty, low knowledge and health-seeking behavior, and persistent weaknesses in the management and delivery of health services.

Despite these fundamental challenges, in recent years key health indicators have shown consistent and considerable improvement. For example, U5MR declined from 160/1,000 (DHS 2001) to 125/1,000 (DHS 2006). Nevertheless, key outcome-level indicators remain troubling. The last Demographic and Health Survey (DHS-3) reported a significant drop in the vaccination rate in Benin. National rates of completed vaccination in children aged 12 to 23 months anytime before the survey declined from 59 percent in 2001 (DHS-2) to 47 percent in 2006 (DHS-3). Infant and child mortality rates remain among the highest in coastal West Africa mainly due to preventable childhood illnesses, especially malaria, acute respiratory infections, and diarrhea. These three illnesses account for 70 percent of visits to health centers and 65 percent of under-5 deaths. Nationally, MMR in the recent DHS was reported as 397 per 100,000 live births. Women in Benin have a lifetime risk of maternal death of 1 in 17.

The Ministry of Health (MOH) is committed to a significant and lasting reduction in child and maternal mortality. Over the past decade, the MOH has reorganized its structure through the creation of health zones or zones sanitaires (often called districts in other African countries). These zones are designed to facilitate decentralized planning and management, as well as to facilitate the efficiency of resource allocation and the rehabilitation of referral units. Each zone covers a population of 100,000 to 150,000 inhabitants. Through this reorganization, the MOH intends to reinforce and reorient current services, promote interventions for high-prevalence diseases, and ultimately promote the effective decentralization of health services.

A wide variety of health facilities, pharmacies, and other services exist in the private sector, and most of these are situated in the urban centers. In addition, many religious institutions and some NGOs run hospitals or dispensaries, or provide training, health education, and other health services. It is estimated that the private/NGO/concessional sector actually provides at least 30 percent of health services in Benin. Overall, 19 percent of medical personnel work in the private sector, including approximately 37 percent of physicians, 16 percent of nurses, and 14 percent of nurse midwives.

The Government of Benin has approved the 3-year, $42 million U.S. President's Malaria Initiative for Benin, which will complement other donor efforts to combat malaria, notably the World Bank's Booster program, and will have a significant impact on reducing the number of deaths related to malaria in pregnant women and children under 5.

MCH interventions at the Mission level

USAID activities focus on 1) creating a supportive policy environment; 2) increasing access to quality services and products; and 3) increasing demand for health serv-

ices and products. For maternal and child health, services and products to vulnerable populations must be increased in the areas of essential and emergency obstetric care (safe delivery through active management of the third stage of labor (AMTSL) and treatment of postpartum hemorrhage), essential newborn care, integrated management of childhood illnesses (IMCI), immunizations (including polio), surveillance, and prevention and treatment of diarrhea with oral rehydration therapy (ORT) and zinc. In 2007, USAID-supported programs reached 462,000 individuals with integrated family health services. It is expected that 400,851 people will be reached in 2010, mostly pregnant women and children under 5. Child survival interventions, including diarrhea disease prevention through social marketing, ultimately target children under 5 nationwide.

Delivery approaches and mechanisms supporting expanded coverage/use of interventions

U.S. Government assistance supports an integrated family health program that addresses family planning, maternal and child health, infectious diseases, and HIV/AIDS. The USAID/Benin Family Health program (2006–2011) includes two major activities: a 5-year, $15.5 million integrated family health project, Projet Intégré de Santé Familiale (PISAF), implemented in the central region of the country, and a 5-year, $14 million social marketing and HIV/AIDS prevention project implemented nationally.

Specific actions supported as part of the MCH approach

USAID focuses on strengthening the health system's ability to provide evidence-based family health services that meet the needs of communities and families and to help communities become more active participants in their own health and in the health system. The approach relies on a multipronged strategy to strengthen health care service systems by working in partnership with Benin's MOH and collaborating organizations to strengthen effective planning, financial, and human resource management for health zones; strengthen local capacity for decentralized management, community mobilization, and behavioral change communication; expand group insurance programs (Mutuelles de Sante); increase availability of health services and products and establish community-based service provisions; strengthen health worker competencies in critical clinical areas by monitoring performance through facilitative supervision and reviewing outcomes; and implement community mobilization and behavior change communication (BCC) efforts to stimulate demand for health services at the community level through peer education, local radio stations, and other media venues.

The USAID program's geographic focus

The focus of USAID's efforts is the Zou/Collines region in central Benin, with complementary work in Borgou/Alibori in northern Benin and Ouémé/Plateau in the southeast. This represents 6 out of the 12 regions of the country and about 50 percent of the population. USAID works in close collaboration with the MOH to ensure that successful tools and best practices developed and implemented in USAID project areas are adopted nationwide.

The Mission program's relationship to the country's health sector and development plans and strategies

The Benin Government has prioritized improving access and quality in its National Health Development Plan for 2007–2011. Despite the fact that 76 percent of the population lives within 5 kilometers of the nearest basic health facility, only 44 percent use the services. The main constraints to health service use are financial and the poor quality of the services.

To achieve the long-term goal of helping the Government of Benin move toward self-sufficiency and the ability to respond to the health needs of its people, USAID assistance focuses on 1) increasing demand for and access to a minimum package of family health care services designed to protect the health of mothers and children, and 2) improving the MOH's ability to provide quality management and services through the creation of a supportive environment that ensures adequate policies, management and planning systems, trained personnel, and community participation and oversight are in place.

Potential for linking Mission MCH resources with other health sector resources and initiatives

USG investments (e.g., PMI, PEPFAR, Title II, OFDA, water, etc.)

In December 2006, Benin was selected as one of the countries to receive funding during the third year of the President's Malaria Initiative (PMI). Inclusion in PMI allows Benin to accelerate delivery on a national level of a package of proven interventions focusing on prevention and effective treatment. Malaria control activities under PMI are planned at a national scale and target pregnant women and children under 5. The program is

designed to achieve 85 percent coverage of the most vulnerable groups with preventive and therapeutic interventions, and reduce malaria deaths by 50 percent.

Peace Corps also supports maternal and child health activities through health volunteers who collaborate with social service centers sponsored by the Ministry of Social and Family Protection and who provide health education with an emphasis on MCH issues.

Investments and initiatives of other donors and international organizations

USG efforts are coordinated with other national and international partners, including nongovernmental and private sectors, to ensure complementary investments and achievement of MDGs. Health donors coordinate through a working group and a senior donor coordination group to share information and develop common positions.

UNICEF's programs include immunization, training, and equipping health centers. The World Bank, UNFPA, and SIDA support safe labor practices. SIDA and UNICEF provide training in IMCI and emergency obstetric and neonatal care, and the World Bank Booster Project supports malaria interventions for prevention and case management.

Planned results for the Mission's MCH investments over the next 5 years

As Benin is striving to achieve the MDGs, USAID plans to contribute to the Government of Benin's target to reduce U5MR to 70 per 1,000 live births and maternal mortality to 250 per 100,000 live births by 2015. These targets are achievable if the resources currently made available by the donor community (UNICEF, World Bank, Global Fund, PMI, etc.) are used to scale up effective and high-impact interventions. USAID will take the opportunity of leading donors' coordination during the next 12 to 18 months to advocate for policies and better complementarity among donors to favor high-impact and scaled-up MCH interventions.

MCH COUNTRY SUMMARY: BENIN	VALUE
MCH FY08 BUDGET	4,116,000 USD
Country Impact Measures	
Number of births annually*	306,000
Number of under-5 deaths annually	38,000
Neonatal mortality rate (per 1,000 live births)	32
Infant mortality rate (per 1,000 live births)	67
Under-5 mortality rate (per 1,000 live births)	125
Maternal mortality ratio (per 100,000 live births)	397
Percent of children underweight (moderate/severe)	18%
Birth Preparedness and Maternity Services	
Percent of women with at least one antenatal care (ANC) visit	87%
Percent of women with at least four antenatal care (ANC) visits	61%
Percent of women with a skilled attendant at birth	78%
Percent of women receiving postpartum visit within 3 days of birth***	66%
Newborn Care and Treatment	
Percent of newborns whose mothers initiate immediate breastfeeding	54%
Immunization	
Percent of children fully immunized at 1 year of age	40%
Percent of DPT3 coverage	67%
Percent of measles coverage	61%
Maternal and Young Child Nutrition, Including Micronutrients	
Percent of mothers receiving iron-folate	N/A
Percent of children receiving adequate age-appropriate feeding	72%
Percent of children under age 5 receiving vitamin A supplement in the past 6 months	61%
Percent of children under 6 months exclusively breastfed	43%
Treatment of Child Illness	
Percent of children with diarrhea treated with ORT	54%
Percent of children with diarrhea treated with zinc	N/A
Percent of children with pneumonia taken to appropriate care	37%
Water, Sanitation, and Hygiene	
Percent of population with access to improved water source**	65%
Percent of population with access to improved sanitation**	30%

* Census International Database
** Joint Monitoring Programme for Water Supply and Sanitation 2008 Report
*** This number is based on the sum of two numbers: within 5 years preceding the survey, mothers whose last live birth occurred in a health facility and who received a postnatal exam before leaving the health facility (62.8%), and mothers whose last live birth occurred outside a health facility and who received a postnatal exam within 3 days of birth (3.1%).
(Unless otherwise noted, the data source is the 2006 Demographic and Health Survey.)

Democratic Republic of the Congo MCH Program Description

Overall MCH and health sector situation

The Democratic Republic of the Congo (DRC), currently recovering from over a decade of war, has a population of almost 62.6 million with a life expectancy at birth of 45 years. Sixty-eight percent of the population is rural, and a majority of the population live below the poverty level. DRC ranks 168 out of 177 countries on the United Nations Human Development Index. In 2003, the DRC's total health expenditure represented only 4 percent of the gross domestic product (GDP), which is less than the 5 percent spent, on average, by other SSA countries.

While the MCH situation in DRC is among the worst in Africa, some indicators have improved over the last decade. Infant and under-5 mortality rates have decreased from 126 per 1,000 to 92 per 1,000, respectively, and from 216 per 1,000 to 148 per 1,000 live births, respectively. However, newborns contribute to almost half of the total IMR. The TFR has also declined from 7.3 to 6.3. MMR is one of the highest in sub-Saharan Africa, at 1,289 deaths per 100,000 live births. The major causes of high mortality rates include lack of essential newborn care and treatment, vaccine-preventable diseases, malnutrition, malaria, tuberculosis, diarrheal disease, acute respiratory infections, poor health infrastructure and management skills, and lack of access to health services due to poverty and long travel distances. Despite the noted improvements, these indicators highlight a strong need for quality improvement and strengthening of the primary health care system.

There are several signs that improvements are possible in the short and medium term. The DRC has recently completed its first democratic election, and the country benefits from the attention of many donors. In 2005, MOH, in partnership with donors, developed and adopted a new strategy called Stratégie de Reinforcement du Système de Santé (SRSS) – Strengthening Health System Strategy (SHSS) – using the health zone model as the entry point for integrated interventions in the health sector. The Government of DRC has set guidelines for a Minimum Package of Services to help provide a basis for uniformity and guidance of service delivery. The government and donors have agreed to focus programs at the health zone level, enabling more targeted, comprehensive, and coherent health programming.

MCH interventions at the Mission level

USAID's program currently focuses on the following MCH priority areas of intervention: birth preparedness and maternity services; treatment of obstetric complications and disabilities; newborn care and treatment; immunizations, including polio; maternal and young child nutrition, including micronutrients; and treatment of child illness. The total population covered is about 10.5 million in 82 health zones, where about 2.1 million are children under 5 and 2.2 million are women of reproductive age.

Delivery approaches and mechanisms supporting expanded coverage/use of interventions

USAID's program in the public sector focuses specifically on strengthening the local capacity to deliver quality integrated primary health care services and on improving health zone management and referral systems. The health program achieves these objectives through training implementing partners, medical staff, and nurses in the management of primary care; mobilizing communities to promote good health practices and care-seeking

behavior; and ensuring appropriate supervision and monitoring of service delivery.

Specific actions supported as part of the MCH approach

USAID's program focuses on strengthening the country's institutional capacity to finance, coordinate, and oversee decentralized health service delivery, including MCH, making it sustainable over time. USAID's programming also includes a policy analysis and support activity, which will provide technical assistance to MOH to develop and disseminate policies that support MCH activities at provincial and district levels.

The USAID program's geographic focus

The USAID program currently focuses on 82 health zones (out of a total of 515 health zones countrywide) in South Kivu, Katanga, East Kasai, and Western Kasai Provinces, representing a population of about 10.5 million. At the national level, support has been provided for routine immunizations, polio eradication, and measles mortality reduction activities.

The Mission program's relationship to the country's health sector and development plans and strategies

Recently, the Government of DRC developed and adopted the SRSS mentioned above and the Road Map for Maternal Mortality Reduction (2006–2008). Additionally, the government has set guidelines for a Minimum Package of Services for a health zone and a complementary package for the general hospital to help provide a basis for uniformity and guidance of service delivery. USAID supports both of these strategies as well as the government's focus on interventions at the health-zone level, enabling more targeted, comprehensive, and coherent health programming. In order to best complement the Government of the DRC's priorities, especially in MCH, the USAID Mission is currently developing a new health strategy.

Potential for linking Mission MCH resources with other health sector resources and initiatives

USG investments (e.g., PMI, PEPFAR, Title II, OFDA, water, etc.)

While DRC is not a PEPFAR focus country, it is considered an important bilateral program by PEPFAR, and the country has received a significant amount of USG funding to control the spread of the HIV/AIDS epidemic. The MCH program works closely with the HIV/AIDS program, specifically in promoting integrated service delivery by providing PMTCT and safe blood transfusion as a component of the package of services in rural health zones. The U.S. Centers for Disease Control and Prevention provide technical assistance to the Government of DRC to implement a program for the prevention of mother-to-child transmission (PMTCT) of HIV. Although not a PMI focus country, USAID malaria investments are being connected to the distribution of subsidized long-lasting insecticide-treated nets (LLINs) to mothers and children under 5 and are strengthening antenatal care interventions against malaria.

Lastly, the Mission also receives support from the Food for Peace Office for displaced persons in urban and peri-urban areas. This funding will be used to form water committees, increase access to treated municipal water, and introduce rain water harvesting technology. Latrines and drainage systems for schools, health centers, and markets will also be constructed. Improved hygienic practices will be promoted.

Investments and initiatives of other donors and international organizations

The DRC Government works with the U.S. Government and other donors, including UNICEF, WHO, UNFPA, the World Bank, the European Union, the Global Alliance for Vaccines and Immunization, and several NGOs, to implement maternal and child health interventions throughout the country. The World Bank, Canadian Embassy, British Department for International Development, Belgium Cooperation, UNFPA, UNICEF, and the EU are making new investments in the DRC and are adopting the same health zone-based approach. More than 70 percent of health zones receive some donor assistance.

Planned results for the Mission's MCH investments over the next 5 years

Over the next 5 years, the DRC plans to reduce by at least 10 percent the current MMR of 1,289 per 100,000 live births, the IMR of 126 per 1,000 live births, and micronutrient deficiency.

MCH COUNTRY SUMMARY: DEMOCRATIC REPUBLIC OF THE CONGO	VALUE
MCH FY08 BUDGET	12,093,000 USD
Country Impact Measures	
Number of births annually*	2,761,000
Number of under-5 deaths annually	409,000
Neonatal mortality rate (per 1,000 live births)	42
Infant mortality rate (per 1,000 live births)	92
Under-5 mortality rate (per 1,000 live births)	148
Maternal mortality ratio (per 100,000 live births)***	1,289
Percent of children underweight (moderate/severe)	25%
Birth Preparedness and Maternity Services	
Percent of women with at least one antenatal care (ANC) visit	85%
Percent of women with at least four antenatal care (ANC) visits	N/A
Percent of women with a skilled attendant at birth	74%
Percent of women receiving postpartum visit within 3 days of birth	N/A
Newborn Care and Treatment	
Percent of newborns whose mothers initiate immediate breastfeeding	36%
Immunization	
Percent of children fully immunized****	31%
Percent of DPT3 coverage	45%
Percent of measles coverage	63%
Maternal and Young Child Nutrition, Including Micronutrients	
Percent of mothers receiving iron-folate	N/A
Percent of children receiving adequate age-appropriate feeding	82%
Percent of children under age 5 receiving vitamin A supplement in the past 6 months***	12%
Percent of children under 6 months exclusively breastfed	36%
Treatment of Child Illness	
Percent of children with diarrhea treated with ORT	45%
Percent of children with diarrhea treated with zinc	N/A
Percent of children with pneumonia taken to appropriate care	42%
Water, Sanitation, and Hygiene	
Percent of population with access to improved water source**	46%
Percent of population with access to improved sanitation**	31%

* Census International Database
** Joint Monitoring Programme for Water Supply and Sanitation 2008 Report
*** Multiple Indicators Cluster Survey (MICS)
**** Fully immunized at any time before the survey
(Unless otherwise noted, the data source is the preliminary 2007 Demographic and Health Survey.)

Ethiopia MCH Program Description

Overall MCH and health sector situation

Health is a major challenge to Ethiopia's development. Half the population lack access to basic health services; health care delivery systems are weak, and the population is largely rural, spread across large regions that often lack roads. These facts, the country's susceptibility to droughts, epidemics, and regional conflicts, and traditionally low government spending on health especially affect the health of women and children: Ethiopia is one of six countries that account for 50 percent of under-5 child deaths worldwide, with approximately 350,000 Ethiopian children estimated to die each year, mainly from preventable and treatable infectious diseases complicated by malnutrition. Women are exposed to the risks of early and frequent childbearing. With one of the highest fertility rates in the world and only 6 percent of women having a trained health professional attendant at birth, almost 20,000 mothers die each year.

In recent years, however, Ethiopia has begun to move forward in MCH. Increased national investment in basic health services along with government-led close cooperation among donor partners contributed to a 25 percent reduction in U5MR between 2000 and 2005. While maternity services have been slow to expand, USAID-supported family planning programs have demonstrated that fertility rates and birth intervals can be improved at program scale. The government has recognized the need for development of a new level of the health system to rapidly increase access to primary health services. To do this, Ethiopia has trained and deployed more than 24,000 new, primarily female health extension workers, and is planning to train 6,000 more by the end of 2008, for a total of 30,000, with a target of having two such workers and a basic health facility in every community. USAID and all donor partners have aligned behind this strategy and are supporting its implementation. With rapid economic growth, national investments in health services have increased. The government has also made major investments in strengthening its health logistics and management information systems, drawing extensively on U.S. technical assistance. If sustained, this set of major commitments is expected to continue improvements in child survival and begin to improve maternal survival and health, as well.

MCH interventions at the Mission level

USAID's program currently focuses on birth preparedness and maternity services; treatment of obstetric complications and disabilities, including fistula; newborn care and treatment; immunization, including polio; maternal and young child nutrition, especially micronutrient supplementation; treatment of child illnesses; and household water and sanitation and hygiene improvement.

Delivery approaches and mechanisms supporting expanded coverage/use of interventions

USAID's major focus is on supporting the government's national rollout of community-based health services and on supporting these services with strengthened health care delivery at formal first-level facilities. These levels are linked by outreach activities, with Health Extension Workers taking the lead in organizing communities to maximize effectiveness of this outreach to provide such services as vitamin A distribution, immunizations, mosquito net distribution, and antenatal care. USAID developed and evaluated the training of community health volunteers who support and amplify the work of the new, formally trained health extension workers. This approach has now been adopted as part of the national program. Increasing support is also being directed at strengthening larger health centers to increase access to emergency obstetric care.

Specific actions supported as part of the MCH approach

USAID is the principal supporter of a unique health financing unit within the Ethiopian MOH. This capacity has assisted in developing Ethiopia's new health financing reform package, which is beginning to be implemented nationwide. Early experience with this new approach of local retention of health revenue has been demonstrated to increase the availability of funds to support essential basic services, including MCH. USAID has provided technical and financial support to major overhauls of Ethiopia's logistics system, increasing availability of essential MCH drugs and commodities, and to the health management information system, supporting improved availability and quality of services. USAID is a major supporter of training for Health Extension Workers, who will be the principal providers of first-level MCH services, and community health volunteers. Training is also provided for higher-level personnel in areas that include sick child treatment and obstetric health care, and for local and regional health system managers and supervisors. USAID also supports training of health officers under an accelerated program.

The USAID program's geographic focus

The MCH activities in Ethiopia are being supported in selected districts of four of Ethiopia's most populous regions, encompassing more than 30 percent of the population.

The Mission program's relationship to the country's health sector and development plans and strategies

The Health Extension Program and system and improvements that USAID is supporting are being implemented as part of the national Health Sector Development Program (HSDP III). USAID has been a full partner in the development of the HSDP, and, as noted, has entirely aligned its MCH programming with Ethiopia's strategy and annual implementation plans.

Potential for linking Mission MCH resources with other health sector resources and initiatives

USG investments (e.g., PMI, PEPFAR, Title II, OFDA, water, etc.)

As a PEPFAR focus country, Ethiopia receives substantial HIV/AIDS resources. As HIV/AIDS services expand, these resources are contributing to strengthening key elements of service delivery in areas such as connecting PMTCT with antenatal care and delivery. In 2007, Ethiopia became a PMI focus country as well; PMI activities are being carried out in Oromia, one of the four regions where USAID's MCH programs are also operating. In Oromia, PMI and MCH resources will be linked to strengthening antenatal care while providing malaria treatment to pregnant women; supporting outreach activities that deliver insecticide-treated nets (ITNs) along with immunization and other interventions; and providing artemisinin-based combination therapy (ACT) treatment for malaria as part of sick child care at community and facility levels. Title II food programs and OFDA emergency responses incorporate key elements of MCH, such as immunization and micronutrient supplementation, and complement routine MCH programs by supporting nutritional status and livelihoods of vulnerable households, helping to preserve health in times of crisis and food shortage.

Investments and initiatives of other donors and international organizations

As it undertakes accelerated investment in the health of its families, Ethiopia is now receiving substantial support from a large number of major donors and international organizations, including GAVI and the Global Fund. USAID is fully engaged in government-partner coordination activities, including participation in implementation reviews of the HSDP and sitting on the Interagency Coordinating Committee for Immunizations, the Country Coordination Mechanism for the Global Fund, and Ministry-led task forces on child survival and reproductive health, among others. With UNICEF, USAID played a lead role in donor coordination in development of a national child survival strategy.

Planned results for the Mission's MCH investments over the next 5 years

The targets are in line with the Ethiopian Government's Health Sector Development Program III, which aims by the end of the 5-year period to:

- Reduce the IMR to 45/1,000
- Reduce the U5MR to 85/1,000
- Reduce the MMR to 500/100,000
- Increase immunization coverage to more than 85 percent

MCH COUNTRY SUMMARY: ETHIOPIA	VALUE
MCH FY08 BUDGET	13,371,000 USD
Country Impact Measures	
Number of births annually*	2,820,000
Number of under-5 deaths annually	347,000
Neonatal mortality rate (per 1,000 live births)	39
Infant mortality rate (per 1,000 live births)	77
Under-5 mortality rate (per 1,000 live births)	123
Maternal mortality ratio (per 100,000 live births)	673
Percent of children underweight (moderate/severe)	38%
Birth Preparedness and Maternity Services	
Percent of women with at least one antenatal care (ANC) visit	28%
Percent of women with at least four antenatal care (ANC) visits	12%
Percent of women with a skilled attendant at birth	6%
Percent of women receiving postpartum visit within 3 days of birth	5%
Newborn Care and Treatment	
Percent of newborns whose mothers initiate immediate breastfeeding	69%
Immunization	
Percent of children fully immunized at 1 year of age	17%
Percent of DPT3 coverage	32%
Percent of measles coverage	35%
Maternal and Young Child Nutrition, Including Micronutrients	
Percent of mothers receiving iron-folate	10%
Percent of children receiving adequate age-appropriate feeding	54%
Percent of children under age 5 receiving vitamin A supplement in the past 6 months	46%
Percent of children under 6 months exclusively breastfed	49%
Treatment of Child Illness	
Percent of children with diarrhea treated with ORT	32%
Percent of children with diarrhea treated with zinc	0%
Percent of children with pneumonia taken to appropriate care	19%
Water, Sanitation, and Hygiene	
Percent of population with access to improved water source**	42%
Percent of population with access to improved sanitation**	11%

* Census International Database
** Joint Monitoring Programme for Water Supply and Sanitation 2008 Report
(Unless otherwise noted, the data source is 2005 Demographic and Health Survey.)

Ghana MCH Program Description

Overall MCH and health sector situation

Ghana has a population of approximately 23 million, 46 percent of whom are under age 15. In 2005, the total expenditure on health represented 12 percent of the GDP, having steadily risen in the last decade. Ghana's key development trends are generally positive: poverty incidence is 35 percent, down from 52 percent in 1992; life expectancy increased to 57 years; HIV/AIDS adult prevalence remains under 3 percent; and national primary school enrollment level is nearly 80 percent. Yet, the nation still faces major development challenges. Ghana ranked 138 out of 177 countries on the 2005 United Nations Human Development Index.

Despite significant donor resources to the health sector, there has been little improvement in health outcomes in Ghana over the past 10 years. While there was a decline in U5MR in earlier years, from 1998 to 2003, the U5MR increased from 108 to 111 per 1,000, due to an increase in the neonatal mortality rate and a slight increase in the post-neonatal mortality rate. Similarly, the MMR (560 per 100,000 live births) has not declined in the past decade. While the TFR dropped to 4.4 children per woman from 6.9 between 1970 and 1975, women continue to have more children than they desire, primarily due to lack of access to contraceptive services and commodities. Many of these problems are linked at least in part to limited services reaching the community and household level, and to the quality of the MCH services that do reach them.

The Ghana Health Service, with support from UNICEF, Danida, and USAID, is implementing strategy to reduce maternal and child mortality in all 10 regions through high-impact rapid delivery (HIRD) interventions focused on mothers and children. This strategy aims to fill the service delivery gap in Government of Ghana programs at the community level to turn the corner on key MCH indicators, and to move Ghana closer to meeting the MDGs for maternal and child mortality by 2015. Based on a 2006 assessment of USAID priorities in MCH and the partnership effort described above, USAID has honed its strategic focus on MCH to concentrate on reaching the community and household levels through delivery of high-impact prevention and care services for women and children under 5.

MCH interventions at the Mission level

Priority areas of intervention include complementary approaches within communities and among health care workers serving these communities to prevent malnutrition through promotion of complementary feeding and exclusive breastfeeding, and to treat cases of severe acute malnutrition; increase use of focused antenatal care (FANC), including preventive treatment for malaria; increase community awareness about the need for skilled attendance at birth; improve recognition and treatment of obstetric complications; scale up use of AMTSL and prevention of postpartum hemorrhage; improve newborn and neonatal care and treatment; improve hygiene; strengthen delivery of immunization services, including polio; and effectively treat fever and diarrhea in children under 5.

Delivery approaches and mechanisms supporting expanded coverage/use of interventions

Training and supportive supervision of health service providers, including community nurses and volunteers, at the district, subdistrict, and community levels, is offered to increase the quality of priority interventions. Behavioral change messages and interventions are delivered through community networks and groups, such as mother-to-mother support groups, to mothers and caretakers of children

under 5 to increase healthy practices within households. The USAID program works closely with the Ghana Health Services to advance the Community-based Health Planning and Services (CHPS) Initiative, scaling up community-based health service delivery, with emphasis on prevention, delivery of antenatal and essential newborn care, and early recognition of serious illness in children under 5. In more than 100 CHPS zones, USAID-supported MCH efforts are delivered by a trained community nurse covering a subdistrict zone, working in collaboration with community structures, including village health committees and volunteers, and under the leadership of the district health management teams. Increasingly, chemical sellers and other first-line private providers are being targeted for training on effective malaria medications, family planning, use of oral rehydration salts (ORS), and general health promotion messages.

Specific actions supported as part of the MCH approach

While concentrated in under-served communities, USAID's support in MCH also focuses on strengthening health systems and quality of care, including reviewing and developing policies and systems on maternal and child health and technical assistance for BCC. These priority interventions are complemented by malaria, family planning, and water and sanitation interventions.

The USAID program's geographic process

The USAID MCH program focuses geographically in the 30 most underserved districts in the seven southern regions of Ghana (17.5 percent of population), while UNICEF supports similar efforts in the three northern regions and in the central region. The approaches used in these districts are designed and implemented with the full involvement of national and regional policymakers and program managers so that successful models are expanded to other areas.

The Mission program's relationship to the country's health sector and development plans and strategies

All interventions supported by USAID directly support national program guidelines, including the MOH/Ghana Health Services' Five-Year Program of Work 2007–2011, which was developed through extensive dialogue with all health development partners, including USAID. USAID assistance helps shape policies and protocols for key program areas. In 2008, USAID has taken on the development partner lead role for health and HIV/AIDS, a significant responsibility and opportunity to further engage with and shape overall health and development plans in Ghana.

Potential for linking Mission MCH resources with other health sector resources and initiatives

USG investments (e.g., PMI, PEPFAR, Title II, OFDA, water, etc.)

The USAID MCH program is closely linked with the PMI program in Ghana, with its promotion of the use of LLINs and prompt and effective treatment of fever in children under 5 in MCH behavioral change messages targeting communities; its strengthened delivery of FANC to include prevention of malaria in pregnancy; and its effective treatment of malaria with ACTs. The MCH program also leverages P.L. 480 Food for Peace resources in the three northern regions to improve the nutritional status of children, household health, and nutrition behaviors, and increase the use and quality of services provided to women and children. With support from USAID population funding and from PEPFAR, promotion of FP, counseling and testing of pregnant women for HIV, and linkages with PMTCT programs are also integrated into MCH services. Water and sanitation interventions will be scaled up over the coming year in a way that builds on and strengthens the impact of existing interventions in MCH.

Investments and initiatives of other donors and international organizations

Development partners, including DFID, DANIDA, the Netherlands, JICA, and the World Bank, contribute funds for the health sector generally through pooled funding mechanisms. UNICEF supports specific initiatives in child health, including immunizations, safe motherhood, and nutrition programs. UNFPA supports reproductive health programs, including safe motherhood as well as family planning, and WHO provides technical support and advocacy for priority public health programs. Ghana also has large grants from the Global Fund, and the Carter Center is active in Guinea Worm eradication. USAID supports Global Fund and Carter Center activities with targeted technical assistance.

Planned results for the Mission's MCH investments over the next 5 years

Over the next 5 years, USAID's program aims to contribute to a decrease in U5MR of 93/100,000 by increasing access, quality, and use of key services and behaviors. A Demographic and Health Survey in 2008 will assess progress toward this goal.

MCH COUNTRY SUMMARY: GHANA	VALUE
MCH FY08 BUDGET	4,462,000 USD
Country Impact Measures	
Number of births annually*	686,000
Number of under-5 deaths annually	76,000
Neonatal mortality rate (per 1,000 live births)	43
Infant mortality rate (per 1,000 live births)***	71
Under-5 mortality rate (per 1,000 live births)***	111
Maternal mortality ratio (per 100,000 live births)****	560
Percent of children underweight (moderate/severe)***	18%
Birth Preparedness and Maternity Services	
Percent of women with at least one antenatal care (ANC) visit***	95%
Percent of women with at least four antenatal care (ANC) visits	69%
Percent of women with a skilled attendant at birth***	50%
Percent of women receiving postpartum visit within 3 days of birth***	25%
Newborn Care and Treatment	
Percent of newborns whose mothers initiate immediate breastfeeding***	35%
Immunization	
Percent of children fully immunized at 1 year of age***	64%
Percent of DPT3 coverage***	81%
Percent of measles coverage***	78%
Maternal and Young Child Nutrition, Including Micronutrients	
Percent of mothers receiving iron-folate	79%
Percent of children receiving adequate age-appropriate feeding***	52%
Percent of children under age 5 receiving vitamin A supplement in the past 6 months***	60%
Percent of children under 6 months exclusively breastfed***	54%
Treatment of Child Illness	
Percent of children with diarrhea treated with ORT***	37%
Percent of children with diarrhea treated with zinc	N/A
Percent of children with pneumonia taken to appropriate care***	34%
Water, Sanitation, and Hygiene	
Percent of population with access to improved water source***	78%
Percent of population with access to improved sanitation***	61%

* Census International Database
** Joint Monitoring Programme for Water Supply and Sanitation 2008 Report
*** Multiple Indicators Cluster Survey 2006
**** WHO Maternal Mortality Report 2007
(Unless otherwise noted, the data source is the 2003 Demographic and Health Survey.)

Kenya MCH Program Description

Overall MCH and health sector situation

Kenya's health gains of the 1980s and 1990s have begun to reverse, with the country experiencing a general deterioration in health status, with large inequalities existing geographically and by wealth quintiles. The situation has been compounded by the recent postelection violence, which caused the displacement of some 300,000 people, disrupted delivery of basic services in the most affected areas, displaced health workers and closed or rendered partially functional health facilities, and contributed to the pending food crisis.

The health sector has been faced with inadequate funding, weak management systems, and shortages in qualified health staff. The allocation to health remains at about 8 percent, far below the Abuja target of 15 percent. MOH and development partners have begun to respond to the human resource crisis brought about by the freeze on employment in the late 1990s. In 2008, the government launched Vision 2030, a blueprint for development anchored on three pillars: economic, social, and political. The economic pillar aims to improve the prosperity of all Kenyans through a 10 percent economic growth rate by 2012. The National Health Insurance scheme will be implemented and a National Health Care Council created to improve services in the health sector.

In 2007, Kenya recognized the need to scale up investments in child health and maternal health to achieve Kenya's long-term goal, as stated in its National Health Sector Strategic Plan, to reduce U5MR to the MDG target of 33 by 2015 and the MMR to 170 by 2010. From the KDHS 2003, the U5MR was at 115 per 1,000 live births, and the IMR was at 77 per 1,000 live births. UNICEF estimates U5MR to have risen to 121/1,000 in 2006. Kenya has one of the highest numbers of neonatal deaths in the African region, with 43,600 neonatal deaths per year. Other major causes of child deaths include acute respiratory infections (ARI), diarrhea, malaria, and HIV/AIDS. Malnutrition is an underlying factor in about 70 percent of the illnesses that cause death among under-5 children. From the KDHS 2003, 30 percent of children under 5 are stunted, 11 percent are severely stunted. Care-seeking and treatment for major childhood illness remains poor, with only 46 percent of children with reported ARIs having been taken to a health professional, and 51 percent of children with diarrhea receiving ORT. Although malaria is a major cause of morbidity and mortality, the successful increase in ITN coverage (52 percent in 2006) and the use of ACT has reduced child deaths by 44 percent in four sentinel malaria-endemic districts. From 2003 DHS data, immunization coverage stands at 49 percent but is being affected by critical vaccine shortages. HIV/AIDS prevalence has risen to an estimated 7 percent, and there are an estimated 102,000 HIV-positive children in Kenya.

Maternal mortality remains a serious concern, with WHO estimating MMR to have risen to 560 per 100,000 live births in 2005. Studies suggest that the majority of these deaths are due to obstetric complications, including hemorrhage, sepsis, eclampsia, obstructed labor, and unsafe abortion. Only 42 percent of births are attended by a skilled provider (KDHS 2003). Fertility appears to have stalled at an average of 4.9 children per woman. Contraceptive prevalence has also stagnated at 39 percent, although knowledge of FP methods in Kenya is almost universal. The MOH's national reproductive health policy outlines priority actions for the safe motherhood program in Kenya to improve the health of women. They include ensuring access to RH information, skilled care, basic and comprehensive emergency obstetric care, and strengthening the capacity of CORPS (community own resource per-

sons) to support birth preparedness, referrals, postnatal care, and registration of births, among other priorities.

MCH interventions at the Mission level

In 2006, the start of the AIDS Population and Health Integrated Assistance II program (APHIA II) provided the opportunity to focus more resources toward service delivery. This program is composed of seven Cooperative Agreements across the eight provinces of Kenya through which a consortium of partners support integrated HIV/AIDS, FP/RH, and child health services. Utilizing a continuum-of-care strategy, these projects support household, community, and health facility activities aimed at increasing demand, quality, and utilization of services. Interventions will include those addressing the continuum of antenatal and postpartum maternal health, and perinatal, neonatal, and infant child health. Community-level work will include a direct focus on hygiene, sanitation promotion, and water quality interventions, as well as linkages to improvements in drinking water supply and sanitation. In addition, the promotion of exclusive breastfeeding and ORT and the scale-up of immunization services will form a cost-effective approach to preventing diarrhea and other childhood illnesses among children.

Delivery approaches and mechanisms supporting expanded coverage/use of interventions

From home-based care to orphan support, BCC interventions for youth in and out of school, worksite activities, and support for clinical services, the projects are creating networks of health prevention, promotion, care, and treatment. USAID will improve maternal, neonatal, and child health outcomes by supporting the scale-up of high-impact interventions, strengthening health systems, and building human resource capacity. Work will focus on three epidemiologically selected provinces, operating at facility and community levels.

Specific actions supported as part of the MCH approach

Technical Assistance to MOH's Division of Child Health will improve planning, quality of care, supervision, and strategic information systems. USAID will continue to provide technical assistance to the Division of Reproductive Health to improve the management of the FP/RH program, which fundamentally focuses on a Safe Motherhood program. USAID has supported the recruitment of more than 800 nurses and clinical officers to help meet the HR shortage in public-sector health facilities for provision of HIV/AIDS services.

The USAID program's geographic focus

The APHIA II integrated service delivery projects work across the eight provinces of Kenya. With FY08 funding, MCH activities will be supported in three provinces, covering about three districts in each one. This includes a population of about 1 million children.

The Mission program's relationship to the country's health sector and development plans and strategies

USAID's MCH program is consistent with the health priorities and levels of care delivery as laid out in the National Health Sector Strategic Plan (NHSSP-II): 2005–2010.

The USAID/Kenya Population and Health program is defined by complementary target populations in clinical and community settings that lend themselves to HIV/AIDS and MCH/FP/RH integration. Malaria, STI, and HIV prevention and treatment are all targeted at pregnant women. Pregnant and postpartum women who attend family planning, antenatal, and PMTCT clinics will receive counseling on both family planning and HIV prevention. The same applies to clients of VCT services who require information about family planning. Postabortion care, integration of family planning with antenatal and postnatal care, and integration of family planning with HIV and sexually transmitted infection (STI) prevention and treatment are also examples of wraparound of program components. Clients who receive home-based care services for HIV serve as an entry point to the rest of the family and provide an opportunity for information dissemination on malaria, family planning, and maternal and child health. Along with the components of the basic care package utilized by caregivers in their home-based care sites are ITNs to guard against malaria. Policy development, community mobilization, behavior change, training, service delivery, quality improvement, personnel management, drugs and commodity availability, research, and monitoring and evaluation are program elements targeted to both maternal health and nutrition, as well as HIV and AIDS projects.

The PMI program that started this year will help to accelerate child survival strategies through its support to case management, prevention, and control of malaria across the country. It includes provision of ACT for clinical care, LLINs targeting children under 5 and pregnant mothers, support for malaria in pregnancy initiatives, and indoor residual spraying (IRS) in both endemic and epidemic districts.

Planned results for the Mission's MCH investments over the next 5 years

Over the 2008–2012 period, USAID will contribute to reducing U5MR by 25 percent, reducing MMR by 25 percent, and improving the enabling environment for provision of public health services nationally.

MCH COUNTRY SUMMARY: KENYA	VALUE
MCH FY08 BUDGET	3,470,000 USD
Country Impact Measures	
Number of births annually*	1,331,000
Number of under-5 deaths annually	153,000
Neonatal mortality rate (per 1,000 live births)	33
Infant mortality rate (per 1,000 live births)	77
Under-5 mortality rate (per 1,000 live births)	115
Maternal mortality ratio (per 100,000 live births)*****	560
Percent of children underweight (moderate/severe)	20%
Birth Preparedness and Maternity Services	
Percent of women with at least one antenatal care (ANC) visit	88%
Percent of women with at least four antenatal care (ANC) visits	51%
Percent of women with a skilled attendant at birth	42%
Percent of women receiving postpartum visit within 3 days of birth***	10%
Newborn Care and Treatment	
Percent of newborns whose mothers initiate immediate breastfeeding	52%
Immunization	
Percent of children fully immunized at 1 year of age	49%
Percent of DPT3 coverage	71%
Percent of measles coverage	73%
Maternal and Young Child Nutrition, Including Micronutrients	
Percent of mothers receiving iron-folate****	2%
Percent of children receiving adequate age-appropriate feeding	84%
Percent of children under age 5 receiving vitamin A supplement in the past 6 months	33%
Percent of children under 6 months exclusively breastfed	13%
Treatment of Child Illness	
Percent of children with diarrhea treated with ORT	51%
Percent of children with diarrhea treated with zinc	N/A
Percent of children with pneumonia taken to appropriate care	46%
Water, Sanitation, and Hygiene	
Percent of population with access to improved water source**	57%
Percent of population with access to improved sanitation**	42%

* Census International Database ** Joint Monitoring Programme for Water Supply and Sanitation 2008 Report *** This number is based only on mothers whose last live birth occurred outside a health facility in the 5 years preceding the survey. This figure represents the percent of women receiving postpartum visit within 2 days of delivery.
**** The percent of women who took iron tablets or syrup 60-90 days in pregnancy ***** WHO Maternal Mortality Report 2007
(Unless otherwise noted, the data source is the 2003 Demographic and Health Survey.)

Liberia MCH Program Description

Overall MCH and health sector situation

Fourteen years of conflict have decimated the health infrastructure and health workforce in Liberia. The destruction of most classrooms and student dormitories and disruption of normal school and university schedules resulted in the downsizing of capacity and delays in educating the health workforce. Similarly, the destruction of buildings and operations during the long conflict resulted in a much-diminished Government of Liberia capacity to provide needed health services. The Sirleaf Administration, democratically elected in 2005, has made firm commitments to provide equitable and effective health care services as it rebuilds the country. The Liberian Government approved a National Health Plan (NHP) that commits the Ministy of Health and Social Welfare (MOHSW) to lead and manage health resources in support of a basic package of health services (BPHS), including reproductive health/family planning, HIV/AIDS, MCH, and the prevention and control of infectious diseases, such as malaria, polio, and tuberculosis. The government estimates that some 390 health facilities (18 hospitals, 55 centers, and 310 clinics) are presently functioning, while another 130 are no longer operational. Survey estimates suggest that only 41 percent of the population has access to health services, 24 percent have access to safe water, and 26 percent have access to sanitation.

From the Liberia Demographic and Health Survey (LDHS) 2007 Preliminary Report, MMR is one of the highest globally at 994 per 100,000 live births. SBA rates are inadequate, with only 46 percent of women delivering with a skilled birth attendant. Referral services are difficult to access by the majority of pregnant women due to long distances, lack of transportation, poor roads and nonavailability of skilled health professionals to deliver care. Neonatal mortality has declined from 44 per 1,000 in 1986, to 32 per 1,000 live births in 2007; major causes of newborn deaths include preterm delivery (27 percent), infections (25 percent), asphyxia (19 percent), and tetanus (14 percent). Liberia has seen significant declines in child mortality since 2000, although levels remain high: IMR has declined from 117 to 72 deaths per 1,000 live births (LDHS 2007); U5MR has declined from 194 to 111 per 1,000 live births. Malaria, ARI, and diarrhea account for most of the under-5 mortality and morbidity. LDHS 2007 data show that 70 percent of children with ARI received treatment from a health provider, and 53 percent of children with diarrhea were treated with ORS. Thirty-nine percent of Liberian children aged 12 to 23 months are fully immunized, with 12 percent never having been immunized. Thirty-nine percent of children are stunted, and 20 percent are severely stunted.

The environment for assisting the Liberian health sector is in a period of transition, moving from a relief format to one of development assistance. Some 75 percent of the health care delivery system depends upon international NGOs that support staff and operations at mostly government-owned facilities throughout the country as part of an emergency humanitarian assistance effort. As a result, the MOHSW must still rely on NGOs that have been directly operating or assisting health service delivery to substantial numbers of the Liberian population. Currently, there are no alternative means for effective service delivery for those portions of the population receiving health care from NGOs. Consequently, the assistance planned for the health sector combines support for short-term improvements to health services through existing delivery channels and includes efforts designed to build longer-term capacities in the sector.

MCH interventions at the Mission level

Under the National Health Policy and Plan, the Liberian government has reaffirmed its commitment to working toward the achievement of the MDGs, with a particular focus on activities that will contribute to overall improvements in maternal and child survival. The MOHSW has the mandate to provide and make available affordable, accessible, reliable, and comprehensive health care in an equitable manner. MOHSW has identified primary health care as the foundation of the health system, a model for improving health care delivery, and the BPHS as the cornerstone of the national health care delivery strategy. In support of these efforts, USAID will expand programs to deliver key maternal, newborn, and child health services at all levels of the health care delivery system in selected counties of Liberia. These interventions will include increasing antenatal care (ANC) visits to 22,000; delivery by a skilled attendant and postpartum care, including IPTp and treatment of acute malarial infections targeting 115 health facilities; emergency obstetric and neonatal care services in seven facilities; AMTSL in 105 facilities; essential newborn care; community-based delivery and BCC components; improved management of childhood illness, including zinc for treatment of diarrhea and training of community health workers; and trained birth attendants (TBAs) in the community/household management of simple, uncomplicated childhood fevers, diarrhea, and ARI.

Delivery approaches and mechanisms supporting expanded coverage/use of interventions

The overall objective of all components of USAID's assistance is to increase access to basic health services. The range of components and interventions envisioned were selected to address some of the most pressing health needs in the country and, as a result of their high potential, to realize measurable change within a 5-year period. In order to increase access to basic health services, the USG will support at least 105 primary health care health facilities and seven emergency obstetric care centers, targeting more than 1 million people in various geographic locations in Liberia. A social marketing, HIV/AIDS, and family planning program targeting out-of-school youths will be supported with Population Services International as the implementer.

Specific actions supported as part of the MCH approach

The overall objective of USAID assistance in building health systems in Liberia is to increase capacity in health financing, health policy and governance, human resources, and health information. More specifically, the anticipated outcomes from this assistance are 1) an established system of national health accounts; 2) a functioning process for exploring private sector partnerships to attract private funding and reduce the population requiring direct public health services; 3) an increase in the number of trained health economists and health planners; and 4) strengthened health financing and governance policies and policy development processes.

The USAID program's geographic focus

The USAID program will support primary health care clinics and emergency obstretic care services in six counties, and outreach immunization services in all 15 counties, and the trained nurses, midwives, and physician assistants will come from all parts of the country.

The Mission program's relationship to the country's health sector and development plans and strategies

The National Health Plan and the national health policies of the Liberian Government are considered the fundamental blueprint for design and implementation of all USAID assistance, and the programs currently under development by USAID will be consistent with and fully supportive of the national approach to health delineated by MOHSW.

Potential for linking Mission MCH resources with other health sector resources and initiatives

The USG collaborates with the Liberian Government and UN agencies, UNFPA, UNICEF, WHO, and national and international NGOs to address key health issues (e.g., maternal, infant, and under-5 mortality reduction strategies). The USG leverages its resources with those of the Global Fund to Fight AIDS, Tuberculosis and Malaria, as well as GAVI, in addressing MCH challenges. Malaria is the leading cause of morbidity and mortality in Liberia. The entire population of approximately 3.6 million people is at risk of malaria, including the estimated 565,000 children under 5 and 188,500 pregnant women. To address this problem, PMI is working with the government to support key activities in the following areas: malaria in pregnancy, procurement and distribution of ITNs, IRS, and malaria case management, including the purchase of ACTs and drugs for severe malaria.

Planned results for the Mission's MCH investments over the next 5 years

The USG will work with the Liberian Government and other development partners in lowering the MMR of 994/100,000 by 25 percent, increasing the rate of delivery by a skilled birth attendant from 49 to 60 percent, increasing overall childhood vaccination coverage to 75 percent, and providing in-service training related to the BPHS and include quality assurance, counseling techniques and patient communication for behavior change, for more than 300 nurses, midwives, and physician assistants in preservice institutions as a means of improving the quality and impact of health care. In addition, regional (30 over 2 years) and some 30 annual in-country scholarships will help in addressing the number of qualified health care workers Liberia needs to meet national goals for service delivery.

With humanitarian relief for health care services tapering down in 2008, the Government of Liberia and its development partners urgently need to ensure a responsive government role in planning, management, and delivery of services. USG FY08 funds will support capacity-building of health program management at all levels and delivery of a BPHS, including family planning, reproductive health, maternal and child health, HIV/AIDS, and malaria. In the coming 1 to 3 years, the primary objective is to roll out effective basic services that will reduce the spread of HIV; maternal mortality and morbidity; and deaths and disability days due to malaria. In FY08, solid increases in malaria, family planning, and MCH funds are essential for moving into transition and in meeting the challenges of poor health and a battered infrastructure. In partnership with the Liberian Government, USAID will make excellent use of these funds to roll out basic services to 70 percent of the population by the end of 2010. The long-term goal is to build the Liberian Government's ability to manage public resources and partner effectively with the private voluntary and commercial sector in stewarding health care for all.

MCH COUNTRY SUMMARY: LIBERIA	VALUE
MCH FY08 BUDGET	5,158,000 USD
Country Impact Measures	
Number of births annually*	140,000
Number of under-5 deaths annually	16,000
Neonatal mortality rate (per 1,000 live births)	32
Infant mortality rate (per 1,000 live births)	72
Under-5 mortality rate (per 1,000 live births)	111
Maternal mortality ratio (per 100,000 live births)	994
Percent of children underweight (moderate/severe)	19%
Birth Preparedness and Maternity Services	
Percent of women with at least one antenatal care (ANC) visit	79%
Percent of women with at least four antenatal care (ANC) visits	N/A
Percent of women with a skilled attendant at birth	46%
Percent of women receiving postpartum visit within 3 days of birth	N/A
Newborn Care and Treatment	
Percent of newborns whose mothers initiate immediate breastfeeding	N/A
Immunization	
Percent of children fully immunized****	39%
Percent of DPT3 coverage	50%
Percent of measles coverage	63%
Maternal and Young Child Nutrition, Including Micronutrients	
Percent of mothers receiving iron-folate	N/A
Percent of children receiving adequate age-appropriate feeding	62%
Percent of children under age 5 receiving vitamin A supplement in the past 6 months***	79%
Percent of children under 6 months exclusively breastfed	29%
Treatment of Child Illness	
Percent of children with diarrhea treated with ORT	58%
Percent of children with diarrhea treated with zinc	N/A
Percent of children with pneumonia taken to appropriate care	70%
Water, Sanitation, and Hygiene	
Percent of population with access to improved water source**	64%
Percent of population with access to improved sanitation**	32%

* Census International Database
** Joint Monitoring Programme for Water Supply and Sanitation 2008 Report
*** State of the World's Children Report 2008
**** Fully immunized at any time before the survey
(Unless otherwise noted, the data source is the 2007 Preliminary Demographic and Health Survey.)

Madagascar MCH Program Description

Overall MCH and health sector situation

Madagascar, an island nation with a population of approximately 20 million people, is a country with enormous potential and major development challenges. Rich forests, arable land, untapped mineral resources, abundant sea life, a democratically elected government, and an industrious workforce are important elements for progress. However, poverty, corruption, weak social, educational, and health systems, illiteracy, low productive investments, harmful natural resource practices and exploitation, and a meager economic infrastructure hamper progress. Life expectancy is 55 years; approximately 30 percent of the population is illiterate; and the per capita income of approximately $280 per annum is one of the lowest in the world. Sixty-one percent of the population lives on less than $1 per day. Madagascar's unique biodiversity is threatened by pressure for agricultural land expansion, partially due to a 2.8 percent annual population growth rate; about 44 percent of the population is under the age of 15.

Within this development context, Madagascar continues to face major health challenges that threaten social and economic development. Health service quality is substantially below standards, and basic medicines and supplies are regularly in short supply. Public and nongovernmental sector capacity to plan effectively and manage health programs is weak, particularly in the areas of financial and administrative management, and the use of data for new activity planning. National health infrastructure, information and logistics systems are extremely weak, and much remains to be done at central and provincial levels to ensure sustainable health financing. Some of the major MCH problems are high U5MR (94 per 1,000), high MMR (469 per 100,000), low contraceptive prevalence rate (24 percent), low percentage of fully vaccinated children (47 percent), chronic malnutrition (42 percent), and limited access to potable water and sanitation (31 percent).

Nevertheless, because of the strong commitment of the Government of Madagascar, favorable policy indices, and the work of USAID and other development partners, key indicators have begun to improve with concerted, strategically planned assistance. Most significantly, there has been a dramatic national-level decline in child mortality, from 164/1,000 in 1997 to 94/1,000 in 2004.

MCH interventions at the Mission level

Diarrheal diseases remain the primary causes of mortality and morbidity among children under 5, but acute respiratory infections, malaria, and poor newborn health are also critical contributors. By addressing infectious diseases, malnutrition, prenatal and delivery care, IMCI, and hygiene and sanitation practices, USAID contributes to improvements in maternal and child health, which ultimately improve human capacity for a productive life, sustainable livelihoods, and economic growth.

Key subelements are birth preparedness and maternity services; newborn care and treatment; immunization, including polio eradication; maternal and young child nutrition, including micronutrients; treatment of child illness; household water sanitation hygiene; and the environment. The planned 5-year results are to continue to lower Madagascar's maternal, child, and infant mortality rates, in line with the Madagascar Action Plan. Recognizing that little attention has focused on activities to promote newborn health, USAID began to support the development of activities promoting optimum care of the newborn with FY07 funds.

Delivery approaches and mechanisms supporting expanded coverage/use of interventions

USAID/Madagascar's health, population, and nutrition program addresses priority maternal and child health problems through integrated programs using state-of-the-art approaches, such as mobilizing communities to action, private-public partnerships, BCC, and social marketing. The overarching focus is on increasing demand for, and availability of, quality health services on Madagascar. The Champion Commune approach, which is tied to governmental budgeting at the decentralized level, is a key component of USAID support for community-based programming on Madagascar.

Specific actions supported as part of the MCH approach

USAID provides expertise in MCH planning, service delivery, and monitoring at all levels of the health system. USAID supports a decentralized health system to promote people-level impact through active engagement of the private sector, community, and civil society. At the national level, support will reach the entire Malagasy population through policy dialogue, institutional capacity development, mass education and communication, and strengthening commodity and health information systems. At the local level, state-of-the-art approaches will mobilize communities to action, engage the private sector, and promote positive behavior change.

The USAID program's geographic focus

USAID/Madagascar's work at the regional, district, and community levels focuses on geographic zones that were selected according to four criteria: building upon existing USAID program activities; population density; availability of some level of public sector health facilities and services; and potential links to other USAID programs, particularly environmental and economic growth. The current intervention zones cover 14 of the 22 regions and approximately two-thirds of the population. Support at the national level for activities such as policy-making, training, BCC, and health systems strengthening has an impact on the whole country.

The Mission program's relationship to the country's health sector and development plans and strategies

Madagascar's efforts to provide health for the poor focus on increasing the availability of quality services and ensuring their financial accessibility. Health is a key goal of the Madagascar Action Plan (MAP) 2007–2012. MAP sets very ambitious targets for reductions in maternal and child mortality, fertility, malaria, tuberculosis, STIs, and HIV/AIDS control, and malnutrition in children under 5. These include the following expectations between 2004–2005 and 2012: average life expectancy increases from 55 to 65 years; the IMR is reduced from 94/1,000 to 47/1,000 and the neonatal mortality rate from 32/1,000 to 17/1,000; percentage of children receiving supplementary micronutrients increases from 80 to 100 percent; the percentage of 1-year-olds immunized against measles increases from 84 to 100 percent; the MMR is reduced from 469/100,000 to 273/100,000; the contraceptive prevalence rate is increased from 18 to 30 percent; and HIV prevalence among pregnant women is reduced from 0.95 percent to 0.8 percent. The Ministry of Health, Family Planning and Social Protection (MOHFPSP) and other Government of Madagascar partners in the health and water sectors are focused on priority programs and activities designed to achieve these goals. The USG is committed to assisting the Government of Madagascar in working toward MAP goals. USG assistance to Madagascar directly supports the Mission Strategic Plan goal to expand and improve health care services.

Potential for linking Mission MCH resources with other health sector resources and initiatives

USG investments (e.g., PMI, PEPFAR, Title II, OFDA, water, etc.)

PMI supports the National Malaria Control strategy and will contribute to the Malagasy Government's objective to halve malaria mortality by 2012, which will also have a consequent large impact on U5MR. In addition, USAID, UNICEF, and MOHFPSP are working closely together to support household diarrhea and pneumonia treatment.

Improving water supply, sanitation, and hygiene is a national priority for Madagascar. With FY08 funds, USAID will scale up activities in hygiene and sanitation to complement water supply activities being planned with the new FY08 DA funds for water. These activities are being jointly planned with the Environment and Rural Development program, and will be jointly managed.

USAID's Title II grantees have a strong focus on maternal and child health, and work closely with the Health Office's community and national programs.

Investments and initiatives of other donors and international organizations

The USG's health programs reinforce key partnerships to improve cooperation, leverage funding, and assure better alignment of activities. The USG is the single largest bilateral donor in the health sector. Other key players include the World Bank, UNICEF, the World Health Organization, the Global Fund, French Cooperation, and the Japan International Cooperative Agency.

The USG's commitment to partnership has paid off through substantial leveraging of funds to support key MOHFPSP programs. In child health, the combined efforts of UNICEF and USAID helped the MOHFPSP develop and implement a child health policy. WHO, World Bank, and UNICEF are key partners for immunizations. USAID, WHO, and the World Bank collaborated to support the national health policy and the national nutrition action plan. USAID also collaborates with the World Food Program and UNICEF in nutrition.

Planned results for the Mission's MCH investments over the next 5 years

Over the next 5 years, USAID's program aims to contribute to the goal of decreasing U5MR to 47 per 1,000 by 2012, as stated in the MAP indicators. USAID also aims to contribute to reducing maternal and infant mortality.

MCH COUNTRY SUMMARY: MADAGASCAR	VALUE
MCH FY08 BUDGET	6,695,000 USD
Country Impact Measures	
Number of births annually*	698,000
Number of under-5 deaths annually	66,000
Neonatal mortality rate (per 1,000 live births)	32
Infant mortality rate (per 1,000 live births)	58
Under-5 mortality rate (per 1,000 live births)	94
Maternal mortality ratio (per 100,000 live births)	469
Percent of dhildren underweight (moderate/severe)	42%
Birth Preparedness and Maternity Services	
Percent of women with at least one antenatal care (ANC) visit	80%
Percent of women with at least four antenatal care (ANC) visits	38%
Percent of women with a skilled attendant at birth	51%
Percent of women receiving postpartum visit within 3 days of birth***	32%
Newborn Care and Treatment	
Percent of newborns whose mothers initiate immediate breastfeeding	62%
Immunization	
Percent of children fully immunized at 1 year of age	47%
Percent of DPT3 coverage	61%
Percent of measles coverage	59%
Maternal and Young Child Nutrition, Including Micronutrients	
Percent of mothers receiving iron-folate	32%
Percent of children receiving adequate age-appropriate feeding	78%
Percent of children under age 5 receiving vitamin A supplement in the past 6 months	76%
Percent of children under 6 months exclusively breastfed	67%
Treatment of Child Illness	
Percent of children with diarrhea treated with ORT	58%
Percent of children with diarrhea treated with zinc	N/A
Percent of children with pneumonia taken to appropriate care	39%
Water, Sanitation, and Hygiene	
Percent of population with access to improved water source**	47%
Percent of population with access to improved sanitation**	12%

* Census International Database
** Joint Monitoring Programme for Water Supply and Sanitation 2008 Report
*** This number is based only on mothers whose last live birth occurred outside a health facility in the 5 years preceding the survey.
(Unless otherwise noted, the data source is the 2003-04 Demographic and Health Survey.)

Malawi MCH Program Description

Overall MCH and health sector situation

Despite sustained efforts to improve the quality of life for its people, Malawi, with a population of approximately 13 million people, remains one of the poorest countries on earth, with a GDP per capita of $600. Malawi's poverty is starkly represented in its demographic and health indicators – an average life expectancy of 37 years, a literacy rate of 63 percent, and 55 percent of the population living on less than $1 per day. Food insecurity is widespread and chronic.

Malawi's major health challenges are high HIV/AIDS prevalence (12 percent), high MMR (984/100,000), coupled with high fertility (6), and high infant and child mortality rates (76/1,000 and 133/1,000, respectively). Lack of knowledge about healthy behaviors, chronic malnutrition, and communicable disease outbreaks, as well as disparities in access to quality health services exacerbate the situation. Analyses of maternal deaths in Africa indicate that hemorrhage and infections remain the major causes of maternal mortality. Although neonatal mortality has declined sharply from 49 to 27 per 1,000 live births since 2000, it accounts for one-third of infant deaths and 20 percent of deaths among children under 5. Care-seeking for treatment of major childhood illnesses such as pneumonia and diarrhea remains poor. While diarrhea incidence has declined, ORS use remains at 61 percent and ORT at 71 percent. Full immunization coverage of children age 12 to 23 months has declined to 64 percent from previous levels in 1992 and 2000 (82 and 70 percent, respectively). Rates of malnutrition remain relatively unchanged from 1992 and 2000 levels, with 48 percent of children under 5 stunted, and of these, 22 percent are severely stunted. Malaria is a major public health problem, especially among pregnant women and children under 5, with malaria accounting for more than 40 percent of all outpatient visits. Notwithstanding the above, Malawi has achieved extraordinary reductions in child and infant mortality over the last decade, and is one of the few African nations on track to meet MDG4.

Despite significant donor resources to the health sector, Malawi's health system remains weak and is confronted by critical shortages in human resources, frequent stock outs of essential drugs, weak HMIS and health management capacity – all within a context of decentralization that is occurring as an "event rather than a process." The single biggest constraint on service delivery is the severe shortage of health manpower. From the 2006 Sector Wide Approach (SWAp) Annual Review, on average, vacancy rates for nurses and medical doctors stood at 61 percent and 62 percent, respectively, in the public health sector. The health system in Malawi has undergone two major changes in the last few years. The MOH and the donor community have implemented a SWAp, which focuses on improving the delivery of the essential health package. Further, the MOH has devolved the delivery of health services to the district level whereby district assemblies, in conjunction with the district health management team, have authority over their capital cost and recurrent cost budgets and are able to set their own priorities within the essential health package.

MCH interventions at the Mission level

USAID/Malawi's maternal and child health portfolio for the next 5 years will 1) respond to the roadmap for accelerating the reduction of maternal and neonatal mortality and morbidity in Malawi, by supporting a few high-impact, evidence-based interventions that address the highest causes of maternal and neonatal death, such as emergency obstetrics, treatment of postpartum hemorrhage, and essential newborn care; 2) improve the

effectiveness, quality, and accessibility of child health services through the development and implementation of high-impact interventions that prevent and reduce illness, mortality, and malnutrition among children under the age of 5 (including IMCI and community-based treatment); 3) promote general child nutrition at community level to advance and increase coverage of nutrition interventions such as essential nutrition actions, with a focus on infant and young child feeding and community-based therapeutic care; 4) promote routine immunization for vaccine-preventable childhood diseases and polio eradication efforts, focusing on service delivery, improved planning, vaccine forecasting, and monitoring and evaluation; and 5) promote consistent and appropriate use of point-of-use (POU) water treatment products by primary caregivers to reduce diarrheal disease mortality and morbidity of children under 5.

Delivery approaches and mechanisms supporting expanded coverage/use of interventions

USAID/Malawi's MCH program works both at national and district levels to expand service coverage and utilization. USAID child health programs will focus on 8 of the 28 districts in Malawi to improve the effectiveness and accessibility of child health and nutrition services through community-based approaches with a focus on training village clinics and community health volunteers to deliver a package of high-impact child health/nutrition interventions (preventive and selected treatment); strengthening zonal and district support systems (especially supportive supervision) for the prevention and management of childhood diarrhea, pneumonia, malaria, and malnutrition; and reinforcing behavior change through multiple communication modes: media/radio, interpersonal, civil leaders, and health workers.

For maternal and neonatal health, the USAID program works closely with the MOH on implementation of integrated community and facility-based essential maternal and newborn care interventions focusing on antenatal care, basic emergency obstetric and newborn care, and postpartum care in three focus districts. USAID is also working at national level to scale up performance and quality improvement in reproductive health, work with providers at hospitals and health centers to prevent malaria in pregnancy, improve national capacity to train skilled providers in basic emergency obstetric and neonatal care, as well as train and supervise service providers at district level. The program also focuses on strengthening preservice training on basic emergency obstetric care for all registered nurse midwives, nurse midwife technicians, and medical assistants, and supports provision of essential newborn care as well as kangaroo mother care for low birthweight babies.

USAID's MCH program also supports the Small Project Assistance Program through the U.S. Peace Corps, in collaboration with host country and community counterparts and NGOs, to support sustainable, grassroots community development through community grants, capacity building and other forms of collaboration. Activities supported under this program include the rehabilitation of under-5 and maternity clinics; MCH and nutrition training programs for mothers; rehabilitation of guardian shelters; and construction of safe drinking water sources, and hygiene education programs.

New areas of support will include micronutrient activities such as strengthening monitoring and use of iodized salt at the ports of entry into Malawi, in retail shops, local markets, and at community and household levels to ensure that Malawi can reach the long-term goal of elimination of iodine deficiency disorders within the next 3 years; and promoting management of acute malnutrition through scaling up of CTC to new districts. Additional activities include support to routine immunization, focusing on service delivery, planning, vaccine forecasting, and monitoring and evaluation.

Specific actions supported as part of the MCH approach

Broad-based health system strengthening and human resource issues are a major focus of donor support through the SWAp, GAVI HSS, and Global Fund grants. USAID program assistance, in addition to MCH areas cited above, will also focus on drugs and medical supply chain management, quality assurance and supervision, improved HMIS, and strengthened zonal and district support systems.

The USAID program's geographic focus

The USAID MCH program focuses geographically on 13 high-need districts that cover approximately one-third of the population.

The Mission program's relationship to the country's health sector and development plans and strategies

The goal of the USAID/Malawi integrated health, population, and nutrition program to help achieve healthier Malawian families is in line with identified priorities of

the Government of Malawi stated in the Joint Program of Work for the Health Sector Wide Approach 2004–2010 and the Malawi Growth and Development Strategy.

Potential for linking Mission MCH resources with other health sector resources and initiatives

USG support for HIV/AIDS interventions in Malawi will continue to be in the areas of prevention, care, treatment, and cross-cutting issues. Currently, USAID is working to expand the reach of service delivery, emphasizing referral systems that link communities, families, and mothers and infants to PMTCT and other HIV/AIDS services. USAID and its partners are currently working to strengthen the integration of child health and nutrition services, pediatric HIV care and PMTCT, as well as HIV/AIDS and family planning.

In support of Malawi's national malaria control program, PMI supports the four key intervention strategies to prevent and treat malaria: IRS, ITNs, use of Coartem as the first-line drug for malaria, and IPTp. Linkages with MCH programs will be achieved through common implementing partners and use of integrated service delivery platforms at both facility (ANC, IMCI) and community (community-based treatment and ITN distribution) levels. As a PMI country, USAID/Malawi, in collaboration with the Government of Malawi, has developed a 3-year strategy outlining the approaches and principles that will be used to reduce current malaria-related mortality by 50 percent.

Planned results for the Mission's MCH investments over the next 5 years

In the next 5 years, USAID/Malawi maternal and child health portfolio activities will contribute to the Malawi Government Accelerated Child Development efforts to increase coverage of selected high-impact maternal, newborn, and child health and nutrition interventions to at least 80 percent by 2011, in order to reduce child death by two-thirds by 2015. Activities will also support the Malawi Government's MOH roadmap for accelerating reduction in maternal and neonatal morbidity and mortality toward the achievements of the MDGs by lowering MMR from 984/100,000 live births by 25 percent, increasing the rate of delivery by a skilled birth attendant from 49 to 60 percent, increasing overall childhood vaccination coverage to 75 percent, and providing in-service training related to the BPHS and including quality assurance, counseling techniques, and patient communication for behavior change, for more than 300 nurses, midwives, and physician assistants in preservice institutions as a means of improving the quality and impact of health care.

MCH COUNTRY SUMMARY: MALAWI	VALUE
MCH FY08 BUDGET	4,955,000 USD
Country Impact Measures	
Number of births annually*	546,000
Number of under-5 deaths annually	73,000
Neonatal mortality rate (per 1,000 live births)	27
Infant mortality rate (per 1,000 live births)	76
Under-5 mortality rate (per 1,000 live births)	133
Maternal mortality ratio (per 100,000 live births)	984
Percent of children underweight (moderate/severe)	23%
Birth Preparedness and Maternity Services	
Percent of women with at least one antenatal care (ANC) visit	95%
Percent of women with at least four antenatal care (ANC) visits	56%
Percent of women with a skilled attendant at birth	57%
Percent of women receiving postpartum visit within 3 days of birth	21%
Newborn Care and Treatment	
Percent of newborns whose mothers initiate immediate breastfeeding	70%
Immunization	
Percent of children fully immunized at 1 year of age	51%
Percent of DPT3 coverage	82%
Percent of measles coverage	79%
Maternal and Young Child Nutrition, Including Micronutrients	
Percent of mothers receiving iron-folate	N/A
Percent of children receiving adequate age-appropriate feeding	78%
Percent of children under age 5 receiving vitamin A supplement in the past 6 months	65%
Percent of children under 6 months exclusively breastfed	53%
Treatment of Child Illness	
Percent of children with diarrhea treated with ORT	71%
Percent of children with diarrhea treated with zinc	N/A
Percent of children with pneumonia taken to appropriate care	20%
Water, Sanitation, and Hygiene	
Percent of population with access to improved water source**	76%
Percent of population with access to improved sanitation**	60%

* Census International Database
** Joint Monitoring Programme for Water Supply and Sanitation 2008 Report
(Unless otherwise noted, the data source is the 2004 Demographic and Health Survey.)

Mali MCH Program Description

Overall MCH and health sector situation

Mali has one of the greatest health challenges of any country in the world, with a MMR of 464 per 100,000 live births, a child mortality rate of 191 per 1,000 live births, and a TFR of 6.6. Although the trend is positive with respect to these and other MCH indicators, the context is still among the most challenging in the world. USAID/Mali's strategic approach is to "significantly decrease the morbidity and mortality of children under 5 and women of reproductive age through the use of proven best practices and high-impact services." Since 2003, USAID's approach has focused on the provision of high-quality High Impact Health Services (HIHS) implemented through a combination of 1) linking communities and health services that are supported by evidence-based national policies; 2) delivering culturally and gender-sensitive community-based interventions; and 3) promoting key household-level health behaviors and practices.

MCH interventions at the Mission level

The following six technical areas comprise the high-impact health services:

- **Malaria prevention and control:** distribution of ITNs; provision of IPTp; provider training and policy development for the transition from chloroquine to ACTs; provision of technical assistance to the national malaria control program, including improved management of Global Fund funding for malaria. In December 2006, Mali was one of the eight new countries selected to become a PMI focus country, and thus, starting with FY08, USAID will increase the level of interventions in the four PMI program priority areas primarily targeting pregnant women and children under 5: 1) ACT for effective case management; 2) sulfadoxine-pyrimethamine for IPTp; 3) IRS; and 4) LLINs.

- **Diarrheal disease prevention and control:** technical assistance to the national diarrheal disease control program in policy development and strategic planning; community-based hygiene interventions; social marketing of ORS as part of overall oral rehydration therapy ORT; and mass media promotion of good hygiene and sanitation practices.

- **HIV/AIDS prevention and control:** training and materials development for voluntary counseling and testing; technical assistance to the National AIDS Control Program in sentinel and high-risk surveillance systems; support to community-based local NGOs in HIV prevention education for most-at-risk groups and counseling; capacity building of the Executive Secretariat for the High Council for National AIDS Control (HCNLS) as well as assisting HCNLS in the decentralization process.

- **Maternal health and family planning:** policy development and provider training in postpartum hemorrhage prevention; training of community service providers in birth planning and expanded antenatal care; provision of contraceptive commodities to the public sector and training in commodity logistics and forecasting; provider training in counseling and the provision of a range of contraceptive methods; training, equipping, and supervising more than 4,000 community-based health volunteers currently providing FP counseling and distribution; training and accreditation of private FP/RH providers; policy and advocacy targeting government, civil society, and religious leaders.

- **Nutrition, including vitamin A supplementation:** technical and financial assistance to fortify wheat flour

with multiple vitamins and cooking oil with vitamin A; provision of vitamin A commodities; technical and financial assistance for semiannual National Nutrition Weeks that include widespread vitamin A supplementation to children 6 to 59 months; and promotion of exclusive breastfeeding.

- **Immunization:** technical assistance to the national immunization coordinating committee for the introduction of new vaccines; technical and financial assistance at the community level to plan and carry out vaccination outreach activities; technical assistance for expanding the Reaching Every District approach; surveillance, planning, and evaluation assistance for National Immunization Days.

Delivery approaches and mechanisms supporting expanded coverage/use of interventions

USAID is currently the largest bilateral donor to the Government of Mali and one of the top four health donors in Mali. USAID/Mali works closely with the MOH and the Ministry of Social Development to support the implementation of the National Health Sector Plan. Direct financial support is provided to MOH each year to implement a variety of high-impact health activities at the central, regional, and local levels. USAID works closely with the ministries on strategic program planning and implementation approaches, strengthening their accounting and administrative capacity, and providing various types of technical assistance when requested.

The HIHS program is supported by three USAID-funded bilateral projects:

- **National Technical Assistance (ATN)**, led by Abt Associates, focuses on national-level strategies, policies, standards, and guidelines. This program will end in September 2008 and will be replaced by a similar but new TASC III award.

- **Keneya Ciwara Project (PKC)**, led by Care International, focuses on community- and household-level service provision and care. This program will end in September 2008 and will be replaced by a follow-on award.

- **Pathways to Health (PTH)**, led by Population Services International, focuses on private sector and social marketing of commodities and provider practices. This program will end in September 2008 and will be replaced by a follow-on award.

In addition, the Groupe Pivot Sante Population (GPSP) (Health and Population Pivot Group) is a local Malian umbrella organization that groups more than 150 local NGOs. GPSP is currently partnering with USAID on a number of activities, including family planning promotion, community-based HIV prevention, and community capacity building, through subagreements with more than 40 local NGOs.

Several of USAID's centrally funded projects also support Mali's health program in MCH and FP/RH, including the Health Policy Initiative, the Capacity Project, the Fertility Awareness Project, the Prevention of Postpartum Hemorrhage Initiative (POPPHI) project, and the Child Survival Grant Program. The new USAID Initiative for Neglected Tropical Diseases selected Mali as one of five fast-track countries and began in-country activities in 2007.

USAID/Mali also provides direct funding to the MOH in support of its work in all the above mentioned technical areas.

To further enhance attainment of the HIHS objectives as well as support other sectors in USAID/Mali's portfolio, several interventions are collaboratively implemented between sectors. For example, the health projects collaborate with democracy and governance projects to strengthen locally elected health committees to openly and transparently manage the health centers, education projects to integrate messages on key health behaviors into school, adult literacy, and teacher training curricula, and cross-cutting communications for development projects to air health messages on local independent radio stations.

Specific actions supported as part of the MCH approach

USAID/Mali will be supporting a 3-year technical assistance program implemented by the Strengthening Pharmaceutical Systems (SPS) program. It will build sustainable capacity of national institutions to carry out the procurement, quality assurance, supply and distribution functions for pharmaceutical products.

USAID funds the Capacity Project to provide institutional support to the Nursing School in Gao, while bilateral funding directly funds the school as well. The Nursing School provides human resource capacity for the health service in the northern regions.

The USAID program's geographic focus

During the last 5-year phase (2004–2008) USAID programs provided national-level technical assistance and district-level support in 15 health districts covering approximately 30 percent of the Malian population. In the new 5-year phase (2009–2013), USAID programs will provide national- and regional-level technical assistance support and community mobilization nationwide with varying levels of intensity depending on the presence of other partners, notably UNICEF.

The Mission program's relationship to the country's health sector and development plans and strategies

PRODESS II is the second National Health and Social Development Program (2005–2011) that USAID supports. The Comité de Suivi (evaluation committee) approves the annual PRODESS operating plan, which includes funding gaps expected to be covered by donors. Several partners (Netherlands, Sweden, and Canada) provide direct budget support on an annual basis. All other donor funds are targeted to subsectors and programs. The Government of Mali contributes mostly to salaries and other operating costs in PRODESS annual budgets. The government also uses Heavily Indebted Poor Countries Initiative funds to pay some MOH salaries, especially at the Centre de santé communautaire (Community Health Center) level. Overall, the government has steadily increased the contribution of the national budget devoted to health from about 6 percent in 2000 to about 8 percent in 2005, with commitments for additional increases in the future. The Government of Mali's goal is to devote 15 percent of the national budget to health by 2015.

To further support the MOH, USAID has served as the chair of the Technical and Financial Health Partners Coordination Group, is a member of the Mali Country Coordinating Mechanism (CCM) of the Global Fund, and has provided critical technical assistance to the development of the latest Mali proposals to the Global Fund, resulting in an additional $56 million for HIV/AIDS and $29 million for malaria.

USAID also partners with other U.S. Government agencies active in Mali in a variety of ways including:

- The U.S. Centers for Disease Control and Prevention, a key technical resource on HIV/AIDS working within the MOH, receives a portion of its funding through a Participating Agency Service Agreement with USAID.
- The National Institutes of Health and USAID share information and planning orientations, particularly in the area of malaria, and USAID recently co-funded with NIH the visit by the president of the University of Mali to the United States.
- USAID also provides technical assistance to the Department of Defense's HIV/AIDS prevention partnership with the Malian Ministry of Defense.

Potential for linking Mission MCH resources with other health sector resources and initiatives

Initiatives:

- Mali has been a Family Planning Repositioning Global Leadership Partner since FY05.
- Mali is a nonfocus PEPFAR country.
- Mali is a PMI country.
- Mali is an International Health Partnership Plus priority country.
- Mali is a Catalytic Initiative country.
- Mali is a National Training and Development Institute country.
- Mali will receive funding for Health Services Strengthening from GAVI.

The Millennium Challenge Corporation approved a 5-year compact agreement for assistance of up to $460.8 million to increase economic performance, including assistance for small and medium-sized enterprises, and agricultural output in order to reduce rural poverty and achieve national food security.

Avian Influenza

At the current time, no cases of avian influenza (AI) have been confirmed in Mali, although surrounding countries (Burkina Faso and Cote d'Ivoire) have reported cases. The Malian response to the avian flu crisis that erupted in Nigeria in 2005 was immediate and well organized, led by the Ministry of Livestock and Fisheries. A national crisis group, which includes the MOH and USAID, was convened and meets weekly. The Government of Mali developed a national action plan within the first months of the crisis and shared with partners and donors in order to mobilize their contributions. Surveillance among domestic and wild birds was

initiated and is continuing through agricultural and wildlife outreach agents. USAID contributed $150,000 in FY06 to the national action plan and also secured the delivery of personal protective equipment (PPE) kits to the government; additional USAID funds were contributed to support the international AI conference. Both health and veterinary services in Mali have been trained in avian flu detection and diagnosis and local laboratories have been scaled up to meet potential demand for testing.

A Pandemic Preparedness design team, led by the International Federation of the Red Cross, will make an initial visit to Mali in July 2008.

Planned results for the Mission's MCH investments over the next 5 years

- Increase percentage of women who have completed a pregnancy in the last 2 years who have received two or more doses of IPTp during that pregnancy from 4 percent (2006) to 85 percent in 2011.
- Increase percentage of children 6 to 59 months old receiving vitamin A supplementation from 80 percent (2006) to 85 percent in 2011.
- Increase percentage of pregnant women sleeping under an ITN from 29 percent (2006) to 85 percent in 2011.
- Increase percentage of women with at least one FANC visit from 70 percent (2006) to 85 percent by 2011.
- Increase percentage of children 12 to 23 months old fully vaccinated prior to first birthday from 48 percent (2006) to 60 percent by 2011.
- Increase percentage of children 12 months old who have received DPT3 from 68 percent (2006) to 80 percent by 2011.
- Increase percentage of children 6 to 59 months old with diarrhea receiving ORT from 24 percent (2006) to 55 percent by 2011.
- Increase percentage of children under 5 with fever in previous 2 weeks treated with appropriate antimalarial drugs within 24 hours of onset of symptoms from 15 percent (2006) to 85 percent by 2011.
- Increase contraceptive prevalence rate for modern methods in women of reproductive age from 6.4 percent (2006) to 10 percent by 2011.

USAID is in the process of realigning its bilateral programs to continue progress in achieving results under the HIHS approach.

MCH COUNTRY SUMMARY: MALI	VALUE
MCH FY08 BUDGET	6,443,000 USD
Country Impact Measures	
Number of births annually*	582,000
Number of under-5 deaths annually	111,000
Neonatal mortality rate (per 1,000 live births)	46
Infant mortality rate (per 1,000 live births)	96
Under-5 mortality rate (per 1,000 live births)	191
Maternal mortality ratio (per 100,000 live births)	464
Percent of children underweight (moderate/severe)	27%
Birth Preparedness and Maternity Services	
Percent of women with at least one antenatal care (ANC) visit	69%
Percent of women with at least four antenatal care (ANC) visits	35%
Percent of women with a skilled attendant at birth	49%
Percent of women receiving postpartum visit within 3 days of birth***	22%
Newborn Care and Treatment	
Percent of newborns whose mothers initiate immediate breastfeeding	46%
Immunization	
Percent of children fully immunized at 1 year of age	42%
Percent of DPT3 coverage	68%
Percent of measles coverage	68%
Maternal and Young Child Nutrition, Including Micronutrients	
Percent of mothers receiving iron-folate	61%
Percent of children receiving adequate age-appropriate feeding	30%
Percent of children under age 5 receiving vitamin A supplement in the past 6 months	72%
Percent of children under 6 months exclusively breastfed	38%
Treatment of Child Illness	
Percent of children with diarrhea treated with ORT	49%
Percent of children with diarrhea treated with zinc	N/A
Percent of children with pneumonia taken to appropriate care	38%
Water, Sanitation, and Hygiene	
Percent of population with access to improved water source**	60%
Percent of population with access to improved sanitation**	45%

* Census International Database
** Joint Monitoring Programme for Water Supply and Sanitation 2008 Report
*** This number is based only on mothers whose last live birth occurred outside a health facility in the 5 years preceding the survey.
(Unless otherwise noted, the data source is the 2006 Demographic and Health Survey.)

Mozambique MCH Program Description

Overall MCH and health sector situation

Mozambique has a population of about 20 million people; 45 percent are below the age of 15, and about 30 percent live in urban areas. Annual health expenditures are $50 per capita. Mozambique has benefited from being a stable democracy with rapid economic growth over the last decade. Nevertheless, a number of health threats limit its sustainability. Mozambique ranked 172 out of 177 countries on the 2007–2008 United Nations Human Development Index. Poverty affects 50 percent of the population, and chronic food insecurity affects 35 percent of the population. Adult HIV/AIDS prevalence is still very high – currently at 16 percent. Disease and poverty have substantially lowered life expectancy, which is currently about 40 years.

With MCH funding, there have been significant declines in U5MR, from 201 to 153 per 1,000 live births in the last decade – a 24 percent decline. Postneonatal mortality remains relatively high at 64 per 1,000 live births, and this reflects the need to capitalize on primary care opportunities for children in the first year of life. The MMR also remains high – currently at 408 per 100,000 live births. The TFR is now at 5.4 children per woman, but 18 percent of women have an unmet need for family planning. Disparities exist between provinces and between urban and rural areas. Many of these problems are linked at least in part to the limited reach of service delivery in rural areas at the community and household levels and the quality of those services that do reach them.

MCH interventions at the Mission level

Priority areas of intervention include access to potable water, vitamin A coverage, safe deliveries performed by a SBA, and access to contraception. Approximately 8 million people in Mozambique are reached with these interventions.

Delivery approaches and mechanisms supporting expanded coverage/use of interventions

Community-based mobilization is coupled with increased capacity at the district and provincial levels for planning and implementation of community-defined solutions. Social marketing plays a vital role in distribution of family planning commodities. The formal private sector is weak and provides services to a very small portion of the urban population.

Specific actions supported as part of the MCH approach

USAID's support in MCH is complemented by funding from PMI and PEPFAR. PMI and PEPFAR funding supports the increase in the number of providers and the efficiency of providers to provide basic health care as well as key HIV and malaria prevention and treatment for pregnant women and children. MCH priority interventions are also complemented by water and sanitation interventions.

The USAID program's geographic focus

The USAID MCH program includes a combination of interventions, both at the central and provincial levels, through an integrated program that will strengthen the policy and management environment, increase access to proven and effective primary health services, and increase community demand for and participation in managing and influencing the availability and quality of health care services.

The geographic focus at the provincial, district, and community levels is in selected districts of four provinces (Nampula, Zambezia, Gaza, and Maputo) whose combined population accounts for 40 percent of the total population in Mozambique. These provinces were selected due to the need to focus interventions to be able to achieve results and were based on the following criteria: 1) total number of the population in the province; 2) health indicators; 3) need to have interventions in all three regions of the country (north, center, and south); and 4) other donor support in health service delivery.

The Mission program's relationship to the country's health sector and development plans and strategies

The Mission has tailored its portfolio to build increased integration of its own activities and has worked with the MOH to support integration with the Government of Mozambique's national health plans. A 5-year Country Assistance Strategy is being developed to reflect a USG response to health and development in Mozambique.

Potential for linking Mission MCH resources with other health sector resources and initiatives

USG investments (e.g., PMI, PEPFAR, Title II, OFDA, water, etc.)

The USAID MCH program works closely with the PEPFAR and PMI programs in Mozambique. A large proportion of assistance to Mozambique is through PEPFAR, which has limited avenues for integration. Examples include the expansion of basic health care through the training of community health workers to support PEPFAR, PMI, and MCH activities.

Future activities to be solicited under a Mission RFA will complement other USAID/Mozambique activities, including those funded through PEPFAR, PMI, P.L. 480, Title II (Food For Peace), and other USAID-funded agricultural and health activities. Proposed activities will target potable water/sanitation and also fit within the context of the GRM's policies, strategies, and programs in health and agriculture, as well as its Action Plan for the Reduction of Absolute Poverty (PARPA II) and its Food and Nutrition Security Strategy.

Investments and initiatives of other donors and international organizations

Mozambique has adopted a sectorwide approach for health sector financing and coordination with nearly all donors using this mechanism. All donor activities support the MOH's National Health Strategy, and donors participate in yearly joint evaluations of the sector's performance. The Health Donor Group has 27 bilateral members. Mozambique has also received increased funds from Canada for Catalytic Initiative for MCH.

Planned results for the Mission's MCH investments over the next 5 years

Planned results are reductions in maternal and U5MR, reduced diarrheal disease mortality, increased number of deliveries with a skilled provider, improved immunization coverage, improved nutritional status of under-5 children, and reduced rates of micronutrient malnutrition.

MCH COUNTRY SUMMARY: MOZAMBIQUE	VALUE
MCH FY08 BUDGET	6,938,000 USD
Country Impact Measures	
Number of births annually*	790,000
Number of under-5 deaths annually	121,000
Neonatal mortality rate (per 1,000 live births)	37
Infant mortality rate (per 1,000 live births)	101
Under-5 mortality rate (per 1,000 live births)	153
Maternal mortality ratio (per 100,000 live births)	408
Percent of children underweight (moderate/severe)	26%
Birth Preparedness and Maternity Services	
Percent of women with at least one antenatal care (ANC) visit	84%
Percent of women with at least four antenatal care (ANC) visits	52%
Percent of women with a skilled attendant at birth	48%
Percent of women receiving postpartum visit within 3 days of birth***	12%
Newborn Care and Treatment	
Percent of newborns whose mothers initiate immediate breastfeeding	65%
Immunization	
Percent of children fully immunized at 1 year of age	53%
Percent of DPT3 coverage	72%
Percent of measles coverage	77%
Maternal and Young Child Nutrition, Including Micronutrients	
Percent of mothers receiving iron-folate	60%
Percent of children receiving adequate age-appropriate feeding	80%
Percent of children under age 5 receiving vitamin A supplement in the past 6 months	50%
Percent of children under 6 months exclusively breastfed	30%
Treatment of Child Illness	
Percent of children with diarrhea treated with ORT	70%
Percent of children with diarrhea treated with zinc	N/A
Percent of children with pneumonia taken to appropriate care	51%
Water, Sanitation, and Hygiene	
Percent of population with access to improved water source**	42%
Percent of population with access to improved sanitation**	31%

* Census International Database
** Joint Monitoring Programme for Water Supply and Sanitation 2008 Report
***This number is based only on mothers whose last live birth occurred outside a health facility in the 5 years preceding the survey.
(Unless otherwise noted, the data source is the 2003 Demographic and Health Survey.)

Nigeria MCH Program Description

Overall MCH and health sector situation

Nigeria's importance stems in part from its oil and natural resource reserves and the fact that it is the most populous country and the fourth largest economy in Africa. However, at an estimated $350 per capita annually, Nigeria still ranks near the bottom 158 out of 177 countries in the United Nations Human Development Index in terms of per capita income, with more than half of the population living in poverty. The situation of MCH in Nigeria is among the worst in Africa and has not improved substantially – and in some areas of the country, has worsened – over the past decade. U5MR is estimated to be 201 deaths/1,000 lives births, MMR 1,100 deaths/100,000 live births, and total fertility to be 5.7 births per woman. Coverage and utilization of key interventions are correspondingly low. The northern part of the country has generally worse indicators and is also the region where polio has proven most difficult to control. The high rates of mortality – especially of maternal mortality and mortality among 1- to 4-year-old children – reflect a significant breakdown of basic services, and particularly of primary health care, in the country.

Nigeria's health situation makes it a major factor in the global achievement of MDGs 4 and 5. With approximately 2.5 percent of the world's population, Nigeria has more than 10 percent of all under-5 and maternal deaths – more than 1 million newborn, infant, and child deaths and more than 50,000 maternal deaths every year.

Despite these massive challenges, there are signs that improvements can be made. Significantly better status of health and other development indicators in some of Nigeria's 36 states show that good leadership and effective use of available resources can make a difference, even in this complex political and social environment. Very recently, a National Health Bill was passed defining for the first time the responsibilities and resources for health at the federal, state, and local levels of Nigeria's decentralized system. Donor partners have reached increasing consensus among themselves and with the government on a strategic framework for the health sector and other development areas. USAID programming has been able to accomplish local improvements in MCH outcomes, especially through programs that mobilize communities themselves and connect them to local health services. Finally, Nigeria's energetic private sector is increasingly being engaged in providing health-related goods, services, and information.

MCH interventions at the Mission level

USAID's program currently focuses on birth preparedness and strengthened emergency maternity services; immunization, with a strong focus on polio; maternal and young child nutrition, especially micronutrient supplementation; and treatment of child illnesses. USAID is also a lead supporter of family planning, a key intervention in a country where women are exposed to the risks of early childbearing and an average of almost six births, and closely spaced pregnancies.

Delivery approaches and mechanisms supporting expanded coverage/use of interventions

USAID programs in the public sector are focused on revitalizing primary health care delivery; to make these services more effective and responsive, a strong element of USAID's MCH programming has been to mobilize communities to promote appropriate health practices and care-seeking, and to demand and support greater functionality of primary health care. For emergency obstetric care, the approach also includes strengthening of first referral-level hospital services and providing the

capacity to manage complicated pregnancies and deliveries. USAID's approach also includes a social marketing program that links to micro-level private sector partners, especially pharmacies and local "patent medicine vendors" that provide a major share of basic treatment services for women and children. Finally, USAID supports routine immunization strengthening in a limited number of states and promotion and implementation of polio eradication campaigns in states having continued transmission of polio virus.

Specific actions supported as part of the MCH approach

USAID's programming includes a policy analysis and support activity that have assisted the development of technical and resource allocation policies favoring improved basic health services, including MCH. The program helps the MOH to provides health services in selected states and local government areas with assistance in strengthening logistics of basic MCH and family planning services, since absence of drugs and commodities is a frequent cause of low effectiveness of health services in Nigeria. A significant investment is being made in strengthening human capacity through training of both health care providers and health system managers; MCH and family planning services are major focuses of this training. Finally, USAID is making unique contributions to polio eradication through quality improvement activities, since low-quality polio campaigns have been determined to be major contributors to the lack of success in eradicating the virus in Nigeria.

The USAID program's geographic focus

Because of past pressures to provide assistance in each of Nigeria's six geopolitical zones, USAID's MCH programs are now being carried out in at least one state in five of these zones. There is new willingness by the government to accept greater focusing of resources, and USAID's new programming cycle will take advantage of this opportunity. Even working in a select number of states, USAID's limited resources will not directly achieve major population coverage; however, they will permit achievement of a program-scale demonstration effect that – through structured linkages to state and national policy – will result in replication and further rollout of USAID-supported approaches.

The Mission program's relationship to the country's health sector and development plans and strategies

At present, Nigeria does not have a health sector strategic plan. The development of such a national plan is being proposed, and several states where USAID is working are also discussing development of state strategic plans for health. USAID will actively participate in all of these planning processes. Nigeria has developed an overall development strategy (the National Economic and Empowerment Development Strategy); in support of this strategy, USAID has joined other major partners (DfID and World Bank) in developing a Country Partnership Strategy that provides an overall framework for health and other development assistance. USAID has also actively participated in development of a national Integrated Maternal, Newborn, and Child Health Strategy.

Potential for linking Mission MCH resources with other health sector resources and initiatives

USG investments (e.g., PMI, PEPFAR, Title II, OFDA, water, etc.)

As PEPFAR-supported programs move from the hospital level to the primary health care level, USAID is identifying opportunities to develop linkages with MCH, including connecting PMTCT with antenatal and maternity care. Currently, PEPFAR funding has been earmarked for nutrition programming through the expansion of community-based nutrition rehabilitation services targeted directly to orphans and vulnerable children. In addition, RH/HIV integration activities are carried out with joint FP/RH and PEPFAR funds in integrating FP into counseling and testing services, PMTCT services, and for meeting the FP needs of HIV-positive clients (including those on antiretroviral therapy [ART]). PEPFAR is also supporting a substantial effort in injection safety, which includes safety of immunization programs. Although not a PMI country, USAID malaria investments are being connected to both antenatal care (treatment of pregnant women and management of severe anemia) and to broader sick child treatment. Linkages with DA-funded water activities are also being developed, including the possibility of providing water supplies to primary health care facilities as part of revitalizing those facilities.

Planned results for the Mission's MCH investments over the next 5 years

Over the next 5 years, USAID's program aims to contribute to improving maternal and child health service delivery in Nigeria by strengthening public and private institutions to increase quality, access, and demand to address underlying causes of poor maternal and child health, including vaccine-preventable diseases and malnutrition. The long-term goals are to eradicate the wild polio virus, reach and maintain immunization coverage rates of 60 percent, and reach 5.7 million children under 5 with nutrition interventions.

MCH COUNTRY SUMMARY: NIGERIA	VALUE
MCH FY08 BUDGET	15,860,000 USD
Country Impact Measures	
Number of births annually*	5,045,000
Number of under-5 deaths annually	1,014,000
Neonatal mortality rate (per 1,000 live births)	48
Infant mortality rate (per 1,000 live births)	100
Under-5 mortality rate (per 1,000 live births)	201
Maternal mortality ratio (per 100,000 live births)***	1,100
Percent of children underweight (moderate/severe)	29%
Birth Preparedness and Maternity Services	
Percent of women with at least one antenatal care (ANC) visit	61%
Percent of women with at least four antenatal care (ANC) visits	47%
Percent of women with a skilled attendant at birth	35%
Percent of women receiving postpartum visit within 3 days of birth****	23%
Newborn Care and Treatment	
Percent of newborns whose mothers initiate immediate breastfeeding	32%
Immunization	
Percent of children fully immunized at 1 year of age	11%
Percent of DPT3 coverage	21%
Percent of measles coverage	36%
Maternal and Young Child Nutrition, Including Micronutrients	
Percent of mothers receiving iron-folate	58%
Percent of children receiving adequate age-appropriate feeding	64%
Percent of children under age 5 receiving vitamin A supplement in the past 6 months	34%
Percent of children under 6 months exclusively breastfed	17%
Treatment of Child Illness	
Percent of children with diarrhea treated with ORT	42%
Percent of children with diarrhea treated with zinc	N/A
Percent of children with pneumonia taken to appropriate care	31%
Water, Sanitation, and Hygiene	
Percent of population with access to improved water source**	47%
Percent of population with access to improved sanitation**	30%

* Census International Database
** Joint Monitoring Programme for Water Supply and Sanitation 2008 Report
*** WHO Maternal Mortality Report 2007
**** This number is based only on mothers whose last live birth occurred outside a health facility in the 5 years preceding the survey.
(Unless otherwise noted, the data source is the 2003 Demographic and Health Survey.)

Rwanda MCH Program Description

Overall MCH and health sector situation

Rwanda, with a population of approximately 9 million people, is the most densely populated country in Africa and is ranked 161 out of 177 countries on the United Nations Human Development Index. The Government of Rwanda has recognized health and population growth as important factors in its economic development; slowing population growth while improving health is one of four priority areas in the 2008–2012 Economic Development and Poverty Reduction Strategy (EDPRS).

Rwanda is making progress in health. According to the 2000 and 2005 Demographic and Health Surveys, infant mortality decreased from 108/1,000 to 86/1,000; U5MR decreased from 196/1,000 to 152/1,000; MMR decreased from 1,071/100,000 to 750/100,000; and use of modern family planning methods increased from 4 to 10 percent. Although these statistics have improved, the 2005 numbers are nearly identical to those shown in 1992 before the genocide and war. Early results from an interim DHS conducted in 2007/2008 are showing continued and significant improvements in nearly all health indicators. Further improvements were measured in infant mortality from 86/1,000 to 62/1,000; U5MR from 152/1,000 to 103/1,000; health center deliveries from 39 to 52 percent; measles vaccination rates from 86 to 90 percent; use of modern family planning methods from 10 to 27 percent; and TFR from 6.1 to 5.5. Continued support and hard work will be required to maintain this momentum and move Rwanda closer to achieving its goals as set out in the Economic Development and Poverty Reduction Strategy and MDGs.

The Government of Rwanda, together with key stakeholders, has developed a Health Sector Strategic Plan (HSSP) for 2005–2009 and has signed an MOU with key development partners to implement the plan. The USG supports the HSSP in maternal and child health; family planning and malaria are supported through PMI, and HIV is supported through PEPFAR. Rwanda is a focus country for both PMI and PEPFAR.

MCH interventions at the Mission level

Priority areas of intervention include training of health care providers in family planning; IMCI; FANC, including malaria in pregnancy; AMTSL; fistula prevention and care and growth monitoring; strengthening the decentralized system for improved management of health programs and increased quality of care; building the capacity of community health workers to improve community-based management of key public health interventions such as IMCI, home-based management of malaria, and distribution of family planning commodities; supporting ongoing decentralization of health services; building sustainability of health services through performance-based financing; strengthening central commodity procurement and distribution systems; and implementing BCC and education campaigns to improve the use of safe water treatment products, LLINs, family planning, antenatal care services, safe delivery practices, and immunization services.

USAID will support the national EPI program to introduce pneumococcal vaccine in 2009. Rwanda will be the first country in Africa to get GAVI approval to introduce pneumococal conjugate vaccine.

Specific actions supported as part of the MCH approach

USAID currently supports all levels of the health system in Rwanda. At the national level, support is provided for

coordinated commodity and logistics systems; health information systems; monitoring and evaluation; policy development; performance-based financing; and human resource planning, management, and development through the medical school, school of public health, and nursing schools. This national-level support improves the quality of and access to MCH services.

The USAID program's geographic focus

USAID works closely with the Government of Rwanda and other partners to ensure that MCH services are available nationwide. This support is coordinated by the government through the Health Sector Strategic Plan (HSSP) and Health Cluster. The Health Cluster is a development partners' group, co-chaired by the Government of Rwanda and the Belgian Embassy, which meets quarterly to review progress and planning in the health sector.

The Mission program's relationship to the country's health sector and development plans and strategies

USAID has signed a memorandum of understanding (MOU) with the Government of Rwanda to support the HSSP for 2005–2009. USAID also supports the government's Economic Development and Poverty Reduction Strategy for 2008–2012, which counts health as one of its priority areas.

Potential for linking Mission MCH resources with other health sector resources and initiatives

USG investments (e.g., PMI, PEPFAR, Title II, OFDA, water, etc.)

All health activities are designed and managed with a focus on integration – BCC, community strengthening, monitoring and evaluation, and performance-based financing activities. As a result, MCH activities have benefited from the significant investments in improving health systems made by PEPFAR and PMI. Outside of health, MCH activities have been integrated into economic strengthening activities in coffee and biodiversity programs being supported by USAID.

Investments and initiatives of other donors and international organizations

Major donors in the health sector include the Belgians, Germans, Swiss, British, the World Bank, and the African Development Bank, as well as the Global Fund. These donors are active members of the Health Cluster and many provide sector budget support to the Government of Rwanda. This support is used for performance-based financing, family planning commodity procurement, sentinel site surveillance for malaria, and capacity building. The UN supports capacity building, scale-up of IMCI, family planning commodity procurement, and work at the policy level. The Government of Rwanda is the recipient of Global Fund awards for HIV, health systems strengthening, TB, and malaria. Global Fund resources are used to finance a large proportion of the country's commodity needs, including bed nets, malaria drugs, antiretrovirals (ARVs), condoms, and opportunistic infection (OI) drugs.

Planned results for the Mission's MCH investments over the next 5 years

Investments in MCH, together with other support in the health sector, will help Rwanda to achieve its EDPRS targets of reducing infant mortality to 57, reducing U5MR to 95, and reducing MMR to 600 by 2012.

MCH COUNTRY SUMMARY: RWANDA	VALUE
MCH FY08 BUDGET	4,459,000 USD
Country Impact Measures	
Number of births annually*	379,000
Number of under-5 deaths annually	58,000
Neonatal mortality rate (per 1,000 live births)**	28
Infant mortality rate (per 1,000 live births)**	62
Under-5 mortality rate (per 1,000 live births)**	103
Maternal mortality ratio (per 100,000 live births)	750
Percent of children underweight (moderate/severe)	25%
Birth Preparedness and Maternity Services	
Percent of women with at least one antenatal care (ANC) visit	95%
Percent of women with at least four antenatal care (ANC) visits	13%
Percent of women with a skilled attendant at birth**	52%
Percent of women receiving postpartum visit within 3 days of birth****	4%
Newborn Care and Treatment	
Perecent of newborns whose mothers initiate immediate breastfeeding	41%
Immunization	
Percent of children fully immunized at 1 year of age**	80%
Percent of DPT3 coverage**	90%
Percent of measles coverage**	90%
Maternal and Young Child Nutrition, Including Micronutrients	
Percent of mothers receiving iron-folate	28%
Percent of children receiving adequate age-appropriate feeding	69%
Percent of children under age 5 receiving vitamin A supplement in the past 6 months	84%
Percent of children under 6 months exclusively breastfed	88%
Treatment of Child Illness	
Percent of children with diarrhea treated with ORT**	31%
Percent of children with diarrhea treated with zinc	N/A
Percent of children with pneumonia taken to appropriate care**	35%
Water, Sanitation, and Hygiene	
Percent of population with access to improved water source***	65%
Percent of population with access to improved sanitation***	23%

* Census International Database
** 2007/08 Preliminary Results of the Interim Demographic and Health Survey
*** Joint Monitoring Programme for Water Supply and Sanitation 2008 Report
**** This number is based only on mothers whose last live birth occurred outside a health facility in the 5 years preceding the survey.
(Unless otherwise noted, the data source is the 2005 Demographic and Health Survey.)

Senegal MCH Program Description

Overall MCH and health sector situation

Senegal has a population estimated at 11.6 million, growing at a rate of 2.6 percent per year, and is ranked 156 out of 177 countries worldwide on the United Nations Human Development Index. Senegal's high infant and MMR, 61/1,000 and 401/100,000, respectively, are largely attributable to inadequate services, including insufficient emphasis on prevention. Fertility has slowly but consistently decreased but remains high, at 5.3 children per woman; only about 10 percent of married women of reproductive age use contraceptives. The adult HIV prevalence rate is estimated at 0.7 percent for adults 15 to 49 years of age, with 56,000 adults 15 to 49 years of age and 5,000 children estimated to be living with HIV/AIDS. Although substantial improvements have been achieved since the 1960s, Senegal's health indicators show that much more progress is needed in order to meet the country's development goals. The three primary objectives of the national health plan as well as the health component of the poverty reduction plan are to reduce maternal and child mortality and morbidity, and to decrease total fertility. In addition, health is one of the government's "competencies" to be decentralized as part of Senegal's overall decentralization plan.

The Senegalese health care system consists of a network of public health facilities. Seven regional hospitals provide relatively advanced care; district health centers (1 per 150,000 inhabitants) are intended to provide first-level referrals and limited hospitalization services (approximately 10 to 20 beds); and health posts (about 1 per 11,000 inhabitants) provide primary curative care, caring for chronic patients (such as tuberculosis patients), prenatal care, family planning, and, to some extent, health promotion activities related to nutrition, hygiene, and sanitation. It is also significant that at the community level, there are thousands of health huts offering basic services provided by community health workers. In all public health facilities in Senegal, patients are charged at a "cost recovery" price for services, drugs, and commodities, and local health committees manage these funds.

Despite progress in MCH indicators over time, there remain significant sectoral issues and constraints that can be summarized as follows: 1) insufficient access to health services; 2) poor quality and low efficiency and accountability in health services; 3) insufficient emphasis on prevention and behavior changes; 4) weak institutional capacity; 5) insufficient coordination with communities and the private sector; 6) inadequate sector financing and budgetary procedures; and 7) high financial barriers to access and to utilization of health services.

MCH interventions at the Mission level

USAID's approach in Senegal is to scale up innovative, high-impact strategies and tools in the health system with the objective of contributing to reducing child and MMR by 25 percent, and increasing contraceptive prevalence by 30 percent over the next 5 years. The Government of Senegal presently has funds, partners, and capacity to implement basic health programs, such as immunization, vitamin A supplementation, and clinical treatment of childhood illnesses. USAID helps decentralize basic services to the community using volunteer community health workers, and introduces and institutionalizes effective approaches.

The Mission's contribution to Senegal's MCH objectives includes institutionalizing a package of interventions to make pregnancy and childbirth safer, supporting integration of a neonatal care package at all health facilities, improving maternal and child nutrition, building capaci-

ty for effective supervision of service delivery and outreach services, and expanding availability of essential services by decentralizing MCH services to the community level wherever possible. All of these activities are currently covering all districts of five regions of the country. Malaria is a major cause of maternal and child morbidity and mortality, and Senegal was selected as a PMI focus country starting in 2007, resulting in malaria being a large focus of the health program in Senegal, with PMI-supported interventions reaching all 11 regions.

Delivery approaches and mechanisms supporting expanded coverage/use of interventions

To ensure that these services and practices become standard over time, the Mission's program improves MCH services by extending IMCI beyond health facilities and into communities, expanding communications designed to encourage more women to access prenatal care services and to prepare birth plans, in addition to increasing the quality of these services, and systemizing safer birth practices and essential newborn care at both clinical and community levels. The Mission also helps fund a regional vitamin A oil fortification project that also contributes to MCH objectives.

Specific actions supported as part of the MCH approach

USAID supports local communities, including locally elected officials, the general public, and civil society, to develop local health plans that improve the quality of maternal and child health services, and provides matching grants to spur financing of these plans. The program also strengthens and expands the coverage of 55 mutual health organizations. Finally, transparency, accountability, and leadership within the health system are all focal points in USAID's program.

The USAID program's geographic focus

The USAID MCH program focuses geographically in 5 of 11 regions (45 percent of Senegal's population estimated at 5.2 million). The family planning program touches additional regions, and the malaria program reaches nationwide. USAID advocates to the Government of Senegal for investment in non-USAID focus regions in order to scale up USAID-supported innovations, such as essential newborn care, matching grants to local health action plans, and safe birth programs nationwide.

The Mission program's relationship to the country's health sector and development plans and strategies

Senegal's national health plan and poverty reduction strategy highlight reductions in both child and maternal morbidity and mortality as two of the country's three primary health objectives, and improvements in MCH services are an integral part of the USG's foreign assistance priorities for Senegal. Mission support is considered by MOH as part of its strategic plan. USAID is a member of the MCH steering committee that follows the implementation and monitors the results.

Potential for linking Mission MCH resources with other health sector resources and initiatives

USG investments (e.g., PMI, PEPFAR, Title II, OFDA, water, etc.)

USAID MCH programs and PMI are integrated in regions where both occur. Title II programs do occur in Senegal but are not well coordinated with the bilateral Mission program. However, as Title II has different focus regions than the bilateral MCH program, there may be potential to link and leverage.

Investments and initiatives of other donors and international organizations

Many other donors (bilateral and multilateral) work in Senegal and much of the work is well coordinated. Many groups working in MCH – MOH, UN agencies, donors, and NGOs – collaborate on an MCH "roadmap." UNICEF funds immunization and district health operations in some regions, and the World Bank pays for MOH budget support and a large nutrition program. The African Development Bank funds health system infrastructure and the World Health Organization provides technical assistance to MOH. GAVI and the Program for Appropriate Technology in Health contribute to immunization. The Japan International Cooperation Agency funds health programs, and volunteers working in MCH and other health elements. All donors generally try to coordinate efforts by attending regular donor coordination meetings, sharing strategic plans and work plans, and undergoing joint planning exercises where possible.

Planned results for the Mission's MCH investments over the next 5 years

Over the next 5 years, the USG program will contribute to a 25 percent decrease in MMR and a 30 percent increase in contraceptive prevalence.

MCH COUNTRY SUMMARY: SENEGAL	VALUE
MCH FY08 BUDGET	4,640,000 USD
Country Impact Measures	
Number of births annually*	464,000
Number of under-5 deaths annually	56,000
Neonatal mortality rate (per 1,000 live births)	35
Infant mortality rate (per 1,000 live births)	61
Under-5 mortality rate (per 1,000 live births)	121
Maternal mortality ratio (per 100,000 live births)	401
Percent of children underweight (moderate/severe)	16%
Birth Preparedness and Maternity Services	
Percent of women with at least one antenatal care (ANC) visit	91%
Percent of women with at least four antenatal care (ANC) visits	40%
Percent of women with a skilled attendant at birth	52%
Percent of women receiving postpartum visit within 3 days of birth***	28%
Newborn Care and Treatment	
Percent of newborns whose mothers initiate immediate breastfeeding	23%
Immunization	
Percent of children fully immunized at 1 year of age	48%
Percent of DPT3 coverage	78%
Percent of measles coverage	74%
Maternal and Young Child Nutrition, Including Micronutrients	
Percent of mothers receiving iron-folate	91%
Percent of children receiving adequate age-appropriate feeding	61%
Percent of children under age 5 receiving vitamin A supplement in the past 6 months	75%
Percent of children under 6 months exclusively breastfed	34%
Treatment of Child Illness	
Percent of children with diarrhea treated with ORT	52%
Percent of children with diarrhea treated with zinc	N/A
Percent of children with pneumonia taken to appropriate care	41%
Water, Sanitation, and Hygiene	
Percent of population with access to Improved Water Source**	77%
Percent of population with access to Improved Sanitation**	28%

* Census International Database
** Joint Monitoring Programme for Water Supply and Sanitation 2008 Report
*** This number is based only on mothers whose last live birth occurred outside a health facility in the 5 years preceding the survey.
(Unless otherwise noted, the data source is the 2005 Demographic and Health Survey.)

Sudan MCH Program Description

Overall MCH and health sector situation

Sudan's population is estimated at 40.2 million (2005). Although OFDA works throughout Sudan, USAID's development program (including health) is focused on Southern Sudan. After decades of civil war, Southern Sudan faces formidable health challenges. Health statistics are very bleak. The IMR is 102/1,000; the U5MR is 135/1,000; the MMR is 2,037/100,000; and the total fertility rate is 5.9. The percent of children fully immunized at 1 year of age is only 2.7 percent. Vitamin A coverage in children under 5 is 40 percent, and only 10 percent of births are delivered by an SBA.

Health services cover approximately 38 percent of the country, leaving clinical or outreach services inaccessible to the majority of the population. HIV/AIDS is an emerging threat due to risky sexual behaviors and Sudan's proximity to the regional pandemic. Family planning use is 1 percent.

Water and sanitation infrastructure is nonexistent or marginal at best, and sanitation and hygiene practices are extremely poor. A wide range of neglected tropical diseases that are controlled elsewhere are endemic in Southern Sudan.

MCH interventions at the Mission level

USAID's largest program investment – Sudan Health Transformation Project (SHTP) – provides support to eight NGOs through a network of more than 99 health facilities and includes the provision of MCH and water and sanitation activities to approximately 1.5 million people. In addition to water and sanitation services, the program focuses on seven high-impact interventions: 1) immunizations; 2) vitamin A; 3) antenatal care; 4) LLINs; 5) case management of malaria; 6) case management of acute respiratory illness; and 7) treatment of diarrhea with ORT.

Delivery approaches and mechanisms supporting expanded coverage/use of interventions

With a nascent health system, USAID and other donors are working closely with MOH to provide the assistance to formulate policies and programs to harmonize health service delivery as the country transitions from emergency to developing. Since health care services are primarily offered by NGOs with a range of organizational policies, standards, and interventions, working toward a standardized health care system with uniform services is extremely challenging.

Although all levels of the health care system need strengthening, USAID focuses support primarily at the community and county levels. Building community responsibility for health care and concomitant outreach services is USAID's strategic approach. To focus directly on the community and community-based services is critical in an environment with a skeletal health system and high burden of preventable diseases. Building the capacity of the county health department is also a fundamental aspect of USAID's approach toward sustainable health care in Southern Sudan.

Specific actions supported as part of the MCH approach

Since limited training/education occurred during the decades of civil war and most health professionals left the country, the dearth of human capacity is a significant issue. The USAID/Capacity Project (with other donors) undertook a human capacity assessment in the health sector and is currently working with the MOH Human Resources Director to define health cadres and

outline position descriptions and training needs. USAID is also providing assistance with the HMIS and is working with the Government of Southern Sudan on health surveillance. A significant part of USAID's health program is to strengthen human capacity.

The USAID program's geographic focus

USAID/Sudan's fragile states strategy focuses the Mission program on the three main cities and areas with a concentration of returnees and refugees.

USAID's program mandate is to build government capacity to deliver health services while working with other partners and donors.

The Mission program's relationship to the country's health sector and development plans and strategies

Since 2002, from the emergence of the Secretariat of Health (predecessor to the MOH) to establishing an MOH, USAID has worked closely with government health officials. MOH's strategy and plans are the blueprint for any USAID health activities.

Potential for linking Mission MCH resources with other health sector resources and initiatives

The World Bank-administered Multi-Donor Trust Fund (MDTF) has awarded contracts to one NGO per state to improve primary health care, referral hospitals, water, and sanitation for four of the 10 Southern Sudan states. These funds will be matched by a one-third contribution from the MOH.

UNICEF is the primary source for vaccines and contributes significantly in strengthening health systems through training community-based health workers, developing behavior change messages, materials, and health aids.

USAID collaborates with the World Health Organization primarily on polio eradication, but also to conduct national campaigns against measles. WHO also provides TB and laboratory technical assistance to MOH to strengthen capacity on epidemic preparedness and response. TB drugs for the national program are funded by Norway and the Global Fund to Fight AIDS, Tuberculosis and Malaria. Medecins Sans Frontieres provides TB drugs in its target areas. The Global Fund has also recently approved a $74 million grant for the next 5 years to strengthen malaria services throughout Southern Sudan.

With USAID and WHO assistance, MOH has successfully secured GAVI funding for health systems strengthening ($11 million). WHO has also worked with MOH to secure GAVI funds for immunization service strengthening.

In the past several years, UNFPA has provided some contraceptives, reproductive health kits, and training in emergency obstetrics and fistula repair in selected sites in Southern Sudan. The next strategic plan (2008–2011) will focus on reproductive rights, population and development, and gender equality. Through Population Services International, the United Kingdom provides social marketing of commodities and technical assistance.

MOH has convened a Roll Back Malaria partnership with international partners to improve coordination. Also, MOH has developed a joint malaria control program for FY08 and secured pledges from various donors to procure and distribute more than 2 million ITNs during the World Malaria Day campaign.

The Carter Center collaborates with other implementing partners to eradicate Guinea worm, onchocerciasis, lymphatic filariasis, and trachoma from Southern Sudan. Organizations such as MSF-Holland, MEDAIR, Malteser, and International Medical Corps work with MOH to prevent and control visceral leishmaniasis (Kala-Azar) and trepanosomiasis (sleeping sickness).

Planned results for the Mission's MCH investments over the next 5 years

USAID/Sudan is currently re-examining its MCH programs, but plans to contribute to a 5 percent reduction in child mortality in the next 5 years.

MCH COUNTRY SUMMARY: SUDAN	VALUE
MCH FY08 BUDGET	12,399,000 USD
Country Impact Measures	
Number of births annually**	1,225,000
Number of under-5 deaths annually	165,000
Neonatal mortality rate (per 1,000 live births)	52
Infant mortality rate (per 1,000 live births)	102
Under-5 mortality rate (per 1,000 live births)	135
Maternal mortality ratio (per 100,000 live births)	2,037
Percent of children underweight (moderate/severe)***	31%
Birth Preparedness and Maternity Services	
Percent of women with at least one antenatal care (ANC) visit	40%
Percent of women with at least four antenatal care (ANC) visits	N/A
Percent of women with a skilled attendant at birth	10%
Percent of women receiving postpartum visit within 3 days of birth	N/A
Newborn Care and Treatment	
Percent of newborns whose mothers initiate immediate breastfeeding	N/A
Immunization	
Percent of children fully immunized at 1 year of age	3%
Percent of DPT3 coverage	24%
Percent of measles coverage	43%
Maternal and Young Child Nutrition, Including Micronutrients	
Percent of mothers receiving iron-folate	N/A
Percent of children receiving adequate age-appropriate feeding****	29%
Percent of children under age 5 receiving vitamin A supplement in the past 6 months	40%
Percent of children under 6 months exclusively breastfed	20%
Treatment of Child Illness	
Percent of children with diarrhea treated with ORT	64%
Percent of children with diarrhea treated with zinc	N/A
Percent of children with pneumonia taken to appropriate care	88%
Water, Sanitation, and Hygiene	
Percent of population with access to improved water source*	70%
Percent of population with access to improved sanitation*	35%

* Joint Monitoring Programme for Water Supply and Sanitation 2008 Report ** State of the World's Children 2008 ***Data are for all Sudan **** These data are weighted average of 6–7 and 8–9 months.
(Unless otherwise noted, the data are for Southern Sudan and the data source is the MICS Sudan Household Health Survey 2007.)

Tanzania MCH Program Description

Overall MCH and health sector situation

Tanzania has a population of about 40 million people; 88 percent are poor and live in rural areas. The country was ranked 159 out of 177 countries in the 2005 United Nations Human Development Index. Tanzania embarked on a fundamental political and economic transformation in the early 1990s and now sustains annual economic growth rates that are among the highest in sub-Saharan Africa. Life expectancy was 65 in 1990 and is now 44, and is expected to drop to 37 by 2010, largely due to a 7 percent HIV/AIDS infection rate and endemic malaria. On the Tanzania mainland and on Zanzibar, the MMR has remained high for the last 10 years without any decline (578 per 100,000 live births). Although infant and child mortality have been reduced by an impressive 31 percent and 24 percent, respectively, in just 5 years, neonatal mortality remains high (32 per 1,000 live births) and accounts for 47 percent of the IMR. The TFR is 5.7.

Over the past year and a half, the Ministry of Health and Social Welfare (MOHSW), the president of Tanzania, and the donor community have performed a great deal of advocacy and policy efforts both nationally and internationally to accelerate achievement of the MDGs for reducing maternal, newborn, and child deaths in Tanzania. As a result, two key strategies are in place: Tanzania Vision 2025, the National Strategy for Growth and Reduction of Poverty (NSGRP-MKUKUTA), and the Primary Health Services Development Program (PHSDP-MMAM) (2007–2017) to ensure fair, equitable, and quality services at the community level. Also, the National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn, and Child Death in Tanzania (2008–2015) was developed and outlines a strategic framework with activities and numerical goals for maternal, newborn, and child health "to improve coordination of interventions and delivery of services" with the following objectives:

- To reduce MMR from 578 to 193 per 100,000 live births
- To reduce neonatal mortality from 32 to 19 per 1,000 live births

The Government of Tanzania is decentralizing the health sector by delegating planning, budgeting, and implementation to districts. An essential package of health interventions is funded by both the government and donors by a sectorwide approach, including government agencies, the donor partner group for health (USG is an active member), and civil society. Most donors have switched modalities to basket funding or general budget support, leaving USG as the major bilateral donor of projects.

MCH interventions at the Mission level

The range of interventions currently supported by the Mission include FANC, IMCI, vitamin A supplementation, malaria control, zinc and ORT for diarrhea treatment, and family planning. All of these programs – with the exception of in-service training through zonal training centers, which cover half the country – provide national coverage or are in the process of being scaled up to national coverage. The biggest impacts on reducing maternal and child mortality are being provided by the family planning and malaria programs, as malaria is the largest killer of children in Tanzania.

As a new MCH priority country, the Mission is preparing a new 5-year strategy to introduce components of basic emergency obstetric care and immediate newborn

care in health centers and dispensaries. Potential activities are 1) advocacy for national policies supportive of emergency obstetric care at lower-level facilities; 2) integrated immediate newborn care and safe birth practices in preservice and in-service training programs; and 3) logistical support for equipment and supplies for maternity services. The Misson's water supply and sanitation programs will expand and build on activities previously achieved under the Water and Development Alliance (USAID and Coca-Cola Foundation GDA) by expanding safe water access and basic sanitation services for schools and health facilities.

Delivery approaches and mechanisms supporting expanded coverage/use of interventions

The Mission focuses on training and supporting supervision of the decentralized health systems at the district (hospital) level for FANC and subdistrict levels (health centers and health posts) for all other activities. For capacity building and sustainability, the Mission works with zonal training centers and also upgrades midwifery preservice training. The Mission's public-private partnerships include social marketing for contraceptives, zinc and ORS, and ITNs. Additional planned activities include community outreach through support to a national community-based primary health care program.

Specific actions supported as part of the MCH approach

The MOHSW decentralized health system is being strengthened in areas of planning, budgeting, supervision and monitoring. The Mission supported the development of a quality improvement system for FANC that will be adapted for other areas. The Norwegian government has been providing support to the MOHSW to adopt an incentive-based scheme to improve performance of providers in support of attaining the MDGs for maternal and child survival. This system is in an early stage of development.

The USAID program's geographic focus

The FANC program is being scaled up nationwide in a phased approach. Most of the regions and districts have been covered. Other child survival activities have also been supported at the national level. Direct support to three zonal training centers covers half the country for training of health care providers in MCH, FP/RH, and malaria.

The Mission program's relationship to the country's health sector and development plans and strategies

The Mission supports the MOHSW health sector strategies listed above.

Potential for linking Mission MCH resources with other health sector resources and initiatives

USG investments (e.g., PMI, PEPFAR, Title II, OFDA, water, etc.)

The FANC program is co-funded with malaria funds as it addresses malaria in pregnancy. The leveraging of PMI monies to support a national program in FANC is synergistic as two of the main PMI interventions – ITNs and IPTp – can be successfully promoted through a strong antenatal care program.

The new maternal and child health activity is being designed with and will receive support from the PEPFAR program as well as PMI. The Mission will harness synergies of funds in maternal and newborn survival especially through PMTCT and postnatal care-type interventions that could cross the continuum of maternal and newborn vulnerabilities through postnatal life.

Investments and initiatives of other donors and international organizations

Other donor-funded projects include UNICEF and Canadian support for vitamin A; Danish support for health logistics; Japanese support for systems development; Dutch and German support for contraceptive social marketing; and Norwegian support for health workers via pay for performance. Other donors support health basket funding that is leveraged by the Mission's interventions.

Planned results for the Mission's MCH investments over the next 5 years

Within the next 5 years, results will include reduction of MMR (currently 578/100,000) by 10 percent and U5MR (currently 112/1,000) by 25 percent, and increase in contraceptive prevalence (currently 20 percent) by 1 percent per year.

MCH COUNTRY SUMMARY: TANZANIA	VALUE
MCH FY08 BUDGET	5,693,000 USD
Country Impact Measures	
Number of births annually*	1,418,000
Number of under-5 deaths annually	159,000
Neonatal mortality rate (per 1,000 live births)	32
Infant mortality rate (per 1,000 live births)	68
Under-5 mortality rate (per 1,000 live births)	112
Maternal mortality ratio (per 100,000 live births)	578
Percent of children underweight (moderate/severe)	22%
Birth Preparedness and Maternity Services	
Percent of women with at least one antenatal care (ANC) visit	97%
Percent of women with at least four antenatal care (ANC) visits	59%
Percent of women with a skilled attendant at birth	46%
Percent of women receiving postpartum visit within 3 days of birth***	13%
Newborn Care and Treatment	
Percent of newborns whose mothers initiate immediate breastfeeding	25%
Immunization	
Percent of children fully immunized at 1 year of age	62%
Percent of DPT3 coverage	86%
Percent of measles coverage	80%
Maternal and Young Child Nutrition, Including Micronutrients	
Percent of mothers receiving iron-folate	61%
Percent of children receiving adequate age-appropriate feeding	91%
Percent of children under age 5 receiving vitamin A supplement in the past 6 months****	92%
Percent of children under 6 months exclusively breastfed	41%
Treatment of Child Illness	
Percent of children with diarrhea treated with ORT	70%
Percent of children with diarrhea treated with zinc	0%
Percent of children with pneumonia taken to appropriate care	57%
Water, Sanitation, and Hygiene	
Percent of population with access to improved water source**	55%
Percent of population with access to improved sanitation**	33%

* Census International Database
** Joint Monitoring Programme for Water Supply and Sanitation 2008 Report
*** This number is based only on mothers whose last live birth occurred outside a health facility in the 5 years preceding the survey.
****TNFC/HKI database on vitamin A coverage in mainland Tanzania, updated March 2008
(Unless otherwise noted, the data source is the 2004 Demographic and Health Survey.)

Uganda MCH Program Description

Overall MCH and health sector situation

Uganda has a population of about 29.5 million, 53 percent of whom are below the age of 15 and of whom only 12 percent live in urban areas. Annual health expenditures are $77 per capita (UNDP, 2005). Uganda has benefited from increased peace and stability with relatively high economic growth. Poverty is now at 31 percent; life expectancy has increased to 50 years; and the national primary school enrollment level is more than 90 percent. Yet, the nation still faces major development challenges. Although Uganda has universal primary and secondary education, the quality of education is still quite poor. Uganda ranked 154 out of 177 countries on the 2007–2008 United Nations Human Development Index. Adult HIV/AIDS prevalence has dropped from historical highs but remains at 6.4 percent. Food insecurity affects 60 percent of the population in northern Uganda.

While MCH funding has had limited national impact, there still have been declines in U5MR, from 162 to 137 per 1,000 in the last 5 years. The high infant morality rate of 71/1,000 live births, out of which 27/1,000 live births are neonatal deaths, reflects the need to capitalize on primary care opportunities for children at birth and in the first year of life. Similarly, the MMR (435 per 100,000 live births) has not declined in the past decade. Exacerbating this, the TFR has remained high at 6.7 children per woman, primarily due to a variety of factors, including lack of access, cultural desire for more children, and early initiation of sexual intercourse, with the latter being the lesser of the factors, and lack of access and cultural desire for more children being the more prominent. Many of these problems are linked, at least in part, to limited service delivery in rural areas reaching the community and household levels, and to the quality of the services that do reach them.

MCH interventions at the Mission level

Priority areas of intervention include nutrition including vitamin A capsule supplementation, folate and iron supplementation during pregnancy, and local food fortification; hygiene improvement; strengthening delivery of immunization services; and community treatment of fever and diarrhea in children under 5. The new initiatives are expanding the nutrition program to include breastfeeding, complementary child feeding, and growth promotion and monitoring; management of obstetrical fistula; and systems strengthening for logistics management. All the interventions are national except the vitamin A supplementation and iron folic acid, which focus on 12 districts, representing 15 percent of the total population. Reducing maternal mortality is another priority area for the Government of Uganda, and one in which USAID wants to strengthen its programming, with a strong focus on reducing the occurrence of postpartum hemorrhage specifically. Postpartum hemorrhage is the second major killer of mothers in Uganda. Programmatic interventions include training of service delivery providers, particularly to perform AMTSL on all delivering mothers, including Misoprostol use, and health communication.

Delivery approaches and mechanisms supporting expanded coverage/use of interventions

Due to the concern that the long fight against HIV/AIDS has placed a strain on basic primary care and that improvements in mortality will not be sustained, greater attention is being directed at revitalizing and expanding basic primary health care services, such as immunizations and modern contraception methods. Village health teams, community medicine distributors,

and reproductive health assistants operate within all districts. Community medicine distributors are linked to primary health facilities. Social marketing focuses on nutrition, diarrhea, and malaria. This work is being transitioned to the indigenous Uganda Health Marketing Group.

Specific actions supported as part of the MCH approach

USAID's support in MCH also focuses on strengthening health systems and quality of care, including support for Uganda's expanded program for immunization, national medical stores for pharmaceutical supply chain management, and the MOH's work to increase recruitment, retention, and quality of health personnel.

The USAID program's geographic focus

The USAID program operates at both national and district levels; there are 83 districts in Uganda. The maternal health interventions are districtwide, and will roll out in up to 20 districts, to be selected upon award of the new RH/CS RFA and expected to represent 25 percent of the population of women of childbearing age and their children under 5.

The Mission program's relationship to the country's health sector and development plans and strategies

USAID contributes to the GOU health sector through the SWAp and the 2005/06–2009/10 HSSP II. USAID programs are implemented through the SWAp coordination mechanisms for policy development, planning, and monitoring. Reduction of maternal mortality is a key national priority to which donor partners are expected to contribute.

Potential for linking Mission MCH resources with other health sector resources and initiatives

USG investments (e.g., PMI, PEPFAR, Title II, OFDA, water, etc.)

The USAID MCH program works closely with PEPFAR and PMI in Uganda. Uganda serves as a worldwide model for combating HIV/AIDS and has moved toward integrated health programs for FP, MCH, malaria, and HIV. Uganda receives substantial HIV/AIDS resources as a PEPFAR country. These resources have contributed to connecting PMTCT and highly active antiretroviral therapy with antenatal care and delivery. Through PMI and PEPFAR, resources are leveraged to support IPT for pregnant women through the PMTCT service points. PMI and MCH resources are used to provide ITNs for children and pregnant women, home-based management of fever for children, and the biannual child days for delivery of a package of child and women's services such as immunization, ITN distribution, vitamin A capsule supplementation, and deworming. All districts have functional village health teams and community medicine distributors, which have been strengthened by PMI, NTD, and Government of Uganda funding. They have been trained in vitamin A capsule distribution as well as home-based management of fever. There is potential for distribution of iron and folate supplementation and ORS/zinc through these health workers. The PMI primarily targets pregnant women and children under 5 with treated bednets; pregnant women receive IPT; and although all people benefit from ACT, the main focus is pregnant women and children under 5.

Investments and initiatives of other donors and international organizations

The MOH works with USG and others through the SWaP coordination mechanisms and the HSSP II. Donors coordinate through the Health Development Partners group. The Government of Uganda and donors subscribe to one coordination and monitoring mechanism. USAID leverages other global alliances, such as GAVI, The Global Fund, and Global Alliance for Improved Nutrition (GAIN), to mobilize and implement CS and MH integration.

Planned results for the Mission's MCH investments over the next 5 years

Short-term outcomes are improved coverage for immunization, vitamin A supplementation, ORS/zinc, improved management of postpartum hemorrhage, institutional deliveries, and newborn care. Long-term outcomes are reductions in maternal and U5MR rates, reduced diarrhea case fatality rates, improved assisted deliveries, improved full immunization coverage, improved nutritional status of under-5 children, and reduced rates of micronutrient malnutrition.

MCH COUNTRY SUMMARY: UGANDA	VALUE
MCH FY08 BUDGET	5,447,000 USD
Country Impact Measures	
Number of births annually*	1,404,000
Number of under-5 deaths annually	192,000
Neonatal mortality rate (per 1,000 live births)	27
Infant mortality rate (per 1,000 live births)	71
Under-5 mortality rate (per 1,000 live births)	137
Maternal mortality ratio (per 100,000 live births)	435
Percent of children underweight (moderate/severe)	23%
Birth Preparedness and Maternity Services	
Percent of women with at least one antenatal care (ANC) visit	95%
Percent of women with at least four antenatal care (ANC) visits	46%
Percent of women with a skilled attendant at birth	46%
Percent of women receiving postpartum visit within 3 days of birth	23%
Newborn Care and Treatment	
Percent of newborns whose mothers initiate immediate breastfeeding	25%
Immunization	
Percent of children fully immunized at 1 year of age	36%
Percent of DPT3 coverage	64%
Percent of measles coverage	68%
Maternal and Young Child Nutrition, Including Micronutrients	
Percent of mothers receiving iron-folate	63%
Percent of children receiving adequate age-appropriate feeding	80%
Percent of children under age 5 receiving vitamin A supplement in the past 6 months	36%
Percent of children under 6 months exclusively breastfed	60%
Treatment of Child Illness	
Percent of children with diarrhea treated with ORT	56%
Percent of children with diarrhea treated with zinc	1%
Percent of children with pneumonia taken to appropriate care	73%
Water, Sanitation, and Hygiene	
Percent of population with access to improved water source**	64%
Percent of population with access to improved sanitation**	33%

* Census International Database
** Joint Monitoring Programme for Water Supply and Sanitation 2008 Report
(Unless otherwise noted, the data source is the 2006 Demographic and Health Survey.)

Zambia MCH Program Description

Overall MCH and health sector situation

With a population of approximately 12 million, Zambia ranked 165 out of 177 countries on the 2005 United Nations Human Development Index. Zambia, a low-income country in southern Africa (GDP per capita is $336), has serious health issues to address, with a high HIV prevalence rate of 14.3 percent among adults, 96 percent of the population at risk for malaria, and stubbornly high rates of child malnutrition. However, Zambia does receive significant U.S. government funding from PEPFAR and PMI. Zambia faces many of the same health systems challenges as its sub-Saharan Africa and low-income peers.

Life expectancy is low at 38 years, compared with 49 years for sub-Saharan Africa and 53 for other low-income countries. U5MR has decreased substantially over the past 5 years. The 2007 DHS estimates that U5MR was 119 per 1,000 live births during the 5-year period before the survey compared to 168 per 1,000 in 2001–2002. Maternal mortality was 729 per 100,000 in 2001–2002. Fertility is high at 6.2, and modern method contraceptive prevalence, at 32.7 percent in 2007, was relatively higher than the sub-Saharan Africa average of 23.4 percent. A major gap confronting all aspects of the health program area is fundamental human capacity constraints that hinder service delivery within the Zambian health system. USAID activities in all program elements are designed to address this constraint.

MCH interventions at the Mission level

USAID's MCH activities in Zambia include support for birth preparedness, emergency obstetric and neonatal care, IMCI at community and facility levels, micronutrient supplementation, maternal and young child nutrition, household-level water purification, and strengthened essential medicines logistics systems. These activities are implemented across the nation. The Zambia MCH portfolio is undergoing a strategic review in preparation for new procurements and some change is expected.

Delivery approaches and mechanisms supporting expanded coverage/use of interventions

USAID supports capacity building and training of MOH staff and strengthening service delivery and logistics systems at the primary health care level. The program includes a BCC component, strategic information management, policy development, and dissemination across all program elements. A new integrated follow-on social marketing activity using FY 2008 funds will include a component to increase access to maternal child health commodities such as POU water disinfectants, as well as increase access to HIV services and family planning commodities.

Specific actions supported as part of the MCH approach

USAID's support in MCH strengthens decentralized health systems and quality of care. The portfolio includes an ongoing nonproject assistance grant to the Ministry of Finance and National Planning to fund MCH interventions in all 72 districts. Technical assistance to develop MCH policies and systems and BCC are part of the program.

The USAID program's geographic focus

The USAID/Zambia MCH program is focused at different levels, depending on the intervention. Community-level BCC activities are focused in 22 districts across the nine

provinces that contain approximately 30 percent of Zambia's population. Social marketing, IMCI, micronutrient supplementation, policy and systems development, and logistics systems improvements are implemented nationwide.

The Mission program's relationship to the country's health sector and development plans and strategies

The Government of Zambia has in place a National Health Strategic Plan (NHSP) for 2006–2011 as well as multiple health system programs and activities. USAID works closely with MOH and adheres to the NHSP. Every year, MOH leads a national planning process in collaboration with all donors and provinces and district health offices to ensure that activities implemented at all levels are identified and costed. USAID partners take part in this annual exercise.

Potential for linking Mission MCH resources with other health sector resources and initiatives

USG investments (e.g., PMI, PEPFAR, Title II, OFDA, water, etc.)

Zambia receives significant funding from PEPFAR and PMI. The USG complements the National Malaria Strategic Plan (NMSP) by supporting activities to deliver proven, cost-effective interventions that focus on children under 5 and pregnant women.

ANC services incorporate both HIV/AIDS and malaria services. Both PMI and PEPFAR have provided technical support, training, and supplies to improve the quality and uptake of ANC services. Specifically, PMI supports IPTp, procurement and distribution of bed nets to pregnant women through the malaria in pregnancy program, and improved detection and case management of malaria in infants and young children. PEPFAR supports improvement of ANC for PMTCT as well as infant follow-up, early HIV/AIDS diagnosis, and linkages to care and treatment.

The PMI/PEPFAR teams work closely together to establish other areas of programmatic synergy. USAID is applying its experience with ARVs and HIV test kits to malaria-related commodities and essential drugs. In terms of monitoring and evaluation, the Smart Card is a PEPFAR-supported activity that has the potential to create a national medical record for patients with HIV/AIDS. A malaria module is being developed that will hopefully be in place in 2009 and make patient-level data available for monitoring and evaluation purposes. Future areas for collaboration that may be explored include supply chain strengthening, FANC, monitoring and evaluation, and diagnostics.

Investments and initiatives of other donors and international organizations

The government prefers support in the form of pooled funding or sector budget support provided to the Ministry of Finance and National Planning that is then passed on to MOH. Relatively few donors, such as the USG, World Bank, Global Fund, and JICA, provide substantial financial resources outside the pooled funding mechanisms. Major pooling contributors include the Netherlands, EU, UK, Sweden, and Canada. Across program elements, WHO provides technical assistance, while the other UN agencies such as UNICEF or UNFPA provide technical assistance and/or commodities in their program element areas. Two foundations provide important support: the Gates Foundation for monitoring and evaluation of malaria activities, and the Clinton Foundation for the procurement of pediatric ARVs. The Clinton Foundation is also moving into support for human resources for health.

Regardless of funding mechanisms, the Zambian health sector has a highly orchestrated and robust donor collaboration process. More than 15 technical working groups exist in the health sector donor division of labor, complemented by six theme groups in HIV/AIDS. Donor, MOH, and implementing partner representatives participate in all groups. All donors have pledged to support MOH's strategic plans. Through the working group meetings, these strategies are developed and donor contributions are discussed, coordinated, and leveraged. The malaria supply chain intervention discussed above is a joint activity, in collaboration with the World Bank.

Planned results for the Mission's MCH investments over the next 5 years

USAID's maternal and child health goals are in line with the Government of Zambia's national goals to reduce mortality by 25 percent and 20 percent, respectively.

MCH COUNTRY SUMMARY: ZAMBIA	VALUE
MCH FY08 BUDGET	7,435,000 USD
Country Impact Measures	
Number of births annually*	450,000
Number of under-5 deaths annually	54,000
Neonatal mortality rate (per 1,000 live births)	37
Infant mortality rate (per 1,000 live births)****	74
Under-5 mortality rate (per 1,000 live births)****	119
Maternal mortality ratio (per 100,000 live births)	729
Percent of children underweight (moderate/severe)	30%
Birth Preparedness and Maternity Services	
Percent of women with at least one antenatal care (ANC) visit	94%
Percent of women with at least four antenatal care (ANC) visits	71%
Percent of women with a skilled attendant at birth	43%
Percent of women receiving postpartum visit within 3 days of birth***	12%
Newborn Care and Treatment	
Percent of newborns whose mothers initiate immediate breastfeeding	51%
Immunization	
Percent of children fully immunized at 1 year of age	57%
Percent of DPT3 coverage	80%
Percent of measles coverage	84%
Maternal and Young Child Nutrition, Including Micronutrients	
Percent of mothers receiving iron-folate	71%
Percent of children receiving adequate age-appropriate feeding	87%
Percent of children under age 5 receiving vitamin A supplement in the past 6 months	67%
Percent of children under 6 months exclusively breastfed	40%
Treatment of Child Illness	
Percent of children with diarrhea treated with ORT	67%
Percent of children with diarrhea treated with zinc	N/A
Percent of children with pneumonia taken to appropriate care	69%
Water, Sanitation, and Hygiene	
Percent of population with access to improved water source**	58%
Percent of population with access to improved sanitation**	52%

* Census International Database
** Joint Monitoring Programme for Water Supply and Sanitation 2008 Report
*** This number is based only on mothers whose last live birth occurred outside a health facility in the 5 years preceding the survey. The value reported is the percent of women receiving postpartum visit within 2 days of delivery.
**** Preliminary Demographic and Health Survey 2007
(Unless otherwise noted, the data source is the 2001-02 Demographic and Health Survey.)

Maternal and Child Health Strategic Approach – Asia

Objectives

By 2013, USAID will work with national governments and national and international partners in Asia to implement sustainable approaches in MCH priority countries that will help improve equitable health services with an aim to:

- Decrease U5MR by 25 percent
- Decrease MMR by 25 percent
- Decrease malnutrition by 15 percent
- Increase skilled attendance at birth by 15 percent in the two lowest quintiles

MCH Priority Countries	
AFGHANISTAN	NEPAL
BANGLADESH	PAKISTAN
CAMBODIA	PHILIPPINES
INDIA*	TAJIKISTAN
INDONESIA	

Problem statement

The Asia region is characterized by high, but falling, fertility and mortality rates and widespread malnutrition. Improvements have not been fast enough and countries, by and large, are not on track to meet MDGs 4 and 5. As progress has been achieved, neonatal mortality has become a proportionately more significant portion of child mortality. Hemorrhage is the biggest killer of childbearing women. In most countries in the region, maternal and child health has not kept pace with economic growth. Countries supported by USAID with CSH funding in maternal and child health display wide variability with respect to health and nutrition status indicators among and within countries. By nature of its large population, India has the greatest number of preventable maternal and child deaths in the world, even though parts of the country now have developed-world standards of health care.

What has been accomplished to date

Asia is a region that has recorded significant improvement in U5MR. In Afghanistan, there has been a reduction of U5MR by 25 percent over the past 5 years. Indonesia, Bangladesh, Nepal, Philippines, and India have reduced U5MR by more than half between 1990 and 2005. Likewise, there have been some successes in maternal mortality reduction, including Bangladesh and Indonesia. While low compared to the rest of the world, skilled attendance at birth is rising. Increasingly, governments are developing and implementing policies to strengthen health systems. Momentum for change and increased investment are evident in the surge of interest from multi-lateral, bilateral, and foundation partners and the involvement of governments in global and national partnerships to accelerate progress toward the maternal and child survival MDGs.

Challenges

The major challenges for USAID's MCH programs in the region include:

- Large population and population momentum
- Poverty
- Urbanization
- Rich-poor disparities
- In South Asia, the lowest per capita MCH spending in the world
- High use of unregulated private sector services
- Gender inequity resulting in excess female child deaths
- Conflict and frequent natural disasters

*Given India's size, the following states will be MCH priority areas rather than the whole country: Uttar Pradesh, Uttaranchal, and Jharkhand.

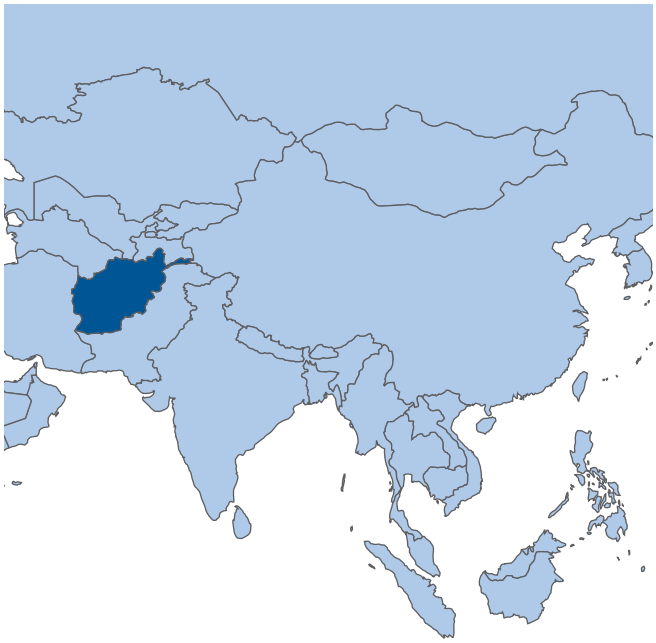
Overall, in Asia, 65 percent of health services are provided by the private sector. There is a relatively low proportion of public health expenditures with respect to overall government expenditures compared with other parts of the developing world. The health systems infrastructure is variable. Human resources are inadequate and often poorly distributed. Drugs and commodities are insufficient, although drug policy, including attention to antimicrobial resistance, is beginning to be addressed. Health information systems differ widely and in many places are inadequate for monitoring, evaluation, and quality improvement.

Strategies

USAID designs country programs according to the epidemiology, strength of health systems in place, commitment of government and all partners, and resources available. In the Asia region, Missions will include the following strategies:

- Leverage country and other resources through policies and technical assistance to promote expansion of high-impact interventions linked with health system strengthening for sustainability in public and private sectors
- Integrate maternal, newborn, and child health programs with family planning and, where possible, with infectious disease programs to reduce cost and improve services for mothers, newborns, and children
- Promote home-based essential newborn care and community-based management of newborn infections to reach the vast majority of newborns who do not have access to care
- Promote community-based care in prevention and treatment of illness and malnutrition to reach the most vulnerable
- Work with partners to scale up evidence-based best practices in MCH
- Emphasize programming approaches that address gender, religious and cultural beliefs, and practices that currently affect use of life-saving services
- Expand services in poor urban areas
- Identify approaches to improve use and delivery of services in both the public and private sector through research and documentation, and use results to inform programs in the country and region
- Advance financing approaches that align incentives with performance and health outcomes
- Promote increased MCH public expenditures on health through policy dialogue
- Enhance and utilize alliances and donor coordination to provide synergy and prevent overlap in use of scarce resources
- Especially in countries in conflict/post-conflict or affected by natural disaster, link with other USAID and USG investments and support flexible programming that delivers high-impact interventions while building local capacity

Afghanistan MCH Program Description



Overall MCH and health sector situation

Afghanistan has an estimated population of 26 million people, with more than 43 percent of the population under the age of 15; 28 percent of adults are literate; 53 percent of Afghans live below the poverty line; and 40 percent are unemployed. Decades of war and misrule have resulted in a country with a demolished infrastructure and some of the highest maternal and child mortality rates, as well as infectious disease rates, in the world.

MMR is estimated at 1,600 deaths per 100,000 live births. U5MR is also high, at 191/1,000, but this represents a 26 percent decline since the fall of the Taliban. Prenatal care coverage has increased to 32 percent and DPT-3 coverage has increased to 35 percent. The contraceptive prevalence rate is currently 16 percent. The quality of care in publicly financed facilities, as measured by independent health facility assessments, increased by about 22 percent from 2004 to 2006. Administrative data indicate that the number of functioning primary health care facilities has increased 39 percent, from 912 in 2002 to 1,485 in 2008, and that the proportion of facilities with at least one skilled female health worker has increased from 39 percent in 2002 to 73 percent in 2007.

The most significant challenges to Afghanistan's health care system are insecurity, lack of female health care providers, and cultural and geographical inaccessibility. However, the most significant opportunities are the use of community "shuras" and CHWs and the strength and public health orientation of the health leadership in the country.

MCH interventions at the Mission level

The Ministry of Public Health's main strategy is to deliver a BPHS through NGOs working throughout the country, primarily in rural areas. The BPHS includes antenatal care, including tetanus toxoid immunization, iron folate supplementation, and treatment of intestinal parasites; delivery care, including infection prevention, monitoring of labor, and prevention of postpartum hemorrhage; recognition, referral, and treatment of obstetric complications; postpartum care, including family planning, breastfeeding, and micronutrient supplementation; and childcare, including essential newborn care, treatment of newborn complications, immunization, vitamin A supplementation, and case management of diarrhea and acute respiratory infection. Since 2003, coverage of these basic services has increased from 9 percent to 82 percent of the population (66 percent of the population is within 2 hours walking distance to the nearest service delivery point).

More than 7 million people (out of a target population of 12 million) use services provided through USAID-supported implementation of the BPHS and Essential Package of Hospital Services (EPHS) in 13 provinces.

Delivery approaches and mechanisms supporting expanded coverage/use of interventions

The USAID strategy to support the MOH in rebuilding the health sector has been a balanced approach to expand services through the BPHS, to strengthen human and systems capacities at central and provincial levels, and to improve infrastructure. The main component of this strategy has been the rollout of the BPHS, delivered primarily through a network of primary care facilities run by NGOs. USAID also supports improving quality of care; strengthening the engagement of the private sector; building human, institutional, and infrastructure capacities at all levels; and scaling up

implementation of cutting-edge and proven clinical and community-based interventions. Additionally, USAID provides contraceptives and essential drugs for primary health care and supports a program of social marketing of contraceptives and health products linked with a BCC program. Ongoing infrastructure improvements include repair of existing facilities and construction of one 50-bed maternity hospital, two 100-bed hospitals, two comprehensive health clinics, and three midwife training centers for preservice and in-service training.

Specific actions supported as part of the MCH approach

USAID is supporting the preservice training and supervision of community health workers and midwives to meet the primary health care needs of a substantial portion of the Afghan population. USAID provides management training and technical assistance to provincial health authorities, establishes continuous quality improvement and quality assurance systems for health services, strengthens health management information systems, improves medical laboratories, and supports the creation of a national coordinated procurement and distribution system for contraceptives and drugs. In addition, USAID is supporting social marketing to increase access to and use of health products for women of reproductive age and children under 5 by working through the private sector in Afghanistan. USAID is also supporting the development of policies and partnerships between the public and private sectors to create an environment for the delivery of quality health services and products in the private sector.

The USAID program's geographic focus

USAID supports the delivery of the BPHS and EPHS in 13 of the country's 34 provinces, which represents a 38 percent geographic coverage and almost 50 percent population coverage. Other donors cover the remaining provinces. USAID supports provincial networks of care in more than 4,300 community health worker posts, more than 380 health facilities and district hospitals, and five provincial hospitals. In addition to supporting BPHS and EPHS, USAID is piloting implementation of cutting-edge, high-impact, proven interventions, such as community-based use of misoprostol to limit postpartum hemorrhage, and is facilitating a nationwide rollout. Through its projects, USAID is providing technical assistance to the central MOPH, supporting policy formulation and strategy development for nationwide impact.

The Mission program's relationship to the country's health sector and development plans and strategies

USAID and other donors' support are aligned with the national priorities set in the Public Health Strategy of the Afghanistan National Development Strategy (ANDS). USAID is supporting the MOPH to rebuild the health sector by focusing government efforts on stewardship of the health sector (opting to contract-out service delivery to NGOs), developing the BPHS and EPHS, prioritizing poor women and children, and coordinating donor support. The MoPH has established, and USAID sits on, both the Consultative Group for Health and Nutrition (CGHN) and Technical Advisory Group (TAG) which meet on a regular basis to coordinate activities of implementers, donors, and policymakers.

Potential for linking Mission MCH resources with other health sector resources and initiatives

USG investments (e.g., PMI, PEPFAR, Title II, OFDA, water, etc.)

USAID is the main USG agency implementing foreign assistance in the health sector, working with Health and Human Services (HHS) and Department of Defense (DOD). HHS/CDC supports Afghanistan's Public Health Institute (APHI) in the areas of disease surveillance and collection and use of epidemiological data, as well as quality improvement and an advanced obstetrics and gynecology training program at Rabia Balki Hospital (RBH) in Kabul. HHS is collaborating with DOD on a Quality Assurance C-section collaborative in Kabul. DOD has an Inter-Agency Agreement with HHS to assign U.S. public health service officers to advise and coordinate health activities by the Command Surgeon Directorates at CSTC-A and Regional Command (RC)-East to provide health care for members of the Afghan National Security Forces (ANSF) and their beneficiaries by integrating the ANSF with the civilian health care system. At the RC-East level, health activities that are supported are identified at the provincial level through the provincial development plans (PDPs) and coordinated with MOPH, USAID, and other donors at central and field levels. The Mission entered into an agreement with the Army Corps of Engineers to provide support for the design and construction of hospitals, clinics, midwife training centers, and provincial teacher resource colleges. More recently, a new multisectoral program to prevent and control diarrheal disease is being developed to address household drinking water and sanitation issues with MCH, OFDA, and DA resources.

Investments and initiatives of other donors and international organizations

The main donors supporting the MOPH are the USG, the World Bank, and the European Commission. The European Commission is supporting NGO delivery of BPHS in nine provinces, and the World Bank is supporting NGO delivery in eight provinces. The World Bank is also supporting MoPH delivery in three provinces, as a pilot to study the effectiveness of direct service delivery by MoPH. Combined, these two donors cover the provinces not covered by USAID for BPHS implementation. Both donors also provide management assistance to the central level of MoPH. Other donors in the health sector include various United Nations organizations, the Japanese International Cooperation Agency (JICA), the French Government, the Asian Development Bank, the Italian Government, privately funded NGOs, and other governments through their respective provincial reconstruction teams. Coordination of activities occurs at the provincial level through the provincial health coordination committees (PHCC) led by the provincial health director and through various working groups, steering committees, the CGHN, and TAG at the national level.

Planned results for the Mission's MCH investments over the next 5 years

The goal of the USG is to support the national efforts to meet Afghan National Development Strategy objectives and MDGs by reducing the MMR by 15 percent, the U5MR by 20 percent, and the IMR by 20 percent from 2000 baseline levels. In addition, type 1 polio transmission will be stopped, and the number of cases of type 3 polio will be reduced, with the ultimate goal of eradicating all types of polio from Afghanistan.

MCH COUNTRY SUMMARY: AFGHANISTAN	VALUE
MCH FY08 BUDGET	38,074,000 USD
Country Impact Measures	
Number of births annually*	1,285,000
Number of under-5 deaths annually	245,000
Neonatal mortality rate (per 1000 live births)****	60
Infant mortality rate (per 1000 live births)	129
Under-5 mortality rate (per 1000 live births)	191
Maternal mortality ratio (per 100,000 live births)******	1,600
Percent of children underweight (moderate/severe)***	39%
Birth Preparedness and Maternity Services	
Percent of women with at least one antenatal care (ANC) visit	32%
Percent of women with at least four antenatal care (ANC) visits	N/A
Percent of women with a skilled attendant at birth	19%
Percent of women receiving postpartum visit within 3 days of birth	N/A
Newborn Care and Treatment	
Percent of newborns whose mothers initiate immediate breastfeeding	37%
Immunization	
Percent of children fully immunized before their 2nd birthday	27%
Percent of DPT3 coverage	35%
Percent of measles coverage	63%
Maternal and Young Child Nutrition, Including Micronutrients	
Percent of mothers receiving iron-folate	29%
Percent of children receiving adequate age-appropriate feeding	28%
Percent of children under age 5 receiving vitamin A supplement in the past 6 months	80%
Percent of children under 6 months exclusively breastfed******	83%
Treatment of Child Illness	
Percent of children with diarrhea treated with ORT	N/A
Percent of children with diarrhea treated with zinc	N/A
Percent of children with pneumonia taken to appropriate care***	28%
Water, Sanitation, and Hygiene	
Percent of population with access to improved water source**	22%
Percent of population with access to improved sanitation**	30%

* Census International Database
** Joint Monitoring Programme for Water Supply and Sanitation 2008 Report
*** Multiple Indicators Cluster Surveys (MICS) 2003
**** State of the World's Children Report 2008
***** WHO Maternal Mortality Report 2007
****** Linda A Bartlett, et al. Maternal Mortality in Afghanistan: Magnitude, Causes, Risk Factors and Preventability, Afghanistan Ministry of Public Health, CDC, UNICEF 2002 MMR 1,600
Unless otherwise noted, the data source is the 2006 Afghanistan Health Survey.)

Bangladesh MCH Program Description

Overall MCH and health sector situation

Bangladesh has a population of approximately 150 million, 33 percent of whom are under age 15, and has by far the highest population density in the world, with over 2,600 persons per square mile. Life expectancy is 63 years. In 2003, the total expenditure on health represented 3.4 percent of the GDP. HIV prevalence remains less than 1 percent among high-risk groups. Substantial progress has been made in education over the last 20 years. Primary school enrollment has increased to 94 percent, the gender balance has improved, and public spending on education has expanded. Bangladesh ranks 139 out of 175 countries on the United Nations Human Development Index.

Bangladesh has achieved remarkable progress in population and health over the past 30 years and is one of six countries that are on track to achieve the MDG for reducing child mortality. In the last 15 years, U5MR has declined from 133 deaths per 1,000 live births to 65. This decline is mostly due to reduction in the child mortality rate from 50 to 14 and the post-neonatal mortality rate from 35 to 15. The neonatal mortality rate, however, remains high at 37, accounting for 57 percent of all under-5 deaths. Although maternal deaths continue to decline steadily, the MMR is still high at about 320 per 100,000 live births. Since the early 1970s, the TFR has declined from 6.3 children per woman to 2.7 in 2007, and the contraceptive prevalence rate has increased from 8 percent to 56 percent. However, unplanned pregnancies still account for 30 percent of all births. Improvements in the use of family planning and maternal and child health services are particularly low in some geographic areas of the country.

The Health, Nutrition, and Population Sector Program 2005–2010 (HNPSP) is a $3.1 billion program to increase quality and use of the Essential Service Package (ESP), which includes family planning, reproductive health, maternal and child health, selected communicable diseases and curative care, improved hospital services, nutritional services, and other selected services at affordable prices. Development partners' contributions to HNPSP account for 44 percent of the total budget of HNPSP; partners include DfID, EC, The World Bank, the Netherlands Government, CIDA, SIDA, and KfW. USAID provides its contribution as non-pooled, parallel funding, and the Government of Bangladesh provides its own contributions for the HNPSP. In addition, there are three newly funded UN projects, funded by DfID, the EC, and AusAID, that aim to reduce maternal and newborn mortality.

MCH interventions at the Mission level

The USAID program increases access to essential maternal health services, including antenatal and postnatal care, SBA, clean delivery, prevention of postpartum hemorrhage in facilities and home deliveries, and home-based newborn care practices. To contribute to the reduction in U5MR, USAID supports the prevention and management of pneumonia and diarrhea, immunizations, and vitamin A supplementation. The USG-assisted nutrition program will potentially reach over 200,000 children, about 2 million cases of child diarrhea will be treated, and approximately 48,000 people will be trained in maternal and child health and nutrition.

Delivery approaches and mechanisms supporting expanded coverage/use of interventions

USAID supports a social franchise network of over 30 NGOs that provide MCH and family planning services through over 300 static clinics, 8,000 satellite clinics,

and 6,000 community health workers who provide services for approximately 20 million people. In addition, USAID supports a community-based essential newborn care program through approximately 300 community health workers and community mobilizers in Sylhet district, covering a population of 1.6 million with plans to expand to 3.4 million by 2009. The Social Marketing Company (SMC) markets ORS through 160,000 sales outlets throughout Bangladesh and has expanded its products to include zinc, micronutrients, and safe delivery kits. In addition, SMC's Blue Star franchise network of over 3,000 "non-graduate" health practitioners provides child health and pregnancy care. SMC's mass media campaigns and community outreach workers increase awareness about maternal, newborn, and child health issues. In the public sector, USAID strengthens facilities to conduct AMTSL services.

Specific actions supported as part of the MCH approach

USAID supports the development of the capacity and efficiency of the private sector through the SMC and the Smiling Sun Franchise; the latter aims to increase cost recovery from 25 percent to 50 percent within the next 5 years. USAID supports the public sector health system to prevent postpartum hemorrhage and provide long-term and permanent family planning methods and contraceptive logistics systems.

The USAID program's geographic focus

USAID supports a nationwide program, allocated by the government, which covers over 20 million people in primarily hard-to-reach areas.

The Mission program's relationship to the country's health sector and development plans and strategies

The Government of Bangladesh is the largest provider of MCH services in the country. Government activities and programs are designed mainly to increase access to facility-based emergency obstetric care services and community-based skilled birth assistance. UN organizations provide financial and technical assistance to MCH activities. The World Bank provides loan support to the national program, while the Asian Development Bank supports an essential service package in major urban areas.

The USG complements these Government of Bangladesh activities by strengthening NGOs to manage and deliver MCH services. USG also provides technical assistance to strengthen the government's drug logistics system. All major donors including USAID work through a health development partners' consortium to coordinate Government of Bangladesh and donor-supported MCH activities. The consortium meets on a regular basis to coordinate programmatic issues, assess technical difficulties, identify implementation gaps, and avoid duplication of effort.

Potential for linking Mission MCH resources with other health sector resources and initiatives

USG investments (e.g., PMI, PEPFAR, Title II, OFDA, water, etc.)

The Title II program aims to increase household food security and to improve the health and nutrition of pregnant women and children under 2. The program includes growth monitoring and promotion and antenatal and postnatal care.

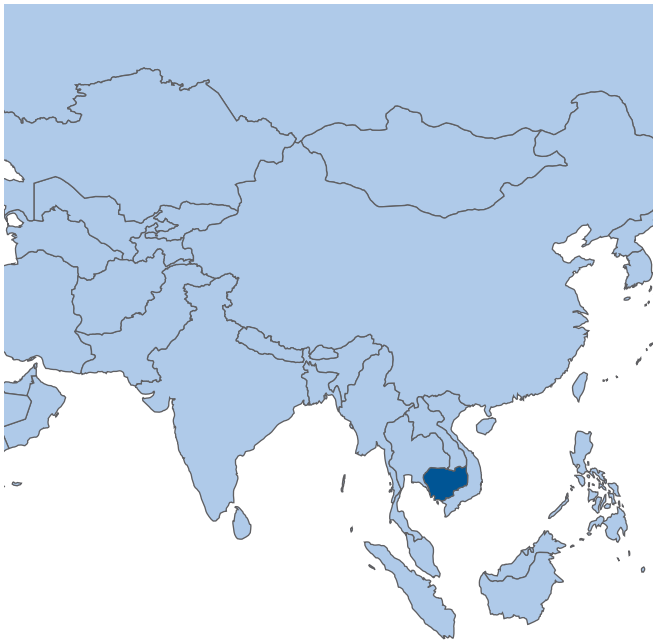
Planned results for the Mission's MCH investments over the next 5 years

Over the next 5 years, USAID will increase antenatal care coverage by 15 percent, essential newborn care services by 50 percent, and AMTSL in all facility deliveries and treatment of children for pneumonia and diarrhea by more than 20 percent in targeted areas.

MCH COUNTRY SUMMARY: BANGLADESH	VALUE
MCH FY08 BUDGET	13,333,000 USD
Country Impact Measures	
Number of births annually*	4,417,000
Number of under-5 deaths annually	287,000
Neonatal mortality rate (per 1,000 live births)	37
Infant mortality rate (per 1,000 live births)	52
Under-5 mortality rate (per 1,000 live births)	65
Maternal mortality ratio (per 100,000 live births)****	322
Percent of children underweight (moderate/severe)	41%
Birth Preparedness and Maternity Services	
Percent of women with at least one antenatal care (ANC) visit	60%
Percent of women with at least four antenatal care (ANC) visits	21%
Percent of women with a skilled attendant at birth	18%
Percent of women receiving postpartum visit within 3 days of birth	20%
Newborn Care and Treatment	
Percent of newborns whose mothers initiate immediate breastfeeding	24%
Immunization	
Percent of children fully immunized***	82%
Percent of DPT3 coverage	91%
Percent of measles coverage	83%
Maternal and Young Child Nutrition, Including Micronutrients	
Percent of mothers receiving iron-folate	N/A
Percent of children receiving adequate age-appropriate feeding	74%
Percent of children under age 5 receiving vitamin A supplement in the past 6 months	88%
Percent of children under 6 months exclusively breastfed	43%
Treatment of Child Illness	
Percent of children with diarrhea treated with ORT	85%
Percent of children with diarrhea treated with zinc	N/A
Percent of children with pneumonia taken to appropriate care	28%
Water, Sanitation, and Hygiene	
Percent of population with access to improved water source**	80%
Percent of population with access to improved sanitation**	36%

* Census International Database ** Joint Monitoring Programme for Water Supply and Sanitation 2008 Report *** Fully immunized at any time before the survey
**** National Institute of Population Research and Training (NIPORT), ORC Macro, Johns Hopkins University and ICDDR,B. 2003. Bangladesh Maternal Health Services and Maternal Mortality Survey 2001. Dhaka, Bangladesh and Calverton, Maryland (USA): NIPORT, ORC Macro, Johns Hopkins University, and ICDDR,B.
Unless otherwise noted, the data source is the 2007 Bangladesh Preliminary Demographic and Health Survey Report.)

Cambodia MCH Program Description



Overall MCH and health sector situation

Many of Cambodia's key health indicators have improved as the country's economy has developed, although there are large disparities in coverage of maternal and child health services between urban and rural populations and wealth quintiles. Child mortality has declined dramatically since 2000: IMR decreased from 99 to 66/1,000 live births, and U5MR dropped from 124 to 83/1,000 live births. The leading causes of death for children under 5 are ARIs (mainly pneumonia), diarrheal diseases, and neonatal conditions, and, in some geographic areas, malaria and dengue fever are a considerable burden. Neonatal deaths are still the highest in Southeast Asia and remain a major contributor to childhood mortality, accounting for more than one-third of overall child deaths. Although antenatal care and assisted deliveries by trained attendants have increased, 78 percent of births still take place at home, with only 44 percent of all births attended by an SBA. Alarmingly, over the past 5 years, the MMR has stagnated at 472 per 100,000 live births. Hemorrhage during and after delivery is the main cause of maternal deaths.

Numerous government-wide reforms are under way in Cambodia against a background of rapid social and economic change (Cambodia has experienced double digit economic growth for the last 3 years). Health system developments have included a new Health Sector Strategic Plan (2008–2015) that places emphasis on reproductive and maternal and child health, design of "contracting" or performance-based models for health service provision, and piloting/expansion of health financing schemes. Despite these reforms, challenges to effective delivery of MCH services include numbers and distribution of human resources across Cambodia, with medical doctors and other trained professionals concentrated in the cities and towns, and ongoing concerns regarding the quality, distribution, and retention of staff remaining in rural areas; limited capacity for decentralized health planning and management (particularly in health centers and operational districts); inadequate financing (from other than out-of-pocket sources that comprise a large share of total health expenditures); rapid proliferation of a largely unregulated private sector; fragmented implementation of MCH programs; and inequitable demand and access to quality.

MCH interventions at the Mission level

Focus will be on the high-impact interventions to address the main causes of maternal and child mortality. Interventions may include, but are not limited to, AMSTL, misoprostol, treatment of postpartum hemorrhage and preeclampsia/eclampsia, essential newborn care, treatment of childhood illness including pneumonia and diarrhea, POU water disinfection, vitamin A, immunization, promotion of infant and young child nutrition including breastfeeding and complementary feeding, and birth spacing.

Delivery approaches and mechanisms supporting expanded coverage/use of interventions

USG supports this goal through new and ongoing activities that increase births attended by trained personnel; improves PMTCT through antenatal, delivery, and postpartum care; strengthens facility and community MCH services; increases access to and improvement of referral systems; develops management capacity at provincial and district levels; supports the implementation of community-based health insurance and health equity funds; and promotes community involvement in quality improvement of public health services. New activities will include water, hygiene, and sanitation activities at house-

hold and health center levels. By 2009, 51,562 births will have been attended by skilled providers, 53,440 newborns will have received essential care, and 10,010 people will have been trained in maternal/newborn health.

Specific actions supported as part of the MCH approach

The USG depends on both public and private support for other goals including rapidly scaling up 12 key child survival interventions; harmonizing training curriculum; improving human resource deployment and supervision; and assuring coordination, planning, and monitoring at all levels of the health system.

The USAID program's geographic focus

Over the next 5 years, USAID will support activities in 12 of the 24 provinces. Based on the MOH's population estimates, USAID's target population in these provinces is approximately 3.4 million (children under 5 years of age and women of reproductive age), which is about 27 percent of the total population.

USAID and other development partners work collaboratively in support of the Royal Government of Cambodia's Health Strategic Plan 2008–2015. USAID implementing partners work to support all levels – national, provincial, district, and community – of the public health system and, whenever possible, in collaboration with other donor-funded programs.

The Mission program's relationship to the country's health sector and development plans and strategies

Under other ongoing projects, USAID supports activities for HIV and STI prevention in high-risk groups and people living with HIV/AIDS (PLWHA). The MCH program will complement these efforts by mainstreaming HIV prevention messages into mass media and community-based BCC and youth reproductive health services. In addition, PMTCT services will be expanded as an integrated part of MCH services.

Potential for linking Mission MCH resources with other health sector resources and initiatives

The MCH program was designed to provide support within the common framework of Cambodia's Health Sector Strategic Plan. In addition, a multi-donor, sector-wide approach program, the Health Sector Support Project 2 (HSSP2) is expected to commence in January 2009 with pooled financing from several donors at a level of over $100 million for 5 years. The HSSP2 donor consortium and MOH hopes to leverage USAID non-pooled funds and technical experience in such areas as health equity funds, provincial/district monitoring, and community-level programming, among others.

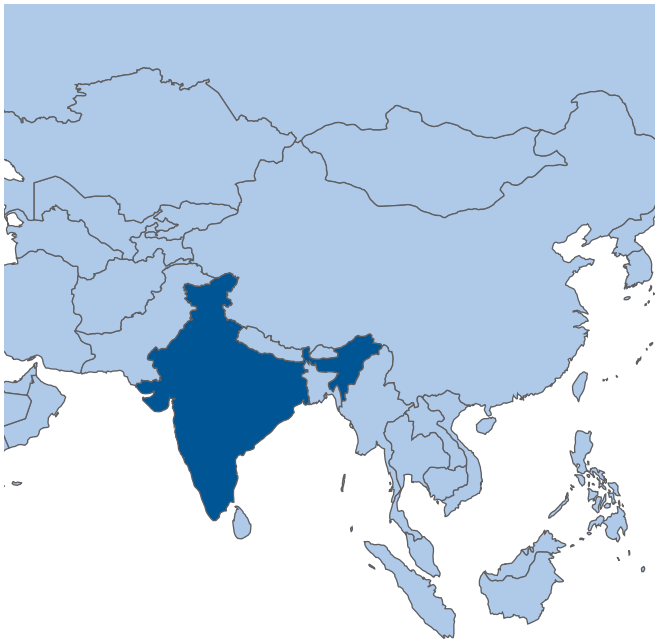
Planned results for the Mission MCH investments over the next 5 years

USAID's maternal and child health programs in Cambodia are working to reduce maternal and under-5 morbidity/mortality by 25 percent by the end of 2013 through high-impact interventions, while building human capital, improving the provision of clinical services, reducing poverty, and strengthening society.

MCH COUNTRY SUMMARY: CAMBODIA	VALUE
MCH FY08 BUDGET	8,555,000 USD
Country Impact Measures	
Number of births annually*	340,000
Number of under-5 deaths annually	28,000
Neonatal mortality rate (per 1,000 live births)	28
Infant mortality rate (per 1,000 live births)	66
Under-5 mortality rate (per 1,000 live births)	83
Maternal mortality ratio (per 100,000 live births)	472
Percent of children underweight (moderate/severe)	33%
Birth Preparedness and Maternity Services	
Percent of women with at least one antenatal care (ANC) visit	73%
Percent of women with at least four antenatal care (ANC) visits	28%
Percent of women with a skilled attendant at birth	44%
Percent of women receiving postpartum visit within 3 days of birth	64%
Newborn Care and Treatment	
Percent of newborns whose mothers initiate immediate breastfeeding	35%
Immunization	
Percent of children fully immunized at 1 year of age	60%
Percent of DPT3 coverage	78%
Percent of measles coverage	77%
Maternal and Young Child Nutrition, Including Micronutrients	
Percent of mothers receiving iron-folate	58%
Percent of children receiving adequate age-appropriate feeding	82%
Percent of children under age 5 receiving vitamin A supplement in the past 6 months	35%
Percent of children under 6 months exclusively breastfed	60%
Treatment of Child Illness	
Percent of children with diarrhea treated with ORT	60%
Percent of children with diarrhea treated with zinc	N/A
Percent of children with pneumonia taken to appropriate care	48%
Water, Sanitation, and Hygiene	
Percent of population with access to improved water source**	65%
Percent of population with access to improved sanitation**	28%

* Census International Database
** Joint Monitoring Programme for Water Supply and Sanitation 2008 Report
(Unless otherwise noted, the data source is the 2005 Demographic and Health Survey.)

India MCH Program Description



Overall MCH and health sector situation

With a population of over 1 billion people, India has one of the fastest-growing economies in the world. Annual economic growth has averaged about 8 percent to 9 percent in recent years; however, India is still very much a country in development transition, with over 700 million of its people living on less than $2 a day. Rooted in this poverty, India's U5MR of 74/1,000 means that almost 2 million young Indian children still die each year – one-fourth of all the world's infant and child deaths. Approximately one-fourth of the world's maternal deaths – almost 120,000 women a year – also occur in India. Increasing the survival and health of mothers and children is essential to improving the future of India's people and to addressing the political challenge represented by this inequity. Beyond this, it will be impossible for the world to accomplish the MDGs without accelerated progress in India.

There has been progress. The 2005–06 National Family Health Survey, which was substantially supported by USAID, identified significant improvements in key health services. For example, use of antenatal care and trained health personnel at birth significantly improved during the 5 years since the preceding survey. Working in some of the most difficult areas of the country, USAID's programs supported improvements in these and other services that were generally above the national averages. Still, however, in 2005–06 more than half of Indian women delivered without skilled attendants, over half of Indian children were not fully immunized, and the high rates of child malnutrition remained unchanged. India also remains one of four countries worldwide where polio is still endemic. Fertility also remains high, with India's population on a trajectory to double by 2050.

In recent years, the Government of India has made massive new commitments of its own resources to improving health, especially maternal and child health. In 2005, the prime minister launched the National Rural Health Mission (NRHM), a $9.5 billion program aimed at reaching poor families with essential health services. India has also committed to nationwide expansion of the massive preschool education and child nutrition program delivered through the Integrated Child Development Scheme (ICDS). In 2008, the Government of India intends to launch a parallel National Urban Health Mission (NUHM). USAID/India's MCH strategy focuses on developing evidence-based program approaches that deliver essential interventions to mothers and children and using these effective programs to guide India's own massive investments.

MCH interventions at the Mission level

Focus areas of USAID's program include birth preparedness and maternity services; newborn care and treatment; immunization, including polio; maternal and young child nutrition; treatment of child illnesses; and household-level improvement of water, sanitation, and environment. These interventions are complemented by USAID's strong support for family planning, including birth spacing and delaying age at marriage to reduce high-risk births.

Delivery approaches and mechanisms supporting expanded coverage/use of interventions

USAID's MCH program has three major components. The largest supports promotion and delivery of high-impact maternal and child health interventions through community-level BCC, services, and demand creation

and through improved public sector service delivery in two states. The Mission also supports policy and program direction to India's new investments in improving the health of the urban poor through the Urban Health Resource Centre, an Indian NGO that was started with USAID support and has now been designated as the national resource center for urban health programs. USAID also supports a selected group of Indian public health institutions in working with the national government to identify key policy issues related to maternal and child health and nutrition. Working with government and other partners, these institutions collect and develop the evidence to inform policy decisions affecting national health investments. In 2007, this collaboration resulted in a new cabinet-level partnership with private sector institutions to address India's persistently high rates of malnutrition. USAID also has direct partnerships with the private sector, including a recently initiated public-private partnership for production and promotion of zinc supplements to treat childhood diarrheal illness. Finally, USAID directly supports promotion and implementation of polio eradication activities in states having continued transmission of the polio virus.

Specific actions supported as part of the MCH approach

In its state-level program support, USAID works to strengthen planning, management, and monitoring of services at state level and below, and also makes substantial investments in human capacity development through capacity building of health care workers and managers. In its urban programs, USAID provides unique support to strengthening the abilities of municipalities that are tasked with managing urban health services to plan and implement effective services. Under the new NUHM, this support will expand to develop new financing approaches that include private sector providers.

The USAID program's geographic focus

The rural health component of USAID's MCH program is focused in Uttar Pradesh and Jharkhand, two of the Indian states with greatest health need (Uttar Pradesh has a population of over 170 million, making it larger than most countries). Experience in these states is connected to state and national level programs and policy direction through systematic program-based evidence generation, including operations and evaluation research. The policy analysis component of the program also draws on these experiences, as well as other programs in India and global evidence, to also help guide India's own MCH investments.

The Mission program's relationship to the country's health sector and development plans and strategies

As noted, USAID's MCH activities have been developed in consultation with the Government of India and partners to help implement and guide India's own health investments, including the new National Rural Health Mission, the NUHM, Universalization of Integrated Child Development Services Scheme (ICDS) and the 11th Five Year Plan. These programs are also directly linked to state- and municipality-level planning and policy, to affect investment of these and other resources at state level.

Potential for linking Mission MCH resources with other health sector resources and initiatives

USG investments (e.g., PMI, PEPFAR, Title II, OFDA, water, etc.)

India has for the past 8 years linked its Title II food program with its MCH program to achieve maximum health and nutrition impact. While the Title II program is phasing down, this integration has served to develop approaches that are now being used in multiple states, including "Nutrition Health Days" for antenatal care, immunization, growth promotion, and food distribution to pregnant and lactating women and children under age 2. Water and sanitation has been a key element of urban health and other urban programming; USAID is now developing a more integrated urban water program approach to build on this experience to improve water availability and health outcomes, using both MCH and Development Assistance resources.

Investments and initiatives of other donors and international organizations

USAID is an active participant in the government-led health sector coordination group with other major partners, including the World Bank, DfID, Norwegian-India Partner Initiative (NIPI) and other donors. USAID also participates in semiannual government-partner reviews of implementation of the National Rural Health Mission, aimed to maximize effective implementation and health impact of that initiative. Because India remains a major focus for the global Polio Eradication Initiative, USAID is also an active member of the Inter-Agency Coordinating Committee for Polio.

Planned results for the Mission's MCH investments over the next 5 years

USAID's program is designed to assist and support the Government of India and selected state governments in achieving their objectives, including:

– Assisting the National Rural Health Mission and NUHM in achieving by 2012:

  - Reduce MMR to 100/100,000 live births nationally
  - Reduce infant mortality to 30/1,000 live births nationally
  - Increase institutional deliveries to 80 percent

– Assisting the state of Uttar Pradesh in achieving:

  - Reduced MMR from 517/100,000 to 127/100,000, resulting in about 20,000 maternal deaths averted in 2012
  - Reduced infant mortality from 71/1,000 to 37/1,000, resulting in about 160,000 infant deaths averted in 2012
  - Increased institutional deliveries from 21 percent to 42 percent, resulting in about 1.5 million more institutional deliveries in 2012

– Assisting the state of Jharkhand in achieving:

  - Reduced maternal mortality from 371/100,000 to 91/100,000, resulting in about 3,000 maternal deaths averted in 2012
  - Reduced infant mortality from 49 to 26, resulting in about 16,000 infant deaths averted in 2012
  - Increased institutional deliveries from 18 percent to 36 percent, resulting in about 165,000 more institutional deliveries in 2012.

Thus in the two States combined, India expects to avert about 23,000 maternal deaths and 180,000 infant deaths, and to increase the number of institutional deliveries by about 166,500 in the year 2012.

USAID will also assist the Integrated Child Development Scheme in achieving by 2015 a reduction in the percentage of underweight children from 46 percent to 27 percent, resulting in about 6 billion fewer underweight children in India.

MCH COUNTRY SUMMARY: INDIA	VALUE
MCH FY08 BUDGET	14,978,000 USD
Country Impact Measures	
Number of births annually*	25,852,000
Number of under-5 deaths annually	1,920,000
Neonatal mortality rate (per 1,000 live births)	39
Infant mortality rate (per 1,000 live births)	57
Under-5 mortality rate (per 1,000 live births)	74
Maternal mortality ratio (per 100,000 live births)***	450
Percent of children underweight (moderate/severe)****	40%
Birth Preparedness and Maternity Services	
Percent of women with at least one antenatal care (ANC) visit*****	77%
Percent of women with at least four antenatal care (ANC) visits*****	37%
Percent of women with a skilled attendant at birth	47%
Percent of women receiving postpartum visit within 3 days of birth	37%
Newborn Care and Treatment	
Percent of newborns whose mothers initiate immediate breastfeeding	25%
Immunization	
Percent of children fully immunized at 1 year of age	36%
Percent of DPT3 coverage	55%
Percent of measles coverage	59%
Maternal and Young Child Nutrition, Including Micronutrients	
Percent of mothers receiving iron-folate	65%
Percent of children receiving adequate age-appropriate feeding	57%
Percent of children under age 5 receiving vitamin A supplement in the past 6 months	18%
Percent of children under 6 months exclusively breastfed	46%
Treatment of Child Illness	
Percent of children with diarrhea treated with ORT	43%
Percent of children with diarrhea treated with zinc	0%
Percent of children with pneumonia taken to appropriate care	69%
Water, Sanitation, and Hygiene	
Percent of population with access to improved water source**	89%
Percent of population with access to improved sanitation**	28%

* Census International Database ** Joint Monitoring Programme for Water Supply and Sanitation 2008 Report *** Source: WHO Maternal Mortality Report 2007
****The reference for percent of children underweight is the median of the 2006 WHO International Reference Population *****This number is based on mothers who had a live birth in the 5 years preceding the survey
(Unless otherwise noted, the data source is the 2005-06 Demographic and Health Survey.)

Indonesia MCH Program Description

Overall MCH and health sector situation

With approximately 240 million people, Indonesia is the world's fourth most populous country. Recent economic growth indicators and Indonesia's classification as a middle-income country mask huge disparities in wealth and access to basic human services. While 18 percent of the population lives below the government poverty line, nearly half of all Indonesians live on less than $2 a day and lack adequate health services, food security, and sanitation.

Less than one third of city dwellers and only 10 percent of rural populations have access to piped water. Indonesians have widely adopted the practice of boiling water, but rising fuel costs and recontamination of treated water disproportionately burden the poor. About 213,000 children under 5 die each year from preventable conditions related to poor delivery and essential newborn care (birth asphyxia, neonatal infection), diarrhea, pneumonia, and measles. Malnutrition is estimated to be an underlying factor in more than half of all child deaths, and rates of malnutrition have been stagnant for several years. For every 100,000 live births, more than 300 women die.

The government of Indonesia significantly under-invests in health with public expenditures at less than 1 percent of GDP. Overall, only around $30 per capita is spent on health, and nearly half of that is borne out-of-pocket by Indonesians themselves. Six years since decentralization, the responsibility for health, education, and other services is now at the local level. USAID continues to support this transition through targeted technical assistance to central and local governments. During this time, Indonesia has seen some success and some setbacks in their national indicators. For example, 73 percent of mothers who gave birth over the past 5 years were assisted by a skilled health professional, a substantial increase from 66 percent 5 years ago. However, Indonesia continues to have a high MMR despite overall increased access to skilled delivery care.

Recent data suggest that Indonesia's dramatic health gains over the past two decades may be stagnating. Indonesia more than halved child mortality between 1987 and 2002, but saw no further reduction in child mortality between 2002 and 2007. Child mortality reduction appears to be stagnant in all age groups: neonatal, postneonatal, and ages 1 to 4 years. These data suggest poor quality controls on health providers, weak public health systems in general, and little improvement in access to primary care and effective disease control and treatment interventions targeting children. Root causes include wide disparities in access to health care between urban and rural populations, lack of financial access to services among the poor, and weak government oversight of the quality of care in the public and private-sectors. Many of the poor qualify for government-sponsored health insurance, but this benefit does not emphasize preventive and primary care services and does not reimburse private providers.

MCH interventions at the Mission level

USAID's maternal and child health assistance continues to focus on strengthening advocacy, management capacity, and service delivery. Working with local government agencies, NGOs, and other partners, vulnerable populations – poor women and children – are the principal beneficiaries of USAID's public health program.

The Health Services Program (HSP) is the principal USAID mechanism to provide technical assistance for improved MCH. The main activities aim to promote positive health practices at the community level, improve access to quality health services in both the public and private sectors, improve the capacity of health planning and budgeting, improve advocacy for MCH with civil society partners, and improve the management and integration of health services. The HSP assists District Health Offices to improve the scope and outcomes of an integrated service package with a focus on interventions proven to reduce mortality, focusing on SBAs, birth preparedness, essential newborn care, early and exclusive breastfeeding, prevention of postpartum hemorrhage, management of diarrhea, and handwashing/ hygiene behaviors.

USAID MCH activities helped over 530,000 women safely deliver babies in the presence of SBAs, provided essential care to 337,000 newborns, treated over 1 million cases of child diarrhea, provided 535,000 children under age 5 with nutrition services, and provided POU treatment for 627 million liters of drinking water.

FY08 resources will continue to fund maternal and child health interventions that address postpartum hemorrhage, newborn care, diarrhea management, malaria in pregnancy, handwashing, and breastfeeding. To increase Indonesia's capacity to provide quality health services, the USG will continue to strengthen clinical provider training and supervision, district planning and budgeting, advocacy for MCH services, and drug commodity management. Selected NGO partners in health advocacy and the Indonesian Midwives Association will be key partners in implementing this assistance. As a result of this assistance, it is anticipated that almost 550,000 births will be aided by SBAs. More than 350,000 newborns will receive essential newborn care, and almost 1.8 million cases of child diarrhea will be treated.

Twenty-five public campaigns will be launched to ensure that households adopt adequate health and hygiene practices. The USG will continue its work with commercial entities to produce and market POU water treatment solutions to improve water quality in households. As a result of this, it is expected that almost 600 million liters of drinking water will be disinfected during the year.

Delivery approaches and mechanisms supporting expanded coverage/use of interventions

Public-private partnership is one central approach to USAID's MCH strategy in Indonesia. One example is the Aman Tirta program, which aims to increase access to safe drinking water by introducing a low-cost, easy-to-use, and safe household-level water purification product, Air RahMat. To expand access to this product, Aman Tirta partners a for-profit private manufacturer and distributor with both government and NGOs working in the areas of health and education.

Private midwives are supported through a franchise program that requires midwives to meet and maintain quality standards of care in order to join the franchise called "Bidan Delima." The Indonesian Midwives' Association manages the program with technical assistance from USAID. It has grown to a membership of about 7,000 (10 percent of all midwives) and continues to be in high demand, attracting new members daily.

Another important approach that is consistent with Indonesia's growing democracy and civic engagement on society is the MCH advocacy program. NGOs, community leaders, District Health Department employees, members of health care professional associations, and members of parliament work together to learn advocacy skills and develop a set of advocacy messages and tools. This team approach has resulted in dramatic increases in MCH budgets at the district level and has fortified community interest and engagement in MCH issues. Many districts are now drafting and advocating for local laws and regulations to institutionalize continued commitment to improved MCH services beyond the life of elected officials.

Specific actions supported as part of the MCH approach

A health systems capacity-building approach has been emphasized in all USG-supported work with an eye toward replication and national scale-up. Program activities are closely planned with the government, and sufficient time and energy is allocated to completing the necessary policy and standards work in collaboration with appropriate government partners and stakeholders. This approach results in greater replication of models, toolkits, strategies, and materials by government systems and other donors. Specific areas that are currently being replicated or scaled up nationally include clinical supportive supervision tools, revisions to provider training packages, district planning and budgeting toolkits, community mobilization for MCH issues, behavior change training and start-up materials, and advocacy training.

Midwives, the majority of whom are also working in the private sector, have been the targets of much of the

health systems strengthening efforts in MCH. Capacity-building of the Indonesian Midwives' Association has been a key priority of the program.

Community mobilization assistance at the village level has led to extensive replication by non-project communities and a strong interest from the MOH because engaged and organized communities are essential to the success of their 10-point cross-sectoral "village preparedness" program covering health, family welfare, women's rights, disaster preparedness, and epidemic readiness.

The USAID program's geographic focus

USAID's MCH activities are focused in six provinces of Java and Sumatra. These two islands collectively account for three quarters of Indonesia's population. MCH program activities have already been successfully replicated and scaled up nationally through the government and other donors.

The Mission program's relationship to the country's health sector and development plans and strategies

The Government of Indonesia and several major international donors support a common agenda to accelerate improvements in maternal and child health. Health is one of nine priorities in Indonesia's Medium-Term National Development Plan (2005–2009). The USAID Mission's MCH programs benefit positively from close collaboration with the Mission's democracy and governance initiatives.

Potential for linking Mission MCH resources with other health sector resources and initiatives

USG investments (e.g., MCC, PEPFAR, Water for the Poor)

USAID is the primary USG agency managing health-related assistance to Indonesia. Assistance through the Millennium Challenge Corporation (MCC) will continue to play a significant role in the USAID MCH program through the first half of FY08. As part of a $55 million MCC threshold program, the USG is managing a $20 million immunization assistance mechanism. This immunization assistance is helping to improve immunization coverage with the longer-term goal of Indonesia achieving MCC Compact eligibility. PEPFAR-funded assistance focuses largely on risk groups, but HIV/AIDS programs are closely coordinated with MCH programs in PMTCT activities.

Investments and initiatives of other donors and international organizations

Key donors such as WHO, UNICEF, GTZ, and AusAID channel support to improve a policy framework that expands primary health care services and improved MCH services to the poor. The World Bank and ADB provide loans that reach provinces and districts and include support for planning, infrastructure, and training. USG-supported MCH activities have developed good technical collaboration with WHO and UNICEF, and UNICEF, GTZ, and AusAID programs have replicated USG-supported assistance packages in their program areas, primarily Eastern Indonesia.

Planned results for the Mission's MCH investments over the next 5 years

The Indonesia Mission is currently undertaking a Mission strategy, and the MCH program is critically reviewing several aspects of the health sector. Major areas of future investment are likely to include:

- Continued support to advocacy and promoting good governance and management of basic human services
- Focused technical assistance on improving key clinical services in the public and private sector – emergency obstetric and neonatal care, increased access to effective management of obstetric complications (PPH and eclampsia) and diarrhea (ORT, zinc, and feeding), and breastfeeding
- New partnership opportunities with the private sector will be explored in food fortification, workplace health promotion, insurance coverage with prevention and MCH benefit packages, private health providers (midwives, nurses, doctors, and specialists), and commercial product manufacturers
- Demand creation for facility-based delivery care and modified approaches to reducing inequity in access to MCH care (insurance schemes, vouchers, etc.)
- Improved service mapping capabilities of the Government of Indonesia (including private providers) and data collection and monitoring systems, including medical audits of perinatal deaths
- Support for effective and appropriate water, sanitation, and hygiene interventions for both urban and rural poor populations. Liaison with USG sources of support to expand water financing solutions to enhance access to water quantity and quality

- Investment in district-district local learning networks and "Internet working" among public health professionals in order to disseminate lessons learned and innovations seen at the district level. Facilitation of local study tours and field-based public health practice training programs

MCH COUNTRY SUMMARY: INDONESIA	VALUE
MCH FY08 BUDGET	12,196,000 USD
Country Impact Measures	
Number of births annually*	4,742,000
Number of under-5 deaths annually	213,000
Neonatal mortality rate (per 1,000 live births)	20
Infant mortality rate (per 1,000 live births)	34
Under-5 mortality rate (per 1,000 live births)	45
Maternal mortality ratio (per 100,000 live births)***	307
Percent of children underweight (moderate/severe)*****	28%
Birth Preparedness and Maternity Services	
Percent of women with at least one antenatal care (ANC) visit	93%
Percent of women with at least four antenatal care (ANC) visits***	81%
Percent of women with a skilled attendant at birth******	73%
Percent of women receiving postpartum visit within 3 days of birth****	62%
Newborn Care and Treatment	
Percent of newborns whose mothers initiate immediate breastfeeding***	39%
Immunization	
Percent of children fully immunized at 1 year of age	N/A
Percent of DPT3 coverage	58%
Percent of measles coverage	72%
Maternal and Young Child Nutrition, Including Micronutrients	
Percent of mothers receiving iron-folate	77%
Percent of children receiving adequate age-appropriate feeding***	75%
Percent of children under age 5 receiving vitamin A supplement in the past 6 months***	75%
Percent of children under 6 months exclusively breastfed	33%
Treatment of Child Illness	
Percent of children with diarrhea treated with ORT***	58%
Percent of children with diarrhea treated with zinc	N/A
Percent of children with pneumonia taken to appropriate care	77%
Water, Sanitation, and Hygiene	
Percent of population with access to improved water source**	80%
Percent of population with access to improved sanitation**	52%

* Census International Database
** Joint Monitoring Programme for Water Supply and Sanitation 2008 Report
*** 2002-03 Demographic and Health Survey
**** This number is based only on mothers whose last live birth occurred outside a health facility in the 5 years preceding the survey.
***** State of the World's Children Report 2008
****** SBA includes doctor, obgyn, nurse, midwife, or village midwife.
(Unless otherwise noted, the data source is the 2007 Indonesia Preliminary DHS.)

Nepal MCH Program Description

Overall MCH and health sector situation

Nepal has a population of approximately 27 million, 38 percent of whom are under the age of 15. In 2003, the total expenditure on health represented 5.3 percent of the GDP. Out of 177 nations on the Human Development Index, Nepal ranks 142. In spite of over 10 years of insurgency, Nepal has made great strides in key health areas. The child mortality rate, which was among the highest in the world, has dropped by 48 percent since 1996, and Nepal is one of six countries that are on track to achieve the MDG for reducing child mortality. The fertility rate has decreased by 33 percent in the same period.

Despite improvements over the past two decades, the health status of mothers and newborns in Nepal remains low. The MMR in Nepal was estimated to be 281 deaths per 100,000 live births in 2006, a significant decrease from the previous estimate of 539 in 1996. Due to rapidly falling infant and U5MR rates, the relative proportion of neonatal deaths among all infant and under-5 deaths has risen to 66 percent and 54 percent, respectively. Discrepancies between urban and rural populations' access to health care is evidenced by the fact that rural women, on average, give birth to four children, while urban women now average only two children. Average life expectancy is 62 years for men and 66 years for women, with half the population composed of children and adolescents.

Nepal faces a concentrated HIV/AIDS epidemic. The HIV prevalence rate is believed to be about 0.5 percent in the general population with pockets of higher prevalence among groups that have high-risk behaviors, such as injecting drug users (35 percent in Kathmandu in 2007) and female sex workers (< 4 percent 2006). Targeted prevention efforts have reduced and contained HIV transmission significantly.

MCH interventions at the Mission level

USAID supports five FP-MCH national health programs through system strengthening: semiannual vitamin A supplementation of children aged 6-59 months, family planning, safe motherhood, community-based IMCI, and the female community health volunteer program. In addition, USAID provides concentrated assistance in 20 districts with high need. Technical areas of support include birth preparedness and maternity services, newborn care and treatment, immunizations including polio, maternal and young child nutrition including micronutrients, and treatment of child illness. USAID supports the implementation of a community-based newborn care package in selected districts, strengthens health facility management committees, which advances local governance efforts, and conducts BCC. Community-based treatment for child pneumonia has expanded to cover two-thirds of all expected cases of pneumonia in 37 densely populated districts. New interventions currently being tested or piloted for the newborn include vitamin A supplementation at birth, "kangaroo" mother care to prevent hypothermia, and plans for umbilical cord care with chlorhexidine. For the mother, plans include preeclampsia and eclampsia prevention and management.

Through partnership with the Government of Nepal, USAID support reaches more than 14 million men and women of reproductive age and 3.6 million children under the age of 5. In 2008, About 12,000 postpartum visits will be made to newly delivered mothers, and 2,000 health workers and 10,000 community health workers will be trained in community-based maternal and newborn care. About 8,000 health workers will be trained in maternal and child health. More than 3,600,000 children from 6 months

to 5 years will receive vitamin A, and 3,000 newborns will receive lifesaving antibiotic treatment for infections.

Delivery approaches and mechanisms supporting expanded coverage/use of interventions

Nationwide, USAID supports the expansion of community-based IMCI and of improvement of community-level services through female community health volunteers. In selected districts, USAID supports community-based maternal and newborn care with a functional referral system. USAID also works in the private sector supporting a social marketing and franchising program for family planning and safe delivery kits reaching all of Nepal's 75 districts.

Specific actions supported as part of the MCH approach

USAID has historically assisted the Government of Nepal with the prioritization of new evidence-based interventions, development of new approaches, piloting, and taking to scale. USAID's support includes health governance and finance, and host-country strategic information. At the central level, USAID supports the Ministry of Health and Population (MOHP) in planning, monitoring/supervision, and development of norms/standards/strategies. USAID partners are active at the field level particularly assisting MOHP with implementing programs and assuring quality.

The USAID program's geographic focus

USAID supports five national programs: family planning, community-based IMCI, safe motherhood, vitamin A supplementation, and female community health volunteers. In addition, USAID provides concentrated assistance in 20 focus districts with high need covering approximately one-third of the country's population. In these districts, USAID helps to build the capacity of local health systems and providers to coordinate, plan, manage, monitor, and implement MCH program activities in these sub-national areas.

The Mission program's relationship to the country's health sector and development plans and strategies

USAID and 11 other donors support the Government of Nepal to implement Nepal's Health Sector Implementation Plan through a Sector-Wide Approach, with the World Bank and the British Department for International Development "pooling" their funds with the government's funds. Other donors include the World Health Organization, the United Nations Children's Fund, the United Nations Population Fund, UNAIDS, Australian Aid, Japan International Cooperation Agency, German Agency for Technical Cooperation, German Development Bank, and Swiss Development Cooperation. U.S. assistance complements the work of these other players in the areas of HIV/AIDS, maternal and child health, and family planning and reproductive health.

To ensure coordination and avoid duplication, USAID facilitates many government-donor technical committees and working groups that develop policy recommendations; national standards, guidelines and training programs; communications strategies and materials; applied research and surveillance plans; and logistics and supply chain management systems. The Global Fund for AIDS, Tuberculosis and Malaria granted $78 million in late 2007 to Nepal. USAID is a voting member on the Country Coordinating Mechanism (CCM) that oversees implementation of grants and is a task force member on CCM reform.

Potential for linking Mission MCH resources with other health sector resources and initiatives

USG investments (e.g., PMI, PEPFAR, Title II, OFDA, water, etc.)

USAID continually looks for opportunities to leverage resources. USAID/Nepal is currently co-funding with USAID/Washington two Child Survival and Health Grants focused on maternal and newborn interventions at the community level. Additionally, USAID received extra un-programmed funds from a prior year and utilized them to advance community-based maternal and newborn initiatives. USAID is also partnering with UNICEF to enhance HIV prevention, treatment, care and support for children in Nepal. USAID and UNICEF are also planning to collaborate on new initiatives to address malnutrition.

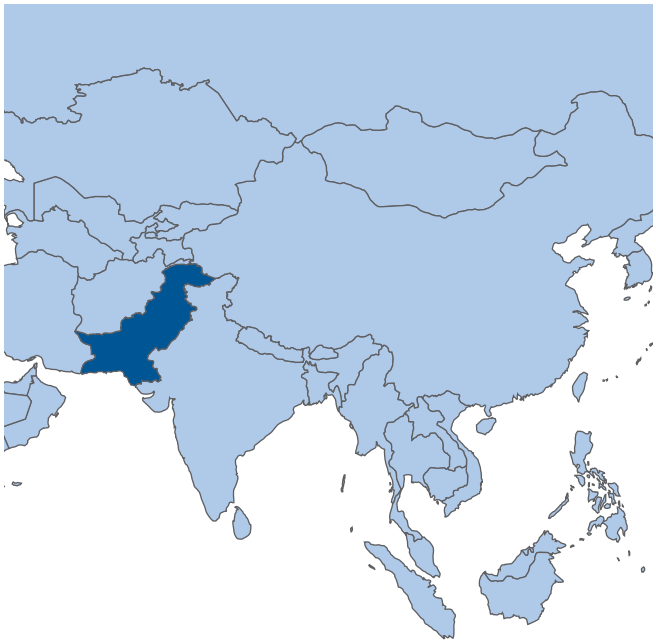
Planned results for the Mission's MCH investments over the next 5 years

Nepal is on track to achieve its MDGs in maternal and child health by 2015. U.S. assistance will work with the Government of Nepal and other donors to support the further reduction of MMR by 54 percent (from 281 in 2006 to 129 per 100,000 live births), and U5MR by 11 percent (from 61 in 2006 to 54 per 1,000 live births).

MCH COUNTRY SUMMARY: NEPAL	VALUE
MCH FY08 BUDGET	7,432,000 USD
Country Impact Measures	
Number of births annually*	876,000
Number of under-5 deaths annually	53,000
Neonatal mortality rate (per 1,000 live births)	33
Infant mortality rate (per 1,000 live births)	48
Under-5 mortality rate (per 1,000 live births)	61
Maternal mortality ratio (per 100,000 live births)	281
Percent of children underweight (moderate/severe)	42%
Birth Preparedness and Maternity Services	
Percent of women with at least one antenatal care (ANC) visit	76%
Percent of women with at least four antenatal care (ANC) visits	30%
Percent of women with a skilled attendant at birth	23%
Percent of women receiving postpartum visit within 3 days of birth	31%
Newborn Care and Treatment	
Percent of newborns whose mothers initiate immediate breastfeeding	35%
Immunization	
Percent of children fully immunized at 1 year of age	80%
Percent of DPT3 coverage	89%
Percent of measles coverage	85%
Maternal and Young Child Nutrition, Including Micronutrients	
Percent of mothers receiving iron-folate	59%
Percent of children receiving adequate age-appropriate feeding	75%
Percent of children under age 5 receiving vitamin A supplement in the past 6 months	88%
Percent of children under 6 months exclusively breastfed	53%
Treatment of Child Illness	
Percent of children with diarrhea treated with ORT	41%
Percent of children with diarrhea treated with zinc	0%
Percent of children with pneumonia taken to appropriate care	43%
Water, Sanitation, and Hygiene	
Percent of population with access to improved water source**	89%
Percent of population with access to improved sanitation**	27%

* Census International Database
** Joint Monitoring Programme for Water Supply and Sanitation 2008 Report
(Unless otherwise noted, the data source is the 2006 Demographic and Health Survey.)

Pakistan MCH Program Description



Overall MCH and health sector situation

Pakistan is the sixth most populous nation in the world with a population of 165 million, 32 percent of whom live below the poverty line. Life expectancy is 64 years. Pakistan ranks 136 out of 177 countries on the 2007–2008 United Nations Human Development Index.

Pakistan's health indicators for women and children are among the worst in the world. An estimated 276 Pakistani women die for every 100,000 live births. More than 65 percent of women in Pakistan deliver their babies at home; less than 2 in 5 women deliver with an SBA. Only 22 percent of married women received professional postnatal care for the last birth within 24 hours. The U5MR is 94 deaths per 1,000 live births. The 2007 Pakistan Demographic and Health Survey shows little change in mortality over time. At 4 to 5 months of age, only 23 percent of infants are exclusively breastfed. In the Federally Administered Tribal Areas (FATA), an estimated 135 out of every 1,000 children under the age of 5 die, often from treatable ailments. Pakistan's TFR of 4.1 children born per woman (4.5 TFR in rural areas) is one of the highest in South Asia. The modern method contraceptive prevalence rate (CPR) has stagnated at around 22 percent for the past several years. Among women ages 20 to 24, 84 percent of births are spaced less than 3 years apart, contributing to the high number of maternal and infant deaths. Yet 50 percent of women with one child want to space the next birth 2 years or more. Poor water and sanitation pose serious public health threats to the Pakistani population, contributing to the spread of disease and child malnutrition. Water- and sanitation-related diseases are responsible for 60 percent of child deaths in Pakistan. Pakistan (along with Afghanistan, India, and Nigeria) remains one of the only countries in the world with endemic polio. With significant USAID support, Pakistan has seen tremendous progress in reducing the number of polio cases, from 2,635 cases in 1994 to only 32 cases in 2007. The disease has now been geographically restricted, with nearly 80 percent of the country's districts considered polio-free for nearly 2 years.

MCH interventions at the Mission level

The 5-year Pakistan Initiative for Mothers and Newborns (PAIMAN) program provides a package of maternity care that includes preparation for birth, skilled attendance at birth, and provision of emergency obstetric care for childbearing women who develop obstetric complications. This program is focused in 11 districts, two FATA Agencies, and two Frontier Regions and benefits more than 2.8 million married couples and 420,000 newborns. The Improved Child Health in FATA program, aimed at children under age 5, includes immunization, prevention and treatment of respiratory infections and diarrhea, newborn care, and nutrition services. Over the next 3 years, the program will reach more than 1.61 million adults and more than 246,000 young children. The Pakistan Safe Drinking Water and Hygiene Promotion Project is communicating hygienic practices to families to reduce the incidence of diarrhea in children under 5 years of age, and will reach 32 million people over 3 years. The 5-year Family Advancement for Life and Health (FALAH) project focuses on pregnancy spacing as a key health intervention to improve the survival and health of the mother, the newborn and the child. The project will also train providers and increase access to quality services in the public and private sectors.

Delivery approaches and mechanisms supporting expanded coverage/use of interventions

PAIMAN informs communities about pregnancy-related dangers and mobilizes villages to plan emergency transport to take pregnant women to hospitals when bleeding or obstructed labor occurs; renovates and equips hospitals and rural health centers and promotes around-the-clock care; trains doctors and lady health visitors (LHVs) to effectively manage pregnancy and newborn emergencies and TBAs to conduct clean deliveries and recognize emergencies that require hospital referral. PAIMAN is building a new cadre of health workers – community midwives – to return to their villages to provide pregnancy care and conduct safe deliveries for years to come.

USAID support to the nationwide polio program maintains an extensive polio surveillance system, holds national immunization days, and conducts follow-on campaigns to reach all children who still are unvaccinated. The Improved Child Health in FATA program moves prevention and care services for children out to the community through "child health days," events designed to build long-term links between community members and their local health facilities; strengthens hospitals, local health facilities, and agency health management teams; trains LHVs and community members to identify child illnesses at the community level and provide essential newborn care; and improves medical stores and child and infant health wards in hospitals.

The Safe Drinking Water and Hygiene Promotion Project conducts campaigns that improve hygiene and sanitation practices, teaches effective household methods of cleaning water and establishes health education efforts in schools. The FALAH project includes a nationwide social marketing program that brings information and quality services to communities and families. The project is also planning a national communications campaign and social mobilization at the community level focused on pregnancy spacing for the health of the mother, newborn, and child. The Strengthening Health Systems in Pakistan Project strengthens the logistics management information systems of essential medicines and contraceptives to ensure their availability at the national, provincial, and district levels throughout the country, and collaborates closely with FALAH.

Specific actions supported as part of the MCH approach

The 2-year Strengthening Health Systems in Pakistan project builds capacity by providing technical assistance to two postgraduate nursing and midwifery institutions, the Pakistan Nursing Council (PNC) and the Midwifery Association of Pakistan (MAP). Primary activities focus on developing a midwifery tutor specialization; strengthening administrative and governing capacity of the PNC and MAP; training midwives, LHVs and nurses to improve nursing and midwifery skills; and developing government capacity in health systems development and administration. Through its targeted health information component, the program raises public awareness and encourages citizens to hold the public and private sectors accountable for providing quality health services. Activities also include training government officials and journalists in using data for decisionmaking, including findings from the 2007 Pakistan Demographic and Health Survey. The program's grant component addresses health systems challenges in the public, private, and commercial sectors. The focus is on public-private partnerships and innovation in addressing public health problems and health systems issues. The Strengthening Health Systems in Pakistan project strengthens the logistics management information systems of essential medicines and contraceptives in the public sector at the national, provincial, and district levels to ensure their availability throughout the country and works closely with FALAH. The PAIMAN Project trains government officials at the district level to prepare and implement annual health plans and budgets, improve supervision approaches, and utilize health information system data to improve management. The project also trains district health officials in Lot Quality Assessment Survey techniques to quickly gather data for monitoring program progress.

The USAID program's geographic focus

PAIMAN is focused in 11 districts, two FATA Agencies, and two Frontier Regions. Its districts include: Balochistan: Jaffarabad, Lasbella; NWFP: Buner, Swat, Upper Dir; Punjab: DG Khan, Jhelum, Khanewal, Rawalpindi; Sindh: Dadu, Sukkur; FATA Agencies: Khyber, Kurram; FATA Frontier Regions: Kohat, Peshawar. The Improved Child Health in FATA program will reach all seven Agencies of FATA and six Frontier Regions. USAID's Pakistan Safe Drinking Water and Hygiene Promotion Project is reaching out to 31.7 million people in 40 districts of Pakistan, including six agencies in FATA and eight earthquake-affected districts. FALAH works in all four provinces of Pakistan, particularly in the rural areas of 20 districts. These are: Balochistan: Gwadar, Jaffarabad, Khuzdar, Lasbella, Turbat and Zhob; NWFP: Buner, Battagram, Charsaddah, Lakki Marwat, Swabi, and Upper Dir;

Sindh: Dadu, Ghotki, Larkana, Sanghar, Sukkur, and Thatta; Punjab: Dera Ghazi Khan and Jehlum. After less than 1 year of implementation, 674,600 couples have been protected by contraceptives for 1 year. The Health Systems Strengthening project is working in the same 20 districts as FALAH. The total population of the 20 FALAH districts is 19,056,000; FALAH will reach 3,048,960 married women of reproductive age. PAIMAN and FALAH are working in eight of the same districts.

The Mission program's relationship to the country's health sector and development plans and strategies

The USAID health program complements and augments the Government of Pakistan's public health strategy with emphasis on coordinating with the government's large effort to train 10,000 midwives within 5 years and supporting child health and vaccination, polio surveillance, safe water, and sanitation.

Potential for linking Mission MCH resources with other health sector resources and initiatives

USG investments (e.g., PMI, PEPFAR, Title II, OFDA, water, etc.)

CDC supports avian influenza surveillance and testing. The State Department, through the Biosecurity Engagement program, enhances laboratory biosafety and supports field epidemiology and laboratory training. USAID/Pakistan also supports CDC to implement the 3-year Field Epidemiology and Laboratory Training Program. The program builds Pakistan's capacity to provide quality disease surveillance – to identify, track and treat disease. USAID/Pakistan leverages USAID's Bureau for Global Health core funds to support technical assistance to the Global Fund TB, HIV/AIDS and malaria activities.

Investments and initiatives of other donors and international organizations

Health donors meet monthly and have an MCH special interest group. The USG supports the polio program in Pakistan through the World Health Organization (WHO). For activities related to district-level services, provision of contraceptives, safe drinking water, and HIV control, it coordinates with DfID, the Government of Norway, CIDA, UNICEF, UNFPA, AUSAID, JICA, GTZ and the World Bank In addition, Pakistan has grants for TB, malaria and HIV/AIDS activities from the Global Fund.

Planned results for the Mission MCH investments over the next 5 years

The USAID/Pakistan maternal-child health program priority is to reduce mother, newborn, and child deaths. Within 5 years the program will significantly increase the number of women delivering with a SBA, and reduce the number of children susceptible to disease. The program will contribute to increased use of family planning. A greater proportion of births will be spaced at least 3 years apart. A smaller proportion of births will occur among women under age 18, and who have five children or more. The program will expand the use of hygiene and sanitation practices. Polio will be eradicated.

MCH COUNTRY SUMMARY: PAKISTAN	VALUE
MCH FY08 BUDGET	13,864,000 USD
Country Impact Measures	
Number of births annually*	4,543,000
Number of under-5 deaths annually	427,000
Neonatal mortality rate (per 1,000 live births)	54
Infant mortality rate (per 1,000 live births)	78
Under-5 mortality rate (per 1,000 live births)	94
Maternal mortality ratio (per 100,000 live births)	276
Percent of children underweight (moderate/severe)****	38%
Birth Preparedness and Maternity Services	
Percent of women with at least one antenatal care (ANC) visit	61%
Percent of women with at least four antenatal care (ANC) visits	28%
Percent of women with a skilled attendant at birth	39%
Percent of women receiving postpartum visit within 3 days of birth	39%
Newborn Care and Treatment	
Percent of newborns whose mothers initiate immediate breastfeeding	29%
Immunization	
Percent of children fully immunized	39%
Percent of DPT3 coverage	59%
Percent of measles coverage	60%
Maternal and Young Child Nutrition, Including Micronutrients	
Percent of mothers receiving iron-folate	43%
Percent of children receiving adequate age-appropriate feeding	36%
Percent of children under age 5 receiving vitamin A supplement in the past 6 months	95%
Percent of children under 6 months exclusively breastfed	37%
Treatment of Child Illness	
Percent of children with diarrhea treated with ORT	47%
Percent of children with diarrhea treated with zinc	N/A
Percent of children with pneumonia taken to appropriate care	69%
Water, Sanitation, and Hygiene	
Percent of population with access to improved water source**	90%
Percent of population with access to improved sanitation**	58%

* Census International Database
** Joint Monitoring Programme for Water Supply and Sanitation 2008 Report
*** WHO Maternal Mortality Report 2007
**** State of the World's Children Report 2008
(Unless otherwise noted, the data source is the 2006-07 Demographic and Health Survey.)

Philippines MCH Program Description

Overall MCH and health sector situation

The Philippines has a population of around 88.6 million, around 37 percent of whom are under age 15. The country's high population growth rate remains a significant factor in the incidence of poverty and poor health status. While infant and under-5 mortality has significantly improved in the past 5 years, there has been no significant reduction in maternal mortality and neonatal deaths for the same period. Malnutrition and infectious diseases like diarrhea, pneumonia, and tuberculosis continue to account for a significant part of the disease burden. Some 20 percent of the population still lacks access to safe water and sanitation. However, the estimated prevalence of HIV/AIDS has remained below 3 percent among most-at-risk groups.

The Philippines' population growth rate of 2.04 percent outstrips the country's ability to generate jobs and provide basic services; consequently 44 percent of the population continues to live on $2 a day or less. In 2005, the total expenditure on health represented only 3.3 percent of the GDP. Furthermore, the education system, once considered to be among the best in Asia, has deteriorated sharply over the last 30 years in terms of quality, affordability, and GOP budget allocation.

MCH interventions at the Mission level

Priority areas of MCH interventions include antenatal, delivery, postpartum, and newborn health services, immunization, breastfeeding, maternal and child nutrition through micronutrient supplementation and food fortification, as well as the appropriate management of common childhood illnesses. Consistent with country objectives, the USG MCH assistance is aimed at accelerating the reduction in maternal and child deaths and promoting overall well being, especially among women and children. USG assistance directed at key national agencies and local governments will cover 40 percent of the country's population by 2011, with a focus on the poor and under-served women and children. At the end of FY08, an estimated 14.4 million people in USG-assisted sites nationwide are targeted to have access to high-quality and affordable MCH services.

Delivery approaches and mechanisms supporting expanded coverage/use of interventions

USAID supports various aspects of MCH implementation, such as the development and implementation of national policies particularly related to standards, regulation, and financing of MCH strategies and the development of health management and operational capacities of local government units (LGUs) to better provide quality health services, especially to the poor. In addition, USAID supports the expansion of MCH services, food fortification, and micronutrient supplementation through the private sector, such as through a network of private midwives and through company-based health providers in over 400 businesses nationwide. Demand-side interventions are also supported through BCC and social marketing as part of the communications strategies of the Department of Health (DOH) and LGUs, as well as through mobilization of community-based organizations.

Specific actions supported as part of the MCH approach

USAID supports the DOH in the establishment of an integrated MCH strategy, supported by issuance of a national policy and technical guidelines. The strategy includes a core service package for MCH, identifying a service catchment area and establishing an effective service delivery structure and network of providers. To

improve budget allocation and spending of DOH funds related to MCH, USAID supports the development of a joint budget execution plan and utilization tracking mechanism. This financing scheme is linked to a grant mechanism aimed at strengthening LGU capacities for MCH implementation.

USAID support is also directed at leveraging national government resources for improved program performance at the local level, such as expanding access to social health insurance among the poor and indigents, increasing the utilization of maternal and newborn services by women and children, and enhancing the capacity of the public and private providers to deliver quality MCH information and services.

The USAID program's geographic focus

USAID support to the health sector covers the entire country as it provides technical assistance to the DOH. More intensive support is provided to 42 provinces (13 of which solely focus on strengthening private sector participation) through its various cooperating agencies (CAs) that cover the focus areas of local health systems development, tuberculosis prevention and control, private sector participation, and health promotion. In all these areas, support for MCH areas is being provided either as a direct deliverable or related product of the CA. DOH takes a lead in coordinating donor activities in MCH and meets regularly with all the donors.

The Mission program's relationship to the country's health sector and development plans and strategies

USAID's family health program is consistent with the Philippine Government's commitments to MDGs 4 and 5 as well as to its National Objectives for Health of reducing maternal and child mortality in the country. In pursuing these goals, USAID support through policy and systems development, local health systems strengthening and increasing private sector participation complements current health sector reform efforts of the country.

Potential for linking Mission MCH resources with other health sector resources and initiatives

USG investments (e.g., PMI, PEPFAR, Title II, OFDA, water, etc.)

USAID is developing the Philippine Water Revolving Fund (PWRF), a facility designed to catalyze the transition to market-based lending by using public and donor resources to leverage private sector funds for water and sanitation infrastructure. FY08 efforts will focus on setting up the fund, strengthening capacity of the PWRF administrator, preparing projects, and addressing critical water and financial-sector policy issues. In conflict-affected areas of Mindanao, USAID will fund community water supply systems. USAID will also assist local governments and private partners to design and install affordable sanitation systems.

Investments and initiatives of other donors and international organizations

The WHO, UNICEF, JICA and the World Bank support the DOH's immunization program and enhancing local capacity to manage obstetric complications. The German Development Agency is supporting development of water and sanitation sector roadmaps expected to further enhance sector investment. The Philippines Development Forum Working Group on Local Government is seeking to rationalize municipal project financing, including water projects. Under the Philippine Water Revolving Fund (PWRF) initiative, USG collaborates with the Japan Bank for International Cooperation (JBIC) and other stakeholders. The Joint Special Operations Task Force – Philippines (JSOTF-P) provides maternal and child health services through targeted medical missions.

Planned results for the mission's MCH investments over the next 5 years

The Philippines' long-term goals for MCH are (1) to reduce the MMR from 209 per 100,000 live births (DHS) in 1993 to 53 by 2015; and (2) to reduce the U5MR from 64 per 1,000 live births in 1993 to 21 by 2015.

MCH COUNTRY SUMMARY: PHILIPPINES	VALUE
MCH FY08 BUDGET	3,720,000 USD
Country Impact Measures	
Number of births annually*	2,225,000
Number of under-5 deaths annually	89,000
Neonatal mortality rate (per 1,000 live births)	17
Infant mortality rate (per 1,000 live births)	29
Under-5 mortality rate (per 1,000 live births)	40
Maternal mortality ratio (per 100,000 live births)***	230
Percent of children underweight (moderate/severe)****	28%
Birth Preparedness and Maternity Services	
Percent of women with at least one antenatal care (ANC) visit	93%
Percent of women with at least four antenatal care (ANC) visits	69%
Percent of women with a skilled attendant at birth	60%
Percent of women receiving postpartum visit within 3 days of birth*****	34%
Newborn Care and Treatment	
Percent of newborns whose mothers initiate immediate breastfeeding	54%
Immunization	
Percent of children fully immunized at 1 year of age	60%
Percent of DPT3 coverage	79%
Percent of measles coverage	80%
Maternal and Young Child Nutrition, Including Micronutrients	
Percent of mothers receiving iron-folate	77%
Percent of children receiving adequate age-appropriate feeding	58%
Percent of children under age 5 receiving vitamin A supplement in the past 6 months	76%
Percent of children under 6 months exclusively breastfed	34%
Treatment of Child Illness	
Percent of children with diarrhea treated with ORT	59%
Percent of children with diarrhea treated with zinc	N/A
Percent of children with pneumonia taken to appropriate care	46%
Water, Sanitation, and Hygiene	
Percent of population with access to improved water source**	93%
Percent of population with access to improved sanitation**	78%

* Census International Database
** Joint Monitoring Programme for Water Supply and Sanitation 2008 Report
*** Source: WHO Maternal Mortality Report 2007
**** Source: State of the World's Children Report 2008
***** This number is based only on mothers whose last live birth occurred outside a health facility in the 5 years preceding the survey.
(Unless otherwise noted, the data source is the 2003 Demographic and Health Survey.)

Tajikistan MCH Program Description

Overall MCH and health sector situation

Despite economic progress and increased political stability, life does not seem to be dramatically improving for the average Tajik. The country is still trying to recover from the civil war and overcome the poverty of the majority of the people without any substantial natural resources. The significant poverty in the country is reflected by high mortality rates among infants (72 per 1,000 live births) and children under 5 (79 per 1,000 live births). While these rates have declined in the last 10 years, improvements for Tajikistan have not matched those observed in the rest of the region.

Factors affecting this critical situation are multifaceted and can be divided into three major categories: poor care during pregnancy and delivery, poor child health care, and inadequate nutrition, water, and hygiene. However, all of the contributors to child mortality can be attributed to poor systems for providing services to the people of Tajikistan, with little government investment into improving them. The government contributes only 2 percent of its annual budget to health care, which leaves the financial burden mostly on the shoulders of individuals, with some contributions coming from international organizations. Tajikistan spends just $12 per capita on health care, one of the lowest rates in the world.

A study conducted by the Netherlands School of Public and Occupational Health in 2006 found Tajikistan to be among the "risky places to be pregnant and to have a child." The study found that women and their families have inadequate knowledge of reproductive health, danger signs during pregnancy, or appropriate prenatal, postnatal, and delivery care. It was also determined that service providers do not create a safe environment for women in labor and lack important basic skills to properly manage deliveries. They work in settings that lack basic equipment, instruments, and hygiene. USAID has found other factors affecting infant mortality in Tajikistan to be the lack of access to proper antenatal and postnatal care and frequent complications in pregnancy resulting from poor nutrition. A high rate of home births assisted by untrained birth attendants, especially in rural areas, is another element affecting child survival.

High rates of child mortality and morbidity result in part from a lack of basic health knowledge among Tajik communities, resulting in inadequate early recognition of the danger signs of childhood illnesses by parents. However, even when care is sought, practitioners are often unable to follow appropriate guidelines, due to a lack of quality training. The practice of exclusive breastfeeding is not widespread, and this is a factor in inadequate childhood health and development. Anemia rates among children under 5 and women are high. A disturbing recent development is that as a result of the emergency situation in Tajikistan over the last year with an energy crisis and food shortages, child and infant mortality appear to be increasing. Child and infant deaths recorded by the MOH for the first quarter of 2008 exceeded deaths for the entire year in 2007.

Chronic and severe malnutrition is also a major contributor to poor child health. Tajikistan has the highest child malnutrition rates in the region. Poor food rations and water-born diarrheal diseases, aggravated by inappropriate child care practices, are the main causes of child malnutrition in Tajikistan. Although Tajikistan has the greatest water resources in the region, limited access to clean water and a high prevalence of water-born diseases constitute a major public health problem. Almost all

regions of the country regularly experience outbreaks of typhoid, diarrhea, or hepatitis. Diarrheal diseases are a leading cause of child death in Tajikistan, with 28 percent of young children relying on surface water, exposing them to the risk of waterborne diseases. Lack of potable water and nonobservance of basic hygiene practices due to lack of knowledge and means cause diarrheal diseases among children and lead to malnutrition.

MCH interventions at the Mission level

USAID's program currently focuses on birth preparedness and maternity services, newborn care and treatment, treatment of child illnesses, health systems strengthening, and household water, sanitation, and hygiene improvement. As new programs are currently being designed and procured, population coverage is still being determined. Nutrition has been addressed in the past through Title 2 programs, which are now ending.

Delivery approaches and mechanisms supporting expanded coverage/use of interventions

The programs will work to scale up, improve, and institutionalize technical interventions proven to be successful in Tajikistan, while building systems to support their continuing implementation for quality MCH services. Activities will be oriented toward scaling up certain packages of services. The birth package includes SBAs, emergency obstetric care, institutional delivery, postpartum hemorrhage control, AMTSL, oxytotics, basic essential neonatal care, and resuscitation. The postpartum/newborn package includes postpartum visits, basic essential neonatal care, exclusive breastfeeding, detecting/managing infection, low-birth-weight special care, and family planning. The community child health package includes breastfeeding and infant-child feeding promotion, community case management, ORT (with zinc), pneumonia, community management of acute malnutrition, POU water, and sanitation.

Specific actions supported as part of the MCH approach

USAID/CAR is improving maternal, neonatal and child health through a multifaceted approach. The ZdravPlus project is improving the policy, finances, service delivery, and community involvement in the entire health system including MCH. They are ensuring the policies are in place to allow for evidence-based approaches to be adopted and implemented, the financial systems are efficient and focused on providing the basic services for the population, the services provided are of high quality, and the community is knowledgeable and involved in their health care. The quality of care for MCH has improved through provider training, community mobilization, population education, and food supplements.

The USAID program's geographic focus

As new programs are currently being designed and procured, population coverage is still being determined. USAID's ongoing health reform activity covers the entire population of Tajikistan for its financial and health information system reforms. Pilot programs to improve the quality of obstetric and neonatal care cover limited populations in urban centers throughout the country. While former USAID MCH programs have focused on Khatlon oblast, new programs will not be directed to a specific geographic area.

The Mission program's relationship to the country's health sector and development plans and strategies

USAID acknowledges that effective partnerships will be critical for achieving the MCH goals. USAID's principal partner for health reform in Tajikistan is the Government of Tajikistan, particularly the Minister of Health. USAID programs are guided by Tajikistan's national strategies and plans. USAID also actively pursues innovative working relationships with private sector partners to enhance health services in Tajikistan priority countries, recognizing that Administrator Fore has set a target of tripling the number of such partnerships during 2008. MCH programs funded by USAID will be strategically positioned to complement the resources provided by international and local partners including other donors, multilateral organizations, and NGOs operating in Tajikistan.

Potential for linking Mission MCH resources with other health sector resources and initiatives

USG investments (e.g., PMI, PEPFAR, Title II, OFDA, water, etc.)

USAID/CAR has been very successful in leveraging USG and non-USG resources for health activities in the region. The health systems project benefits all technical areas, particularly MCH. USAID is currently advocating for continuing food assistance to Tajikistan. Additional programs to support safe water are planned for 2010.

Investments and initiatives of other donors and international organizations

The World Bank's $14 million Community and Basic Health Project supports the Government of Tajikistan to

administer a basic package of health benefits and to introduce financing reforms into primary health care. The Asian Development Bank's Health Sector Reform Project aims to improve the management capacity of the health sector and system efficiency through institutional strengthening and reforms, focusing on equitable access for women and children.

Planned results for the Mission's MCH investments over the next 5 years

USAID's investments in MCH over the next 5 years will be oriented toward assisting the government of Tajikistan to achieve its health-related MDGs: to reduce by two thirds, between 1990 and 2015, the U5MR, and to reduce by three quarters, between 1990 and 2015, the MMR.

MCH COUNTRY SUMMARY: TAJIKISTAN	VALUE
MCH FY08 BUDGET	744,000 USD
Country Impact Measures	
Number of births annually*	171,000
Number of under-5 deaths annually	14,000
Neonatal mortality rate (per 1,000 live births)**	38
Infant mortality rate (per 1,000 live births)	72
Under-5 mortality rate (per 1,000 live births)	79
Maternal mortality ratio (per 100,000 live births)	97
Percent of children underweight (moderate/severe)	17%
Birth Preparedness and Maternity Services	
Percent of women with at least one antenatal care (ANC) visit	77%
Percent of women with at least four antenatal care (ANC) visits	N/A
Percent of women with a skilled attendant at birth	83%
Percent of women receiving postpartum visit within 3 days of birth	N/A
Newborn Care and Treatment	
Percent of newborns whose mothers initiate immediate breastfeeding	61%
Immunization	
Percent of children fully immunized at 1 year of age	71%
Percent of DPT3 coverage	82%
Percent of measles coverage	91%
Maternal and Young Child Nutrition, Including Micronutrients	
Percent of mothers receiving iron-folate	48%
Percent of children receiving adequate age-appropriate feeding	16%
Percent of children under age 5 receiving vitamin A supplement in the past 6 months	47%
Percent of children under 6 months exclusively breastfed	26%
Treatment of Child Illness	
Percent of children with diarrhea treated with ORT	58%
Percent of children with diarrhea treated with zinc	N/A
Percent of children with pneumonia taken to appropriate care	41%
Water, Sanitation, and Hygiene	
Percent of population with access to improved water source	70%
Percent of population with acess to improved sanitation	94%

* Census International Database
** State of the World's Children Report 2008
(Unless otherwise noted, the data source is the 2005 Multiple Indicators Cluster Survey)

Maternal and Child Health Strategic Approach – Europe and Eurasia

Objectives

By 2013, in Azerbaijan, the only "MCH Priority Country in E&E," USAID will help improve the quality of reproductive, antenatal, and child health services with an aim to contribute to the following global goals:

- Decrease U5MR by 25 percent
- Decrease MMR by 25 percent
- Increase the number of GDA partnerships focused on MCH

MCH Priority Country
AZERBAIJAN

Note: USAID's MCH activities and programs in other countries of the Europe and Eurasia Region are supported by funds from accounts other than the CSH MCH account. These strategic considerations and approaches apply to those other country programs as well.

Problem statement

Health indicators for women and children have not paralleled the positive economic progress made by many countries in Europe and Eurasia (E&E). Under-5 mortality rates are unacceptably high, and regionally, remain over 10 times higher than the EU average. While the majority of births take place in a medical facility with trained attendants, most infant deaths in the regions still take place during the first 6 days after birth. More effective newborn care techniques, including simple practices such as immediate breastfeeding, skin-to-skin contact, and "rooming in," could address such problems as hypothermia, which in some E&E countries accounts for more than 60 percent of infant mortality. In Eurasia, the majority of deaths before 5 years occur during the neonatal and infant periods.

Breastfeeding rates in E&E are below WHO's recommended levels, with a resulting deleterious effect on infant nutritional intake. Continuous breastfeeding, in addition to contributing to improved child nutritional status, increases birth spacing and leads to a reduction in unplanned pregnancies (and therefore abortions). Iodine deficiency disorders, which can contribute to mental retardation in children, are also a concern in the region. Only approximately 52 percent of households use iodized salt.

The opportunity to reduce MMR through simple interventions also exists in the E&E region. Postpartum hemorrhage remains a significant risk. By focusing on basic obstetric practices in hospitals and other health facilities, maternal and infant mortality could be dramatically improved.

What has been accomplished to date

Investing in mothers and children in E&E has proven critical to the future of the region and demonstrates enormous returns. The most pressing maternal and child health problems are largely preventable – the solutions well-known, and there is a relatively high capacity for implementation and efficient replication. With relatively minimal investment, high-impact interventions can be introduced that contribute to a reduction in overall MCH mortality and morbidity. Additionally, the same solutions that address MCH have also introduced concepts of integrating services, a goal of health care reform throughout post-Soviet countries. Political will exists in many E&E countries for supporting and potentially co-financing MCH interventions. Government officials frequently cite MCH as a top priority in health.

MCH interventions pose an important opportunity in E&E to reduce abortion and improve maternal health by integrating family planning counseling and services into postabortion care, postpartum visits, and child immunization services. Studies show that these are low-cost and high-impact interventions that can reach women at times when they are particularly open to behavior change messages around modern contraceptive use.

Given the foundation of political interest and infrastructure, USAID can now assist in identifying and addressing MCH gaps, constraints, and major unmet

needs. In this region, USAID is now poised to leverage significant country and other donor resources through policies and technical assistance to promote the expansion of high-impact interventions linked with health system strengthening that will support countries in achieving and maintaining critical MCH outcomes.

Challenges

- Regionally, health systems have been slow to decentralize, adopt modern technologies, and integrate service delivery.
- In several countries, lack of political will has also resulted in persistent or even growing corruption in the health sector.
- Particularly troubling are recent indications of backsliding in the region, based on U5MR and falling immunization levels.
- Though the vast majority of births occur in a health facility, the over-medicalization of pregnancy, including the overuse of C-sections and unnecessary medications, presents one of the greatest threats to safe pregnancy in the region.

Strategies

The MCH strategic approach in E&E will focus on the countries that show the slowest progress, measured primarily by U5MR. Programming will focus on:

- Programming through GDA partnerships in order to leverage additional resources and technical assistance, and to promote sustainability
- Introducing more effective newborn care techniques to address preventable fatalities due to such simple threats as hypothermia and malnutrition
- Targeted training of health care providers to promote the adoption of modern best practices in reproductive health
- Antenatal care, newborn care, treatment of postpartum hemorrhage, postabortion care and emergency obstetric care within integrated MCH services
- Child health programs including vaccine delivery
- Multichannel breastfeeding promotion and support, and introduction of nutrition programs as part of other MCH activities
- Family planning counseling and services integrated into postabortion care visits, postpartum visits, and child immunization visits

Azerbaijan MCH Program Description

Overall MCH and health sector situation

Azerbaijan, an important U.S. ally due to its strategic geopolitical location, has a population of 8.12 million. It is a predominantly Muslim nation with a secular democracy. Despite the country's growing oil wealth, about one -third of its people live below the poverty line.

Key health indicators have declined dramatically since Azerbaijan became independent in 1991. The most vulnerable demographic groups are children under 5 and women of childbearing age. Azerbaijan has a high U5MR for the E&E region, although there has been significant improvement from 92/1,000 births in 2001 to 50 in 2006. Azerbaijan has a very high abortion rate (71/1,000 women of reproductive age), a consequence of very low utilization of modern contraceptive methods, which is approximately 14 percent and among the lowest worldwide. The number of new HIV infections has been steadily increasing since the 1990s, and the estimated prevalence is 0.1 percent. Prevention and treatment of HIV and other STIs remain largely inadequate. Incidence of TB has increased by 50 percent since 1995 and is about 75 cases per 100,000 per year. (TB prevalence is at 87/100,000) Proper screening and reporting does not exist in the civil sector, but it is suspected that there are high rates of multidrug-resistant tuberculosis (MDR-TB). According to the most recent WHO drug resistance surveillance report, the highest MDR-TB rate was recorded in Baku, Azerbaijan, where nearly a quarter of all new TB cases (22.3 percent) were reported as MDR-TB.

As of 2004, Azerbaijan spent only 0.9 percent of its GDP on public health expenditures, the lowest in the E&E region and fifth lowest in the world. The quality and access to health care services in the country, including reproductive health and family planning, remain serious concerns. While the MOH budget increased approximately 60 percent in real terms over the past 2 years, and the World Bank has provided a $50 million loan to support health care reform, the health care system remains severely underfunded and poorly managed. A potential exists for increased public investment in health from oil revenues.

MCH interventions at the Mission level

Priority areas for MCH interventions include improving primary health care services, which are focused in five pilot districts, care for marginalized children reaching approximately 11,300 children, and a family planning and reproductive health program covering six rural regions and two urban areas of Baku City and Absheron. Assessments in the private sector to improve FP/RH services through that sector were also conducted, and interventions are being designed based on the recommendations. There is a need for a much larger and more integrated MCH/FP program in the country, based on the health indicators above.

Delivery approaches and mechanisms supporting expanded coverage/use of interventions

USG health-related assistance supports the improvement of primary health care services through provision of technical assistance to design and implement the country's new Primary Health Care Reform Agenda. Many of the targeted health facilities are for the first time beginning to meet international standards. Integrated management of childhood illness protocols were initiated in nine districts. Additionally, networks of local health departments, NGOs, communities, and the private sector are collaborating to improve the quality and access to local FP/RH services.

Specific actions supported as part of the MCH approach

Health sector reform forms a significant part of the Mission portfolio. These activities are implemented by the Primary Health Care Strengthening Project, in collaboration with the Health Sector Reform Project. These activities are co-funded by the MOH, World Bank, USAID, and WHO. USG assistance in this area focuses on increasing public expenditure, improving the quality and resource allocation for PHC services, improving the legal framework for an improved PHC sector, and promoting personal responsibility for better health. These efforts help to ensure greater efficiency in health budget allocations aimed at expanding access to high-quality services. Improved health sector governance will be achieved through creation of reliable and accurate information systems, ensuring a cadre of trained health care professionals, improving financial management, and increasing interaction of health care professionals and policymakers with community civilian and local governments.

The USAID program's geographic focus

Since the Mission's efforts are focused on assisting the government of Azerbaijan in designing and implementing the country's new PHC Reform Strategy, the impact of our assistance will affect the entire country. This will be achieved in partnership with MOH, World Bank, UNICEF, and WHO.

The Mission program's relationship to the country's health sector and development plans and strategies

The Mission's program complements the work of the Government of Azerbaijan's Health Sector Reform Project by providing technical assistance to MOH staff to build the MOH's capacity to design and implement reforms.

Potential for linking Mission MCH resources with other health sector resources and initiatives

The USG ($8 million) works closely with WHO ($40,000), UNICEF ($470,000), The World Bank ($50 million), and the MOH ($28 million) National Center of Public Health Reforms to co-finance and partner in the institutionalization of National Health Accounts, development of the primary health care master plan, and piloting PHC models in target districts. The USG collaborates with WHO and UNFPA in expanding FP/RH services. This ensures better coordination and regular sharing of information and experiences. For example, the USG, WHO, and UNFPA worked closely to provide TA to the MOH in the development of the National Reproductive Health Strategy (NRHS). The USG will pilot test selected models and interventions regarding RH and contraceptive choices, while UNFPA works with adolescents to increase their awareness of FP/RH and sustain behavior change, improve logistics management systems, and establish emergency RH services in remote areas. All these activities together will help advance the GOAJ's health reform agenda. The USG complements UNFPA's efforts by creating a more favorable policy environment, broadening the availability of contraceptive services, and increasing public awareness of FP/RH.

Planned results for the Mission's MCH investments over the next 5 years

This initiative will allow the Mission to begin developing a strategic plan to address MCH indicators.

MCH COUNTRY SUMMARY: AZERBAIJAN	VALUE
MCH FY08 BUDGET	744,000 USD
Country Impact Measures	
Number of births annually*	129,000
Number of under-5 deaths annually	6,500
Neonatal mortality rate (per 1,000 live births)	28
Infant mortality rate (per 1,000 live births)	43
Under-5 mortality rate (per 1,000 live births)	50
Maternal mortality ratio (per 100,000 live births)****	82
Percent of children underweight (moderate/severe)	8%
Birth Preparedness and Maternity Services	
Percent of women with at least one antenatal care (ANC) visit	77%
Percent of women with at least four antenatal care (ANC) visits*****	45%
Percent of women with a skilled attendant at birth	89%
Percent of women receiving postpartum visit within 3 days of birth	66%
Newborn Care and Treatment	
Percent of newborns whose mothers initiate immediate breastfeeding	32%
Immunization	
Percent of children fully immunized at 1 year of age**	60%
Percent of DPT3 coverage**	71%
Percent of measles coverage**	74%
Maternal and Young Child Nutrition, Including Micronutrients	
Percent of mothers receiving iron-folate	23%
Percent of children receiving adequate age-appropriate feeding	44%
Percent of children under age 5 receiving vitamin A supplement in the past 6 months	4%
Percent of children under 6 months exclusively breastfed	12%
Treatment of Child Illness	
Percent of children with diarrhea treated with ORT	31%
Percent of children with diarrhea treated with zinc	N/A
Percent of children with pneumonia taken to appropriate care	N/A
Water, Sanitation, and Hygiene	
Percent of population with access to improved water source***	78%
Percent of population with access to improved sanitation***	80%

* Census International Database ** This refers to children 18-29 months. *** Joint Monitoring Programme for Water Supply and Sanitation 2008 Report **** WHO Maternal Mortality Report 2007 ***** This number is based on mothers whose last live birth occurred in the 5 years preceding the survey.
Unless otherwise noted, the data source is the 2006 Preliminary Demographic and Health Survey.)

Maternal and Child Health Strategic Approach – Latin America and the Caribbean

Objectives

By 2013, USAID will work with national governments and national and international partners to implement sustainable approaches that will help improve equitable health services with an aim in priority countries to:

- Decrease U5MR by 25 percent
- Decrease MMR by 25 percent
- Decrease malnutrition by 15 percent

In other ongoing MCH programs

- Increase the use of AMTSL in four Central American countries from a range of 3 percent to 7 percent to 75 percent in each of the four focus countries (El Salvador, Honduras, Guatemala, and Nicaragua)
- Define parameters for graduating a country to sustaining partner status in health and draft multiyear phase-out plans in three or four LAC countries (depending on defined parameters)

In all LAC MCH programs

- Increase skilled attendance at birth by 5 percent in the two lowest quintiles
- Decrease newborn mortality by 5 percent in the region
- Increase access to essential newborn care by 5 percent among the poorest quintile in the region

Problem statement

MCH program efforts in the LAC region vary depending on level of need and status of current health indicators. Bolivia, Guatemala, and Haiti are the high-priority countries of the region for MCH work. Reaching the poorest-quintile women and children through more efficient health systems so as to ensure sustainability of health improvements is the focus of efforts in the other ongoing MCH programs of Dominican Republic, El Salvador, Honduras, Nicaragua, and Peru.

MCH Priority Countries
BOLIVIA
GUATEMALA
HAITI

Inequities in the region remain the largest barrier to sustainable improvements in health. In Bolivia, infant mortality is 72/1,000 for the poorest quintile versus 27/1,000 for the richest. In Honduras 43.2 percent of the poorest children suffer stunting, versus 5 percent of the wealthiest. In Guatemala 9.3 percent of the poorest women have a SBA versus 91.5 percent of the wealthiest quintile. Additionally, a PAHO study found that approximately 47 percent of the population in LAC is excluded from health services.

What has been accomplished to date

As the LAC region has achieved many successes related to maternal and child survival, Missions have moved to targeted programs according to country context, with the goal of ensuring that past gains are sustainable and addressing barriers to continued improvement. In general, funding is directed less toward nationwide IMCI and immunizations and has moved more into targeted quality-of-care programming with an emphasis on ensuring that country health systems operate efficiently and are able to reach the poorest of the poor. The exception to this targeting of resources is Haiti, where the Mission supports almost 50 percent of the primary care health system of the country.

Challenges

The major challenges for USAID's MCH programs in the region include:

- Rich-poor disparities in access to quality health services
- Urbanization

Strategies

The key strategy of the LAC bureau is to sustain gains made to date and to target efforts to the poorest quintile

of women and children of the region, especially in the LAC focus countries of Haiti, Bolivia, and Guatemala.

The regional program makes strategic investments to inform policy change through targeted research and pilot multicountry interventions.

Priorities for both priority and other ongoing MCH programs include:

- Moving from knowledge to practice replacing expensive cascade training models through utilization of research on the barriers to implementation of clearly effective practices
- Decreasing neonatal sepsis at hospital and community levels
- Continuing to support maternal mortality reduction by improving surveillance through Reproductive Age Mortality Surveys (RAMOS) and development of a "real-time" reporting system to be pilot tested in two to three countries
- Slowing development of antimicrobial resistance through an ecological community/institution initiative involving prescribers, users, and drug quality (priority maternal and child high-use drugs)
- Preventing and treating postpartum hemorrhage through high-quality antenatal care (prevention and treatment of anemia), universal AMTSL, and improved coverage and quality of postpartum care
- Identifying treatment care practices that are contributing to pregnancy-induced hypertension (PIH), which has become the leading cause of maternal mortality in the region, and addressing those issues
- Determining which factors affect a country's ability to sustain improvements in maternal and child health, prevent backsliding of gains, and address these factors
- Ensuring that public resources are used primarily to benefit the poorest of the poor through tracking funding flows and programming to address discrepancies
- Identifying and addressing systemic inefficiencies due to corruption, mismanagement or poor resource allocations
- Improving health information systems so that service and outcome data are reliably tracked in-country

It is anticipated that this careful targeting of vulnerable countries and sub-populations will result in substantive improvements in health care by 2013.

Bolivia MCH Program Description

Overall MCH and health sector situation

Bolivia has a population of 9.1 million, 34 percent of whom are below the age of 15. In 2003, the total expenditure on health represented 6.7 percent of GDP. Although the nation faces major development challenges, there has been a decrease in the U5MR from 116 to 75 and in the IMR from 75 to 54/1,000 live births in the period between 1994 and 2003. The MMR, at 229/100,000 live births, has declined from 390/100,000 live births, in 1994. Despite these declines, Bolivia's health indicators are the second worst in the hemisphere. The use of SBAs is 61 percent. The TFR dropped to 3.8 children (3.1 urban; 5.5 rural) in 2003 from 4.2 in 1998 and modern contraceptive prevalence has increased from 12.2 in 1989 to 35 in 2003. This low use of modern FP means that some women continue to have more children than they desire, with desired fertility attained often by their mid-20s. The unmet need for spacing births is 6 percent and for limiting births is 17 percent, and there is wide disparity between the lowest and highest wealth quintiles as well as between rural and urban areas.

Bolivia finds itself facing a number of significant challenges. Deep social divisions mark the resource-rich eastern lowlands region and the indigenous–majority western altiplano. Political upheaval, high inflation, and recent heavy rains and flooding have posed enormous challenges for improving health. The MOH is responsible for maximizing the effectiveness of external financing for national, regional, and local health sector programs; it has recently initiated efforts to improve harmonization of donor programs with MOH policies and priorities. USAID is the only USG agency with a comprehensive health program in Bolivia, and it supports the Bolivian government's efforts to decentralize health services to reach underserved populations and promote a public health model based on community, family, and intercultural health.

MCH interventions at the Mission level

Priority areas of intervention include prenatal and postnatal care, emergency obstetric care, nutrition, immunization, family planning, postabortion care, and drinking water supply and sanitation. Programs reach people in peri-urban or urban areas in all nine of Bolivia's departments and in the rural areas of four departments.

Delivery approaches and mechanisms supporting expanded coverage/use of interventions

The program focuses on support to community health services for prenatal and postnatal care and basic child health services; improved case management of severely malnourished children; the development of emergency obstetric care networks; family planning services that include commodities, as well as support to approaches that allow men and women to make educated decisions about their reproductive lives; and improved access to postabortion care. Programs address a host of factors that affect use of services including proximity, transport, compassionate, efficient, and effective care; and respect for non-harmful, traditional cultural practices. USAID promotes an integrated approach that gives women and children access to life-saving health care that includes attention to quality of care, healthy practices in the home, and a well-functioning referral system through support for training, technical assistance, commodities and subgrants to municipal health facilities and NGOs. Several USG partners are building local capacities to design, deliver, and evaluate community health activities.

Specific actions supported as part of the MCH approach

USAID is helping to improve the institutional capacity of two private sector institutions: PROSALUD, the largest network of private health service providers in the country, which provides over 500,000 consultations nationwide per year; and CIES, with nine centers across the country, which specializes in reproductive and maternal and child health.

The USAID program's geographic focus

USAID's program supports activities in all nine of Bolivia's departments.

The Mission program's relationship to the country's health sector and development plans and strategies

The Mission's health program directly supports the Government of Bolivia's National Development Plan (PND) and the MOH's plan for the health sector. Specifically, USAID's activities support the national "Zero Malnutrition" policy and the MOH's framework policies concerning family, community and intercultural health and health promotion. USAID and its partners also participate in numerous technical working groups to advance programming in technical areas including vaccinations, maternal health, and Chagas disease.

Potential for linking Mission MCH resources with other health sector resources and initiatives

USG investments (e.g., PMI, PEPFAR, Title II, OFDA, water, etc.)

USAID has a monetization program, funded through PL 480/Title II Food Security Funding resources, that contributes to reduced maternal and child morbidity and mortality and is closely coordinated with other health activities. FY08 will be the final year for PL-480 Title II assistance to Bolivia. USAID provides funding for HIV/AIDS programming in Bolivia, including through the CDC to provide technical assistance for HIV/AIDS behavioral research, voluntary counseling and testing, laboratory performance improvement, and epidemiological surveillance. The DOD is using other funding sources to provide direct health services to the population and to sponsor Bolivian military participation in regional and international conferences on health issues.

Investments and initiatives of other donors and international organizations

USAID participates in a donor technical working group that includes bilateral and multilateral donors including Canada, Belgium, Japan, the EU, France, Venezuela, UNICEF, UNFPA, PAHO, and the Global Fund for HIV/AIDS, Tuberculosis and Malaria. USAID coordinates with and provides funding to PAHO on malaria and with UNFPA on maternal health.

Planned results for the Mission's MCH investments over the next 5 years

Over the next 5 years, USAID's program expects to contribute to the establishment of emergency obstetric and neonatal care networks that will save the lives of mothers and babies, and to reduce child morbidity and mortality as a result of better treatment in health centers and improved prevention measures in homes and communities.

MCH COUNTRY SUMMARY: BOLIVIA	VALUE
MCH FY08 BUDGET	6,510,000 USD
Country Impact Measures	
Number of births annually*	219,000
Number of under-5 deaths annually	16,000
Neonatal mortality rate (per 1,000 live births)	27
Infant mortality rate (per 1,000 live births)	54
Under-5 mortality rate (per 1,000 live births)	75
Maternal mortality ratio (per 100,000 live births)	229
Percent of children underweight (moderate/severe)	9%
Birth Preparedness and Maternity Services	
Percent of women with at least one antenatal care (ANC) visit	79%
Percent of women with at least four antenatal care (ANC) visits	58%
Percent of women with a skilled attendant at birth	67%
Percent of women receiving postpartum visit within 3 days of birth***	9%
Newborn Care and Treatment	
Percent of newborns whose mothers initiate immediate breastfeeding	61%
Immunization	
Percent of children fully immunized at 1 year of age****	75%
Percent of DPT3 coverage	72%
Percent of measles coverage	64%
Maternal and Young Child Nutrition, Including Micronutrients	
Percent of mothers receiving iron-folate	N/A
Percent of children receiving adequate age-appropriate feeding	74%
Percent of children under age 5 receiving vitamin A supplement in the past 6 months	60%
Percent of children under 6 months exclusively breastfed	54%
Treatment of Child Illness	
Percent of children with diarrhea treated with ORT	64%
Percent of children with diarrhea treated with zinc	N/A
Percent of children with pneumonia taken to appropriate care	52%
Water, Sanitation, and Hygiene	
Percent of population with access to improved water source**	86%
Percent of population with access to improved sanitation**	43%

* Census International Database
** Joint Monitoring Programme for Water Supply and Sanitation 2008 Report
*** This number is based only on mothers whose last live birth occurred outside a health facility in the 5 years preceding the survey.
**** The National Health Information System
(Unless otherwise noted, the data source is the 2003 Demographic and Health Survey.)

Guatemala MCH Program Description

Overall MCH and health sector situation

Guatemala is the most populous country in the Central America region, with a population of 13.4 million. The majority of the population is composed of multiple linguistic groups of Mayan descent. Guatemala ranks second lowest in Latin America on the United Nations Human Development Index, as well as in other key indicators, including life expectancy and literacy. The country remains dependent on foreign aid from multilateral lenders and foreign governments.

Although most health indicators have improved steadily over the past 20 years, Guatemala's health indicators are more characteristic of less developed countries. According to the latest Reproductive Health Survey (2002), Guatemala has one of the lowest rates of modern contraceptive use in the LAC region at 34.4 percent, with an overall TFR of 4.4, one of the highest in LAC. The IMR of 39/1,000 live births is the highest in Central America, and more than half of infant deaths are during the first month after birth. The MMR is 153/100,000 live births, and the percentage of births attended by a skilled provider is 41 percent, the second lowest in the region after Haiti. Stunted growth is manifested in 55 percent of children under age 5 in rural areas and 36.5 percent in urban populations, with chronic malnutrition at 69 percent for indigenous children. Unfortunately, there has been little improvement in this indicator over the past few years.

Other partners working on health in Guatemala include a World Bank loan amounting to $49 million, in which the Government of Guatemala will launch a program that expands upon USAID-funded interventions aimed at improving the health and nutritional status of mothers and children under age 2. The government, with a $51.6 million loan from the IDB, will support the construction and refurbishment of selected hospitals in the public health network. Save the Children receives Gates Foundation funds for neonatal care improvement. Plan International works on water and sanitation, HIV/AIDS, and access to primary health care. The World Food Program works with $5.8 million for micronutrients and prevention and treatment of malnutrition. The Global Fund designates $62.7 million to prevent and control the HIV/AIDS epidemic, including treatment for PLWHA and prevention and control of malaria and tuberculosis. JICA has assigned $20.9 million for MCH, potable water, and hospital refurbishing. Other donors include UNICEF, PAHO, the University of Colorado, CDC, and ONUSIDA.

MCH interventions at the Mission level

Priority areas for MCH interventions include delivery of critical cost-effective proven MCH, including food security and nutrition interventions, with emphasis on rural, indigenous, and poor populations; reducing neonatal mortality; and scale-up of a sustainable integrated model for maternal and neonatal health improvement. USAID-funded activities directly or indirectly benefit approximately 6 million people.

Delivery approaches and mechanisms supporting expanded coverage/use of interventions

The USAID/Guatemala program focuses its efforts on technical assistance and leveraging its expertise for maximum impact on maternal-child health through a variety of approaches, including public-private partnerships for health and education, technical and financial support for subcontracting local NGOs to deliver primary health services, training 120 Mayan auxiliary nurses for improved attendance at birth, promotion of exclusive

breastfeeding/complementary feeding, improved immunization coverage, improved food security, and weaning/child feeding practices; conducting permanent policy dialogue to improve operational policies aimed at adapting and implementing cost-effective interventions to the local context; supporting the MOH in expanding its programs to isolated rural areas through local NGO subcontracts for service provision, testing and scaling up integrated strategies to improve quality and coverage of care at both the public health services network and at the community level, supporting decisionmakers with data for decision-making, and improved access to FP services. The program complements the work of other donors supporting the MOH in developing national norms and technical guidelines, improving access and quality of services, and monitoring performance. The largely USG-funded Demographic and Health Survey is used by the donor community and by the Government of Guatemala to gauge health needs, design interventions, and measure impact.

Specific actions supported as part of the MCH approach

USAID's support also focuses on health governance and finance. Specifically, USAID's TA aims at strengthening the MOH systems and processes to improve efficiency, transparency, quality, equity, and impact of health interventions. USAID support focuses on the design and implementation of a Quality Management System (QMS) in the MOH based on ISO Standard 9001:2001. The purpose of the QMS is to strengthen the basic capabilities within the different areas/levels of the MOH in order for their systems and processes to operate under the highest standards of quality. By implementing a QMS, improved efficiency, transparency and governance is expected within the MOH, as well as improved quality of services provided to final/internal clients and suppliers. USAID assistance also includes limited operational research and policy dialogue and civil society strengthening aimed at improving public health expenditures. Several alliances with the private sector allow for increased health financing, coverage, and quality of MCH services.

The USAID program's geographic focus

The USAID MCH program focuses geographically in the rural Mayan highland populations to bridge the enormous health gap between these groups and the rest of the country. This represents 7 of the 22 departments. However, strategies and approaches implemented in those geographic regions are often scaled up by the MOH through the official adoption of such approaches and contained in the technical guidelines, norms, and operational policies implemented with regular MOH resources and/or other donor/lender resources such as The World Bank.

The Mission program's relationship to the country's health sector and development plans and strategies

These priority interventions are complemented by food security interventions carried out by the PL-480 Title II implementing partners. Interventions/activities are well aligned with Government of Guatemala plans, including the health and nutrition strategic plans. In addition, health/nutrition and education interventions are managed as a vital continuum, as nutrition/health status and education are highly correlated and facilitate long-term employment, productivity, and economic development in the country.

Potential for linking Mission MCH resources with other health sector resources and initiatives

USG investments (e.g., PMI, PEPFAR, Title II, OFDA, water, etc.)

The USAID MCH program works closely with the PL-480 Title II Program, the bilateral and regional HIV/AIDS programs, CDC and USDA on avian flu preparedness and response, U.S. PVOs, among other U.S. partners, to ensure proper coordination and efficiency. USAID and other USG organizations, such as CDC, provide TA to the MOH; often this guidance and TA is captured by the Government of Guatemala official guidelines and protocols, which in turn are followed by all of those organizations working in-country. In addition, planning and implementation is done in a coordinated fashion.

Investments and initiatives of other donors and international organizations

Non-USG participants in MCH are the Government of Guatemala, bilateral donors such as Sweden, and multilateral donors PAHO, UNICEF, and the United Nations Population Fund.

Through a $49 million World Bank loan, the Government of Guatemala will launch a program that expands upon USAID-funded interventions aimed at improving the health and nutritional status of mothers and children under age 2. The government, with a $51.6 million loan from the IDB, will support the construction and refurbishment of the public health network. Save the Children receives Gates Foundation

funds for neonatal care improvement. Plan International works on water and sanitation, HIV/AIDS, and MCH.

Planned results for the mission's MCH investments over the next 5 years

Over the next 5 years, USAID's program aims to reduce the IMR from 39/1,000 to 23/1,000, the MMR from 153/100,000 to 138/100,000, and chronic malnutrition in children 3 to 23 months from 44 percent to 35 percent, and to improve the food security of rural Guatemalan families as well as the health and nutritional status of children 0 to 36 months and pregnant and lactating women.

MCH COUNTRY SUMMARY: GUATEMALA	VALUE
MCH FY08 BUDGET	4,660,000 USD
Country Impact Measures	
Number of births annually*	366,000
Number of under-5 deaths annually	19,000
Neonatal mortality rate (per 1,000 live births)	23
Infant mortality rate (per 1,000 live births)	39
Under-5 mortality rate (per 1,000 live births)	53
Maternal mortality ratio (per 100,000 live births)****	153
Percent of children underweight (moderate/severe)	23%
Birth Preparedness and Maternity Services	
Percent of women with at least one antenatal care (ANC) visit	84%
Percent of women with at least four antenatal care (ANC) visits	N/A
Percent of women with a skilled attendant at birth	41%
Percent of women receiving postpartum visit within 3 days of birth	N/A
Newborn Care and Treatment	
Percent of newborns whose mothers initiate immediate breastfeeding	60%
Immunization	
Percent of children fully immunized at 1 year of age	N/A
Percent of DPT3 coverage	77%
Percent of Measles coverage	75%
Maternal and Young Child Nutrition, Including Micronutrients	
Percent of mothers receiving iron-folate	N/A
Percent of children receiving adequate age-appropriate feeding	72%
Percent of children under age 5 receiving vitamin A supplement in the past 6 months***	44%
Percent of children under 6 months exclusively breastfed	51%
Treatment of Child Illness	
Percent of children with diarrhea treated with ORT*****	41%
Percent of children with diarrhea treated with zinc	N/A
Percent of children with pneumonia taken to appropriate care	64%
Water, Sanitation, and Hygiene	
Percent of population with access to improved water source**	96%
Percent of population with access to improved sanitation**	84%

* Census International Database
** Joint Monitoring Programme for Water Supply and Sanitation 2008 Report
*** State of the World's Children Report 2008
**** Duarte et al. 2003
***** Treated with ORS or home solution (does not include children given increased liquids)
(Unless otherwise noted, the data source is the 2002 Guatemala Reproductive Health Survey.)

Haiti MCH Program Description

Overall MCH and health sector situation

Haiti occupies one third of the Hispaniola Island it shares with the Dominican Republic. The population density is 300 inhabitants per square kilometer, with a total population of 8.9 million. In certain areas of Port-au-Prince, this density reaches 2,500. Haiti's GNP per capita in 2003 was $332, down from $632 in 1980, a decline of 90 percent over 23 years, whereas the GNP per capita for the Latin America and Caribbean (LAC) region was $3,580 in 2005. Two thirds of Haiti's population lives in abject poverty. Life expectancy at birth is 49.5 years, compared to 70.5 years for the LAC region, and the IMR is 57/1,000 live births (31/1,000 live births for the LAC region). Fifty percent of the population is below 24 years of age, and over 50 percent of these young people have never attended or did not complete primary school. UNESCO 2005 data indicate that only 66.2 percent of youth 15 to 24 years of age are literate, compared to 95.5 percent for the LAC region.

Haiti's health indicators reveal that the country's health system is weak. Nearly 40 percent of Haitians have no access to basic primary health care. Haiti has the highest U5MR in the Western Hemisphere, with approximately 9 percent of children dying before reaching age 5, followed by Bolivia with 8 percent. Haiti has the highest MMR in the region at approximately 630 deaths/100,000 live births – close to the MMRs, in some regions of Africa. While the recent 2005 Demographic and Health Survey suggests that trends in mortality and morbidity from all causes are decreasing, they are still worrisome. Most of the full range of indicators underlying the mortality rates have either stagnated or worsened over the last 5 years. Breastfeeding has fallen to unacceptably low levels. Childhood immunization rates range from 10 percent to 40 percent nationwide. The incidence of diarrhea and ARI among children has held steady, but rates of treatment of ARI have been nearly halved. Malnutrition among children and pregnant women remains high. Only 26 percent of women had a skilled attendant at birth. Haiti has one of the oldest HIV/AIDS epidemics in the western hemisphere. Although the HIV prevalence rate has decreased over the past 10 years, it is still a generalized epidemic with a national HIV prevalence rate of 3 to 4 percent.

The 2005 DHS concluded that the fertility rate fell from 4.7 children per woman in 2000 to an average of 4 children per women in 2005. The rapidly dropping rates of fertility do not correspond with the stagnant levels of contraceptive use. The contraceptive prevalence rate (the number of women of reproductive age using contraception) increased only slightly from 22 percent in 2000 to 24.8 percent in 2005 and remains one of the lowest rates in the Western Hemisphere.

The dismal state of key health indicators is a result of lack of access to quality health care services and to potable water, as well as chronic food insecurity. Access to quality health care across the country is challenged due to degradation of the environment, poor health infrastructure, and disruption of services (notably within the capital of Port-au-Prince, which has struggled with insecurity and violence in several neighborhoods over the last several years). Insecurity and violence have also contributed to a deterioration of services including lack of equipment, inadequately trained staff, and poor management of health facilities, especially by the public sector. Although communities and civil society are engaged, notably via NGO support, and participate in addressing health issues, both the supply and demand sides of health services need to be strengthened in both the public and non-public health care delivery sectors.

The NGO sector has been the stable provider of health care services both in urban and rural settings, despite the cycles of civil and political unrest in Haiti. Several international PVOs and local Haitian NGOs are present in Haiti and have a breadth of experience in delivering both clinic and community-based health care and support services. While the Government of Haiti is building its own capacity to strategically lead and manage the delivery of health care services on a national scale, the NGO sector remains a strong partner to the Government of Haiti and provides a solid foundation for the entire health sector.

MCH interventions at the Mission level

Priority areas of intervention include family planning, prenatal and postpartum care, assisted deliveries, treatment of diarrheal diseases and ARIs in children, nutrition counseling and education (including promotion of breastfeeding), and vitamin A supplementation. In 152 clinics, it is expected that annually upwards of 80,000 children will be fully vaccinated and 55,000 treated for life-threatening diarrhea and acute respiratory illness; 316,000 children will be reached in community nutrition programs; and 350,000 women will be reached with reproductive health care services including family planning, antenatal and postpartum care, and skilled attendance at delivery.

Delivery approaches and mechanisms supporting expanded coverage/use of interventions

The program has three main focuses: deliver a basic package of health care services, provide support to the Government of Haiti to increase its capacity to carry out the executive function of managing a national health care system, and mobilize private sector partners to improve the health sector in Haiti. A majority of the maternal and child health, family planning, tuberculosis, and water and sanitation development assistance to Haiti is programmed into one integrated health services program called Pwoje Djanm.

Specific actions supported as part of the MCH approach

USAID support focuses on reforming and strengthening three health management systems: financial management, information management, and health commodities management and logistics. Programs emphasize increasing public sector capacity in order to increase Haitian Government leadership and management to effectively plan, regulate, and lead the health sector.

The USAID program's geographic focus

USAID plans to provide access to 50 percent of the population in Haiti through 80 NGO clinics and 72 public sector clinics that are spread throughout the 10 regional departments of the country, primarily serving rural and secondary city populations in 59 of the 133 "communes" of the country.

The Mission program's relationship to the country's health sector and development plans and strategies

The Government of Haiti's health program is operating under the Plan Strategique National pour la Reforme du Secteur de la Sante 2005–2010. USAID's Pwoje Djanm relates to the National Strategy and is operationalized through an agreement between the project and each department.

Potential for linking Mission MCH resources with other health sector resources and initiatives

USG investments (e.g., PMI, PEPFAR, Title II, OFDA, water, etc.)

USAID provides family planning commodities to all USG-supported sites that are delivering family planning services. Haiti is a USG focus country for HIV/AIDS under PEPFAR. CDC and USAID are the two primary USG agencies responsible for implementing HIV/AIDS development assistance in Haiti, through a comprehensive program. The USG PEPFAR program supports clinical services through eight implementing partners, each with its own network of HIV/AIDS service delivery sites. USAID/Haiti has a Title II food assistance program, and each partner uses the funding from monetized food programming to deliver clinic- and/or community-based health care services, particularly in maternal and child health.

Investments and initiatives of other donors and international organizations

USAID works with other partners including the Global Fund, the Canadian government, French Cooperation, the EU, the Inter-American Development Bank, WHO/PAHO, UNICEF, the Gates Foundation, the Clinton Foundation, the UNIBANK Foundation, Rotary and Pure Water for the World.

Planned results for the Mission's MCH investments over the next 5 years

Over the next 5 years, USAID's program expects to increase access to essential health services to 50 percent of the total population and reduce maternal and child morbidity and mortality.

MCH COUNTRY SUMMARY: HAITI	VALUE
MCH FY08 BUDGET	9,316,000 USD
Country Impact Measures	
Number of births annually*	300,000
Number of under-5 deaths annually	26,000
Neonatal mortality rate (per 1,000 live births)	25
Infant mortality rate (per 1,000 live births)	57
Under-5 mortality rate (per 1,000 live births)	86
Maternal mortality ratio (per 100,000 live births)	630
Percent of children underweight (moderate/severe)	22%
Birth Preparedness and Maternity Services	
Percent of women with at least one antenatal care (ANC) visit	86%
Percent of women with at least four antenatal care (ANC) visits	52%
Percent of women with a skilled attendant at birth	26%
Percent of women receiving postpartum visit within 3 days of birth	30%
Newborn Care and Treatment	
Percent of newborns whose mothers initiate immediate breastfeeding	44%
Immunization	
Percent of children fully immunized at 1 year of age	33%
Percent of DPT3 coverage	23%
Percent of measles coverage	58%
Maternal and Young Child Nutrition, Including Micronutrients	
Percent of mothers receiving iron-folate	N/A
Percent of children receiving adequate age-appropriate feeding	80%
Percent of children under age 5 receiving vitamin A supplement in the past 6 months	29%
Percent of children under 6 months exclusively breastfed	41%
Treatment of Child Illness	
Percent of children with diarrhea treated with ORT	59%
Percent of children with diarrhea treated with zinc	N/A
Percent of children with pneumonia taken to appropriate care	35%
Water, Sanitation, and Hygiene	
Percent of population with access to improved water source**	58%
Percent of population with access to improved access to improved sanitation**	19%

* Census International Database
** Joint Monitoring Programme for Water Supply and Sanitation 2008 Report
(Unless otherwise noted, the data source is the 2005 Demographic and Health Survey.)

Indicator Definitions

The standard data sources for the indicators included in this report are the Census Bureau's Census International Database and the Demographic and Health Surveys (DHS). *Where these sources are not available or outdated, the sources used are cited in the footnote of each table.*

Where indicators deviate from the definitions below, a notation has been made in the table.

Country Impact Measures

- Number of births annually (thousands): The number of live births, annually, within a country. The data source is the Census Bureau's Census International Database.

- Number of under-5 deaths annually (thousands): The number of deaths among children 0–4 years old, annually, within a country. It is calculated using the number of births, annually, from the Census Bureau above and the U5MR below.

- Neonatal Mortality Rate (NNMR) (per 1,000 live births): The estimated number of infant deaths in the first month of life in a given year per 1,000 live births in that same year (births in the 5-year period preceding survey).

- Infant Mortality Rate (IMR) (per 1,000 live births): The estimated annual number of deaths of infants under 12 months in a given year per 1,000 live births in that same year (births in the 5-year period preceding survey).

- Under-5 Mortality Rate (U5MR) (per 1,000 live births): Annual number of deaths that occur in children 0–4 years old in a given year per 1,000 live births in that same year (births in the 5-year period preceding survey).

- Maternal Mortality Ratio (MMR) (per 100,000 live births): The estimated number of women who die as a result of pregnancy or childbirth per 100,000 live births, arrived at mostly through the "sisterhood method." The data are aggregated based on different time periods ranging from 0 to 14 years preceding the survey.

- Percent of children underweight (moderate/severe): Percentage of children under 3 years of age whose weight-for-age is below –2 standard deviations (SD) from the median of the NCHS/CDC/WHO international reference population. This number reflects the percent of children below –2 SD from the median as well as children who are below –3 SD from the median.

Birth Preparedness and Maternity Services

- Percent of women with at least one antenatal care visit: Percentage of women of reproductive age (15–49) who had at least one antenatal care contact during their last pregnancy in the 3 years prior to the most recent survey conducted in that country.

- Percent of women with at least four antenatal care visits: Percentage of women of reproductive age (15–49) who had four or more antenatal care contacts during their last pregnancy in the 3 years prior to the survey.

- Percent of women with a skilled attendant at birth: The percentage of births/deliveries that occur with the assistance of any skilled health worker during the 5-year period preceding the survey. The term "skilled health worker" refers to an accredited health professional – such as a midwife, doctor, or nurse – who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth, and the immediate postnatal period, and in the identification, management, and referral of complications in women and newborns.

- Percent of women receiving a postpartum visit within 3 days of birth: Among women giving birth in the 5 years preceding the survey, the percentage of women receiving their first postnatal checkup 0–2 days from their last live birth. Calculated as the sum of the time between delivery and mother's first postnatal checkup.

Newborn Care and Treatment

- Percent of newborns receiving essential newborn care: The percent of newborns who had clean delivery and cord care, warmth, early and exclusive breastfeeding, and early recognition of and referral for complications

in the first month of life. *This indicator is currently under development and data are not yet available.*

- Percent of newborns whose mothers initiate immediate breastfeeding: For last-born children ever breastfed in the 5 years preceding the survey, the percentage who started breastfeeding within 1 hour of birth.

Immunization

- Percent of children fully immunized at 1 year of age: Percentage of children age 12–23 months who received BCG, measles, and three doses each of DPT and polio vaccine (excluding polio vaccine given at birth) by 12 months of age.

- Diphtheria, Pertussis, and Tetanus vaccine – third dose (DPT3) coverage: Proportion of living children 12–23 months old who have received three complete doses of vaccines against diphtheria, pertussis, and tetanus at any time before the survey.

- Measles coverage: Percentage of living children 12–23 months old who have received one dose of measles-containing vaccine at any time before the survey.

Maternal and Young Child Nutrition, Including Micronutrients

- Percent of mothers receiving iron folate: Women with a live birth in the last 5 years before the survey who "took iron tablets" during the pregnancy of their last birth.

- Percent of children receiving adequate age-appropriate feeding: Among infants 6–9 months old who were born in the 3 years before the survey, the percentage who were breastfed and received complementary feeding in the 24 hours before the survey.

- Percent of children under 5 years of age receiving vitamin A supplement in the past 6 months: Percentage of living children 6–59 months old who received vitamin A supplements in the 6 months preceding the survey.

- Percent of children under 6 months exclusively breastfed: Among infants under 6 months who were born in the 3 years before the survey, the percentage who were exclusively breastfed in the 24 hours before the survey. Exclusive breastfeeding is defined as providing no food or liquid other than breast milk to the child.

Treatment of Child Illness

- Percent of children with diarrhea treated with ORT: Percentage of children under 5 with diarrhea in the 2 weeks prior to the survey who received increased fluids, ORS, or recommended home solution (RHS).

- Percent of children with diarrhea treated with zinc: Percentage of children under 5 with diarrhea in the 2 weeks prior to the survey who received zinc supplements.

- Percent of children with pneumonia taken to appropriate care: Percentage of children under 5 years who were ill with an ARI, which is associated with cough, rapid breathing, and a high fever, during the 2 weeks preceding the survey for whom care was sought from a health facility or health care provider.

Household-Level Water, Sanitation, and Hygiene

The data source for these two indicators is the WHO/UNICEF Joint Monitoring Programme 2008 report.

- Access to improved water source: The proportion of the population with access to safe drinking water is an indicator expressed as the percentage of people using improved drinking water sources or delivery points. Improved drinking water refers to water piped into dwelling, plot, or yard; public tap/standpipe; tube-well/borehole; protected, dug well; protected spring; and rainwater collection.

- Access to improved sanitation: The proportion of the population with access to basic sanitation is an indicator expressed as the percentage of people using improved sanitation facilities. Improved sanitation refers to facilities with a connection to a public sewer, connection to a septic system, pour-flush latrine, simple pit latrine, and ventilated improved pit latrine.

Acronyms and Abbreviations

ABCs	Abstinence, Be faithful, and correct and consistent use of Condoms
ACSM	Advocacy, Communication and Social Mobilization
ACT	Artemisinin-Based Combination Therapy
AFDB	African Development Bank
AFR	Bureau for Africa
AFRO	African Regional Office, WHO
AI	Avian Influenza
AIDS	Acquired Immune Deficiency Syndrome
AIHA	American International Health Alliance
AMR	Antimicrobial Resistance
AMTSL	Active Management of the Third Stage of Labor
ANCs	Antenatal Clinics
ANERA	American Near East Refugee Aid
ARI	Acute Respiratory Infection
ART	Antiretroviral Therapy
ARV	Antiretroviral
AU	African Union
BCC	Behavior Change Communication
BPHS	Basic Package of Health Services
BUCEN	United States Bureau of the Census
CA	Cooperating Agency
CABA	Children Affected by AIDS
CBO	Community-Based Organization
CBRH	Community-Based Reproductive Health
CDC	Centers for Disease Control and Prevention
CHSRs	Country Health Statistical Reports
CHW	Community Health Worker
CIMCI	Community-Integrated Management of Childhood Illness
CPR	Contraceptive Prevalence Rate
CRTU	Contraceptive and Reproductive Technology Research and Utilization Program
CS	Child Survival
CS	Contraceptive Security
CS/MH	Child Survival and Maternal Health
CSH	Child Survival and Health
CSHGP	Child Survival and Health Grants Program
CSLG	Commodities Security and Logistics Group
CSM	Contraceptive Social Marketing
CSWs	Commercial Sex Workers
DCOF	Displaced Children and Orphans Fund
DD	Diarrheal Disease

DFA	Development Fund for Africa
DfID	Department for International Development, United Kingdom
DG	Democracy and Governance
DHAPP	Department of Defense HIV/AIDS Prevention Program
DHF	Dengue Hemorrhagic Fever
DHS	Demographic and Health Surveys
DHT	District Health Team
DPT3	Diphtheria, Pertussis, and Tetanus vaccine – third dose
EBR	Exclusive Breastfeeding Rate
EHP	Environmental Health Project
ENC	Essential Newborn Care
END	Early Neonatal Death
ENMR	Early Neonatal Mortality Rate
EOC	Essential Obstestric Care
EmOC	Emergency Obstetrics Care
EU	European Union
FANC	Focused Antenatal Care
FANTA	Food and Nutrition Technical Assistance
FBO	Faith-Based Organization
FCHV	Female Community Health Volunteer
FP/RH	Family Planning and Reproductive Health
FY	Fiscal Year
GAI	Global AIDS Initiative
GAIN	Global Alliance for Improved Nutrition
GAVI	Global Alliance for Vaccines and Immunization
GDP	Gross Domestic Product
GH	Bureau for Global Health
GNP	Gross National Product
HIRD	High-Impact Rapid Delivery
HMIS	Health Management Information System
IDA	Iron Deficiency Anemia
IDB	Inter-American Development Bank
IDD	Iodine Deficiency Disorder
IDFA	International Disaster and Famine Assistance
IDP	Internally Displaced Persons
IDRC	International Development Research Center
IMCI	Integrated Management of Childhood Illness
IMF	International Monetary Fund
IMR	Infant Mortality Rate
IPTp	Intermittent Preventive Treatment for Pregnant Women
IRD	International Relief and Development
IRH	Institute for Reproductive Health
IRS	Indoor Residual Spraying
ITN	Insecticide-Treated Net

IWRM	Integrated Water Resources Management
LAC	Bureau for Latin America and the Caribbean
LAPMs	Long-Acting Permanent Methods
LHV	Lady Health Visitor
LLIN	Long-Lasting Insecticide-Treated Mosquito Net
LMIS	Logistics Management Information System
MARP	Most-at-Risk Population
MCH	Maternal and Child Health
MCP	Malaria Communities Program
MCPR	Modern Contraceptive Prevalence Rate
MDG	Millennium Development Goal
MDR-TB	Multidrug-Resistant Tuberculosis
MH	Maternal Health
MICS	Multiple Indicator Cluster Surveys
MIP	Malaria in Pregnancy
MMV	Medicines for Malaria Venture
MMR	Maternal Mortality Ratio
MOH	Ministry of Health
MOHP	Ministry of Health and Population
MOP	Malaria Operational Plan
MORA	Malaria Obligations Reporting Application
MTCT	Mother-to-Child Transmission
MVDP	Malaria Vaccine Development Program
MVI	Malaria Vaccine Initiative
NDRA	National Drug Regulatory Authority
NFHS	National Family Health Survey
NGO	Nongovernmental Organization
NHA	National Health Account
NHCs	National Health Campaigns
NIDs	National Polio Immunization Days
NIH	National Institutes of Health
NIS	Newly Independent States
NMCP	National Malaria Control Program
NMR	Neonatal Mortality Rate
NTD	Neglected Tropical Disease
NTP	National Tuberculosis Program
OC	Oral Contraceptive
OPV	Oral Polio Vaccine
ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy
OVC	Orphans and Vulnerable Children
PD	Postdelivery
PL	Public Law
PEI	Polio Eradication Initiative

PEP	Postexposure Prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PFD	Partners for Development
PHC	Primary Health Care
PHR	Partnership for Health Reform
PI	Performance Improvement
PIMS	Patient Information Management System
PIO	Public International Organization
PLWHA	People Living With HIV/AIDS
PMI	President's Malaria Initiative
PMTCT	Prevention of Mother-to-Child Transmission (of HIV)
POU	Point-of-Use Water Quality
POUZN	Point-of-Use Water Disinfection and Zinc Treatment
PSI	Population Services International
PVO	Private Voluntary Organization
RCH	Reproductive and Child Health
REDSO/ESA	Regional Economic Development Services Office for East and Southern Africa
RH	Reproductive Health
RHC	Reproductive Health Commodity
RHI	Reproductive Health Interchange
SADC	South Africa Development Community
SAFE	Sanitation and Family Education
SAM	Severe Acute Malnutrition
SBA	Skilled Birth Attendant
SCMS	Supply Chain Management System
SDP	Service Delivery Point
SEARO	Southeast Asia Regional Office, WHO
SEED	Support for East European Democracy
SIDA	Swedish International Development Agency
STI	Sexually Transmitted Infection
SWAp	Sectorwide Approach
TASC	Technical Assistance and Support Contract
TB	Tuberculosis
TB CAP	Tuberculosis Control Assistance Project
TBA	Traditional Birth Attendant
TBCTA	Tuberculosis Coalition for Technical Assistance
TC	Testing and Counseling
TFR	Total Fertility Rate
TOT	Training of Trainers
U5MR	Under-5 Mortality Rate
UN	United Nations
UNAIDS	United Nations Joint Program on HIV/AIDS
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund

UNGASS	United Nations General Assembly Special Session
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USG	United States Government
USMHRP	United States Military HIV Research Program
VAD	Vitamin A Deficiency
VADD	Vitamin A Deficiency Disorders
VB	Vector-borne Disease
VBC	Vector Biology and Control Project
VC	Vulnerable Children
VCT	Voluntary Counseling and Testing
VITA	Volunteers in Technical Assistance
VRC	Vaccine Research Center
WARP	West Africa Regional Program
WAWI	West Africa Water Initiative
WFP	World Food Program
WHO	World Health Organization
WID	Office of Women in Development
WIH	Women and Infant Health
WJEI	Women's Justice and Empowerment Initiative
WSS	Water Supply and Sanitation
WSSCC	Water Supply and Sanitation Collaborative Council
WSSWM	Water Supply, Sanitation, and Wastewater Management
WTO	World Trade Organization
WV	World Vision
WWTP	Wastewater Treatment Plant
XDR-TB	Extensively Drug-Resistant Tuberculosis
YARH	Young Adult Reproductive Health
YFI	Youth-Friendly Initiative
YRH	Youth Reproductive Health
ZMCP	Zambia Malaria Control Program

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