Associate Award Brief—Zimbabwe

Select Health and Demographic Data for Zimbabwe	
GDP per capita (USD)*	778
Total population	13,061,239
Maternal mortality ratio (deaths/100,000 live births)	960
Skilled birth attendant coverage	66
Antenatal care, 4+ visits	65
Neonatal mortality rate (deaths/1,000 live births)	31
Infant mortality rate (deaths/1,000 live births)	57
Under-five mortality (deaths/1,000 live births)	84
Treatment for acute respiratory infection	48
Oral rehydration therapy for treatment of diarrhea	74
Diphtheria-pertussis-tetanus vaccine coverage (3 doses)	73
Modern contraceptive prevalence rate	57
Total fertility rate	4.1
Total health expenditure per capita (USD)	66.42
Sources: Zimbabwe Population Census 2012; World Bank*; Zimbabwe Demographic and Health Survey 2010–2011.	

Major Activities

- **Maternal Health:** Scale-up of Standards-Based Management and Recognition (SBM-R) at health facility level and performance quality improvement (PQI) at community level; Emergency obstetric and newborn care (EmONC)
- **Newborn Health:** Kangaroo Mother Care (KMC); Helping Babies Breath (HBB)
- **Child Health:** SBM-R at health facility level and PQI at community level; Diarrhea case management, ORT/zinc; malaria community case management (CCM)
- **Immunization:** New vaccine introduction (PCV-13 and Rotavirus vaccine introduction); routine immunization: Reaching Every District (RED)
- **Nutrition:** IYCF; Baby Friendly Hospital Initiative (BFHI); health systems strengthening: policy, planning, coordination, and research; HMIS/M&E strengthening; competency-based training approaches; health promotion, communication, and advocacy

Program Dates	January 2014–December 2016					
Award Amount	Redacted					
Geographic Coverage	No. (%) of provinces	1 (10%)	No. of districts	7	No. of facilities	277
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MCHIP Partners	*JSI (lead organization)*: Child health, immunization, pediatric HIV/prevention of mother-to-child transmission of HIV (PMTCT), program management/administration; *Jhpiego*: maternal health, quality improvement, clinical training; *Save the Children*: newborn health, community health, and monitoring and evaluation (M&E); *PATH*: nutrition.					
Key Partners	Zimbabwe Ministry of Health and Child Care (MOHCC) reproductive health, Expanded Program on Immunization (EPI), child health, nutrition, HIV, and monitoring and evaluation (M&E) units; University of Zimbabwe; UNICEF; UNFPA; World Health Organization (WHO); World Bank; United Kingdom Department for International Development (DFID); Absolute Return for Kids (ARK); Plan International; Elizabeth Glaser Pediatric AIDS Foundation (EGPAF); Organization for Public Health Interventions and Development (OPHID); Population Services International (PSI); Population Services Zimbabwe (PSZ), International Rescue Committee (IRC), and Cordaid.					

Acronyms and Abbreviations

AA	Associate Award
ANC	Antenatal Care
BCC	Behavior Change Communication
CBT	Competency-based Training
cPQI	Community Performance and Quality Improvement
CSO	Civil Society Organizations
DHE	District Health Executive
EmONC	Emergency Obstetric and Newborn Care
ENC	Essential Newborn Care
EPI	Expanded Programme on Immunization
ETAT	Emergency Triage and Treatment
HBB	Helping Babies Breathe
HF	Health Facility
HMIS	Health Management Information System
IMNCI	Integrated Management of Newborn and Childhood Illness
KMC	Kangaroo Mother Care
MCCM	Malaria Community Case Management
MCHIP	Maternal and Child Health Integrated Program
MIP	Malaria in Pregnancy
MNCH	Maternal, Newborn and Child Health
MNH	Maternal and Newborn Health
MOHCC	(Zimbabwe's) Ministry of Health and Child Care (Formerly MOHCW)
MPMA	Maternal and Perinatal Mortality Audits
PHE	Provincial Health Executive
PMTCT	Prevention of Mother-to-Child Transmission
PNC	Postnatal Care
PPFP	Postpartum Family Planning
PPIUD	Postpartum Intrauterine Device
PSE	Pre-service Education
QA/QI	Quality Insurance/Quality Improvement
SBM-R	Standards-Based Management and Recognition
USG	U.S. Government
VHW	Village Health Worker

Background

MCHIP was launched in Zimbabwe in 2010, with Field Support funding from USAID/Zimbabwe that was used to design and implement a three-year technical assistance project. The project's objectives were to support the Ministry of Health and Child Care (MOHCC) to develop and roll out maternal and child health policies, strategies, guidelines, and training programs; to improve the quality of clinical care for women, infants, and young children in health facilities in Manicaland province and support national-level scale-up plans; to build the capacity of Village Health Workers (VHWs) in providing maternal, newborn, and child health (MNCH) information and services in two districts of the same province (Mutare and Chimanimani); and to support the national immunization program (ZEPI) in increasing routine immunization coverage and introducing new, lifesaving vaccines countrywide.

During its first three years, MCHIP contributed to the development and/or updating of many critical policies, strategies, guidelines, and training packages with partners, including the Reproductive Health Policy, Emergency Obstetric and Newborn Care (EmONC), and Helping Babies Breathe (HBB) training packages, National Nutrition Strategy, Quality Assurance/Quality Improvement(QA/QI) Policy and Strategy, Malaria Community Case Management (MCCM) training package, Integrated Management of Newborn and Childhood Illnesses (IMNCI) training package revision, and others. In Manicaland province, MCHIP worked intensively with the Provincial Health Executive (PHE) and the District Health Executives (DHEs) in Mutare and Chimanimani districts to introduce performance standards for maternal, newborn, and child health and to improve the quality of maternal, newborn and child health. The Standards-Based Management and Recognition (SBM-R) approach was implemented in 21 high-volume health facilities. Other MCHIP achievements include collaborating closely with the MOHCC in preparation for the introduction of pneumococcal and rotavirus vaccines; the development and rollout of the new MCCM training module and a community health information system (HIS) in communities with a high burden of malaria; the testing of a Community Performance and Quality Improvement (cPQI) strategy in Chimanimani district that includes peer-to-peer supervision; and MNCH refresher training and MCCM training.

MCHIP's Field Support-funded project in Zimbabwe ended in early May 2014, and under a newly awarded, three-year Associate Award (AA), MCHIP's important work is continuing in Zimbabwe. There was a four-month period of overlap between the MCHIP Field Support-funded project and the follow-on Associate Award (AA). This period was used to fully close out activities supported under the MCHIP Lead Award and strategically position and ramp up activities under the AA, which resulted in a smooth and continuous provision of critical services and project activities.

The objectives of the MCHIP/Zimbabwe AA are to:

1. Strengthen the capacity of the MOHCC at national level to formulate evidence-based national health policies, strategies and programs to enhance scale-up of high-impact maternal, newborn, and child health interventions;
2. Strengthen the capacity of the MOHCC at provincial and district levels to improve the quality of integrated maternal, newborn, and child health services at health facilities and in the community to support national-level scale-up plans; and
3. Strengthen the capacity of Civil Society Organizations (CSOs) to implement MNCH activities and manage U.S. Government (USG) funding.

Activities

During its first year, the MCHIP/Zimbabwe AA will build on its successful experience over the past three years and re-double efforts to strengthen the capacity of the MOHCC to deliver high-quality MNCH services at scale. The project will support the finalization of key MNCH policies and strategies needed to help continue to ensure an enabling environment for implementation; advocate for the adoption, revitalization, and scale-up of selected high-impact interventions whose implementation has not started or is lagging behind; work through national coordination platforms and leverage other partner resources to strengthen the capacity of the MOHCC to implement MNCH interventions; and strengthen information systems to improve accountability for high-quality service delivery and the use of data in making decisions.

The project will also expand the promising work on improving quality of care provided at health facilities and also through community health workers, while taking deliberate steps to mitigate the underlying causes of excess maternal, newborn, and child mortality. This will include an emphasis on reducing the detrimental effects of malaria in pregnancy (MIP), improving the prevention and treatment of malaria at the community level, and collaborating with other partners to address the effects of malnutrition.

Under the AA, the project will expand its geographic focus under MCHIP to continue to target interventions in health facilities and communities in Manicaland province where most preventable maternal, newborn, and child deaths occur. It will also extend to Matabeleland North and South provinces, through additional resources from the ELMA Vaccines and Immunization Foundation (a project co-share activity), with a standard package of immunization interventions and support for the introduction of rotavirus vaccine.

The boxes below provide specific details about planned program activities, by objective.

Objective 1. National Health Policies and Strategies

LIFE OF PROJECT RESULTS	PY1 RESULTS
▪ National MNCH policies, strategies, guidelines, and tools developed/finalized with MCHIP support ▪ MNCH program coordination, planning and monitoring strengthened through MCHIP support for national steering committees/technical working groups (TWGs), and national review and planning meetings ▪ Availability of a competent MNCH workforce increased through strengthening of in-service and pre-service clinical training; rollout of a standardized, integrated supportive supervision (SS) protocol; and development and dissemination of MNCH job aids for health workers ▪ MNCH pre-service education (PSE) curricula for nurses, doctors, and other health professionals improved through inclusion/updating of content on basic EmONC, HBB, IMNCI, maternal nutrition, infant and young child feeding (IYCF), and immunization, as well as skills strengthening of instructors in competency-based training (CBT) approaches ▪ Greater focus on and resources and commodities available for MIP, maternal and child nutrition, pneumonia and diarrhea case management, prevention of mother-to-child transmission (PMTCT), and postpartum family planning (PPFP)/postpartum IUD (PPIUD) interventions through collaboration with partners/donors supporting antenatal care (ANC) and postnatal care (PNC) programming ▪ Strategic information systems strengthened through improvements to the national HMIS, inclusion of quality and community indicators within the HMIS, and	▪ National Reproductive Health Policy finalized and provinces oriented ▪ National MNH 2014 Implementation Plan finalized and resourced ▪ National Nutrition Strategy approved and launched ▪ Emergency Triage and Treatment (ETAT) guidelines adapted and master trainers trained ▪ 80 national trainers trained in MCCM, including environmental waste management standards ▪ VHW toolkit (including behavior change communication [BCC] messages and counseling materials) enhanced and available ▪ World Health Days commemorated with MCHIP support ▪ Rotavirus vaccine rolled out and achieving at least 60% coverage achieved in all provinces in PY1 ▪ ELMA Foundation activities launched at national level and in Matabeleland North and South (cost-share) ▪ National QI policy and strategy disseminated to all provinces ▪ National MNCH Competency-Based Training of Trainers Guide finalized and 100 national trainers trained ▪ National clinical training database generating regular reports

LIFE OF PROJECT RESULTS	PY1 RESULTS
revitalization of the Maternal and Perinatal Mortality Audits (MPMA) system nationally ▪ New MNCH approaches and tools explored, lessons learned documented, and best practices shared with MNCH stakeholders	▪ Scale-up plan for introduction of antenatal corticosteroids in place ▪ HMIS indicators and community health information system components included in revised HMIS strategy ▪ 20 provincial focal persons oriented on the revised maternal and perinatal notification system and MPMAs ▪ Electronic Maternal Perinatal Death Notification system tested in one province ▪ National guidelines for verbal autopsy finalized and 30 provincial focal points oriented ▪ Promising MCHIP tools and approaches shared with and adopted at national level and by other partners ▪ At least two new Program Learning studies with IRB approval and under way

Objective 2. Facility and Community MNCH Care

LIFE OF PROJECT RESULTS	PY1 RESULTS
▪ Increased number of health facilities (HFs) satisfying criteria for QI standards (SBM-R) in MNCH ▪ Increased number of HFs and VHWs implementing SBM-R in MNCH ▪ Reduced cause-specific mortality rates for MNCH cases in supported HFs and supported communities ▪ Increased number of health workers and VHWs trained in MNCH ▪ Rotavirus antigen introduced in Manicaland (seven districts) and in Matebeleland South (Mat South) ▪ Increased immunization coverage in Manicaland and Mat South for all antigens ▪ Increased essential newborn care (ENC) coverage of all newborns ▪ Increased number of eligible newborns receiving HBB, Kangaroo Mother Care (KMC) and IMNCI ▪ Improved survival rates for newborns managed with Kangaroo Mother Care (KMC), IMNCI, and HBB ▪ Increased number of districts with costed implementation plans ▪ Increased number of districts conducting MPMAs ▪ Increased number of VHWs satisfying set criteria for managing MNCH cases ▪ Increased institutional deliveries ▪ Increased timeliness, completeness and quality of MNCH data in the province ▪ Increased number of pregnant women and newborns receiving at least one home visit according to national schedule ▪ Increased coverage of key prevention and treatment interventions for maternal health, including MIP, maternal nutrition, pre-eclampsia/eclampsia, postpartum hemorrhage, obstructed labor and sepsis ▪ Increased number of women and newborns who received core MNH package (preventive treatments in ANC, active management of the third stage of labor with use of partograph and delayed cord clamping, and EmONC) ▪ Improved coverage of PPFP ▪ Improved coverage of sick children who receive correct treatment, appropriate care, and follow-up	▪ 60% of facilities satisfying set criteria for quality improvement standards (SBM-R) in MNCH ▪ 7 districts implementing quality improvement activities (SBM-R) in MNCH ▪ 60% of all health workers and VHWs trained in MNCH in target districts/facilities ▪ Rotavirus antigen vaccine introduced in Manicaland with USAID support ▪ Immunization coverage in Manicaland increased to above 60% for Rotavirus vaccine and 80% for all other antigens ▪ KMC, HBB and BEmONC scaled up to all 7 districts in Manicaland ▪ 7 districts in Manicaland implementing costed MNCH plans and holding regular review meetings ▪ 7 districts in Manicaland conducting MPMA and using findings to improve MNCH plans ▪ Increased timeliness, completeness, and quality of MNCH data in the province ▪ Increased number of pregnant women, newborns, and children receiving quality MNCH care ▪ Maternal, newborn, and child cause specific mortality rates reduced in the 7 districts ▪ 7 districts managing sick children according to IMNCI/ETAT at 80% of target facilities ▪ Coverage for MIP and MCCM increased in the 5 malaria priority districts of Manicaland ▪ All VHWs in Chimanimani receiving MCHIP support showing improved performance ▪ C-PQI approach adapted and introduction begun in Mutasa district ▪ 250 VHWs trained in key household and family practices ▪ Communities, families and individuals in MCHIP-supported districts of Manicaland receiving messages about key household health practices ▪ Baselines for selected project interventions conducted ▪ Two integrated MNCH data quality assessments conducted and findings used to improve project performance ▪ PHE/DHE data quality improved through training and continuous support

LIFE OF PROJECT RESULTS	PY1 RESULTS
▪ Increased number of households that report receiving MNCH BCC messages ▪ Increased number of individuals and families adopting and supporting key household practices and health-seeking behavior for MNCH ▪ Improved capacity of communities and sub-groups to plan for and support MNCH services ▪ Improved coverage for community MNCH intervention packages for MNCH, including home visits for MNC, MCCM, early referral for sick children and home care for sick children according to IMNCI	▪ MPMA information system developed and in use at provincial/district level ▪

Objective 3. CSO Capacity Building

LIFE OF PROJECT RESULTS	PY1 RESULTS
▪ Increased number of local CSOs in Manicaland with the capacity to design, implement, and monitor community MNCH programs ▪ Increased number of local CSOs in Manicaland with the capacity to handle USG funds responsibly (i.e., comply with standard USG operating procedures and financial regulations) ▪ Increased number of target communities reached with MNCH information ▪ Increased number of target communities that have implemented activities to improve use of key MNCH services ▪ Increased community level support and household behaviors ▪ Increased recognition of danger signs of illness and early care seeking ▪ Participation of pregnant women during the antenatal period (through women-to-women groups, grandmother/grandfather support) ▪ Increased number of birth plans and increased knowledge of maternal and newborn danger signs by families, including husbands, grandmothers/grandfathers and women ▪ Improved exclusive breastfeeding (mothers support groups model)	▪ Proposed CSO engagement plan developed with PHE, DHEs and other partners in Manicaland (including proposed CSO scope(s) of work, selection criteria, selection process, templates for subawards, budgets and financial reports, tools for organizational assessment and strengthening, among others) ▪ At least one CSO selected, awarded subagreement, and implementing agreed-upon scope or scopes of work ▪ Lessons learned by and with CSO(s), DHE, and communities captured and used to refine CSO engagement plan for PY 2–3 ▪ CSO engagement plan ready for implementation across districts in PY2–3

Results

While the new AA began on January 1, 2014, the preceding MCHIP award was extended through the end of May 2014 to ensure continuity in activity coverage and complete spending of Field Support pipeline funds. The focus for the first quarter of the AA was to provide a seamless transition between the two awards—consolidating program learnings, achievements, and final documentation efforts under the three-year MCHIP/Zimbabwe project on the one hand, while refining planned activities under PY1 of the follow-on AA and implementing baseline data collection and other start-up activities on the other hand. First quarter start-up activities included activity microplanning, updating key project indicators in consultation with USAID and other key stakeholders, and conducting environmental, data verification, and other assessments.

The MCHIP/Zimbabwe AA team also continued to make significant contributions to the national MNCH agenda by supporting upstream, national-level activities and local

implementation of high-impact interventions. First quarter results are summarized below, by project objective:

Objective 1: Strengthen the capacity of the MOHCC at national level to formulate evidence-based national health policies, strategies, and programs to enhance scale-up of high-impact MNCH health interventions.

During Q1, the team joined other partners in supporting the MOHCC with annual planning and review activities. The project team made significant contributions to the process and content of national MOHCC plans, including through participation in a national 2014 reproductive health annual planning meeting, national Expanded Programme on Immunization (EPI) quarterly review meeting, and a national Health Management Information Systems (HMIS) 2014 annual work planning meeting. Participation in these work planning sessions enabled the MCHIP/Zimbabwe AA to align its annual workplan with national priorities for the year and identify opportunities for collaboration, harmonization, and partnerships in support of government-led plans. Additionally, the MCHIP/Zimbabwe AA supported the development of a national, costed Nutrition strategy and QI strategy and provided national-level support for TrainSMART system training.

Objective 2: Strengthen the capacity of the MOHCC at provincial and district levels to improve the quality of integrated MNCH services at HFs and in the community to support national-level scale-up plans at provincial, district, and health facility levels.

In January 2014, the project team continued to provide substantial technical and financial support to province-wide EPI activities. Rotavirus vaccine introduction mop-up trainings were completed in Nyanga, Makoni, and Chimanimani districts, with 113 health workers trained. With the completion of these trainings, Manicaland became the only province to have completed its trainings well before the end of the planned vaccine introduction launch in late spring.

Objective 3: Strengthen the capacity of CSOs to implement MNCH activities and manage U.S. Government (USG) funding.

The project began intensive microplanning during the first quarter of the AA to refine proposed workplan activities under this objective; consolidate findings from the team's CSO literature review and CSO mapping efforts under MCHIP; develop a draft CSO engagement framework; brainstorm criteria for CSO selection; and identify potential candidate CSOs to be engaged under the AA.

Recommendations and Next Steps

Amidst some encouraging data showing gains in combatting mortality and morbidity, Zimbabwe still has a long way to go to reverse the unacceptably high mortality levels among women and children under five. Under the three-year, USAID-funded MCHIP/Zimbabwe AA awarded in January 2014, MCHIP will continue to support the Zimbabwe MOHCC in advancing MNCH. This project will incorporate final recommendations from MCHIP/Zimbabwe into the programmatic design for the follow-on AA, as outlined below.

At the national level, recommendations for MCHIP's way forward include:

- Continue to advocate for and support the provision of high-level coordination for MNCH activities within the MOHCC, in order to strengthen national-level strategic planning, coordination, and program implementation.
- Continue to support the MOHCC's efforts in developing key, evidence-based national policies, standards, guidelines, and training packages.
- Continue to advocate for a "beyond the numbers" approach to providing high-quality health care nationwide and assist the MOHCC to identify a single national approach to QI.
- Advocate for inclusion and standardization of high-impact MNCH packages and CBT approaches into pre-service education curricula.
- Improve MNCH service integration by working with partners and providing technical support to MOHCC counterparts to ensure that current national ANC and PNC platforms are used to strengthen malaria in pregnancy (MIP), maternal nutrition and anemia, IYCF, PMTCT, and PPFP/PPIUD interventions.
- Continue to support the MOHCC in health information systems and M&E.
- Continue technical assistance and support for national MNCH advocacy, communication, and social mobilization activities.

At the provincial/district level, recommendations for MCHIP's way forward include:

- Improve, expand, and maintain facility-based MNH SBM-R activities in Manicaland in ways, including:
  - Expand coverage of SBM-R activities to new districts to equip health workers to deliver evidence-based, integrated services that are humanistic, respectful, and client-centered.
  - Increase focus on provincial hospital and high-volume referral sites (i.e., non-learning site district hospitals in Manicaland). Prioritize all Manicaland district hospitals and Mutare Provincial hospital for additional targeted interventions.
  - Seek ways to simplify SBM-R tools, and/or reduce the number of SBM-R performance standards/verification criteria without compromising the resulting quality of care. Adapt SBM-R tools for greater focus on the main causes of MNH mortality and morbidity (e.g., greater focus on critical pathways).
  - Revise the SBM-R scoring system to make it less punitive and more encouraging.
  - Change the SBM-R approach such that participating health workers are recognized in an appropriate manner earlier in the process, in order to increase motivation and retention.
  - Continue to refine the SBM-R approach for child health as piloted in Zimbabwe by making tools more responsive to changes in the quality of care delivered to children, for example. Pilot new QI tools to address the quality of services provided to sick children at the provincial and district hospital levels. In addition, work with Mutare Provincial Hospital specifically to improve in-patient care for sick children.
  - Involve more partners and engage more policymakers in the QI process, in order to facilitate national-level adoption, scale-up, and rollout.
  - Test new ways to link quality of care improvements to MNC mortality and outcome data.

- Prioritize support for districts with high MNCH mortality and morbidity, and within this context, prioritize support for high-impact MNCH interventions and activities such as ENC, KMC, HBB, EmONC, malaria case management, and RED.
- Continue to utilize a CBT approach to capacity-building at sub-national level, with a sustained emphasis on post-training follow up, on-the-job training, and supportive supervision.
- Continue to support strategic planning, coordination, data review/M&E, and evidence-based decision-making at the provincial, district, and facility levels. Continue focus on providing technical assistance to the MOHCC and seeking opportunities to leverage partner resources in order to amplify the project's technical reach within the province/districts.

At the community level, recommendations for MCHIP's way forward under the Associate Award include:

- Scaling up community-based child survival interventions (e.g., early care seeking for pneumonia, reducing indoor air pollution, cIYCF, malaria community case management, use of long-lasting insecticide-treated bed nets, etc.), in conjunction with strengthening health facility service provision. A key recommendation is to continue, refine, and expand the cPQI approach to one or more additional Manicaland districts and further assess results in six to 12 months.
- Prioritizing civil society capacity-building by partnering with local CSOs and strengthening their capacity to mobilize communities for improved knowledge, access to, and utilization of MNCH services. Working with CSOs will foster further community engagement and facilitate sustainability and local ownership of community interventions.