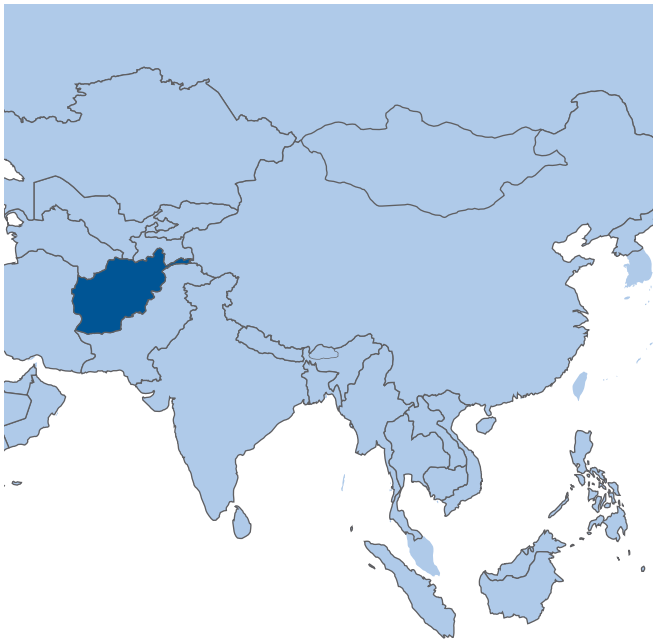
Afghanistan MCH Program Description



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.

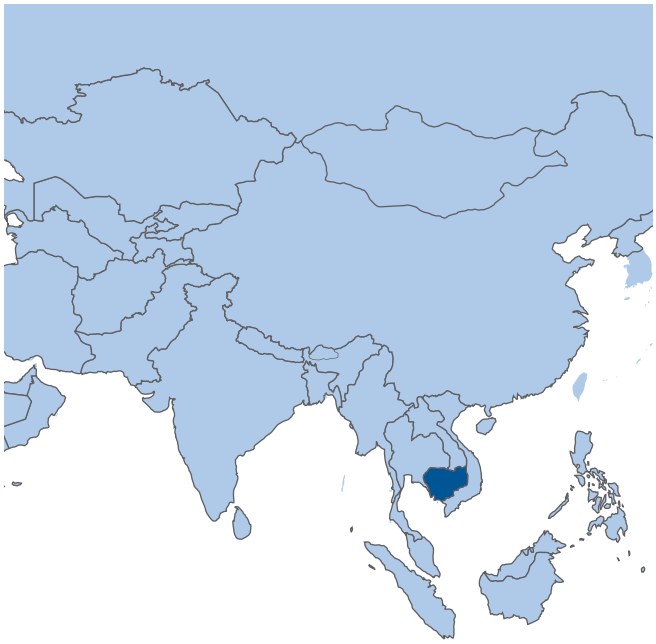
Planned results for the Mission's MCH investments over the next 5 years

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.

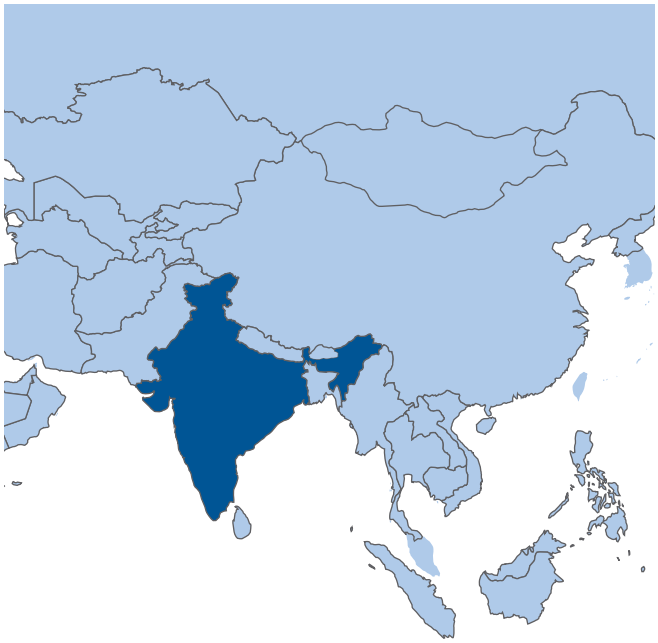
Planned results for the Mission MCH investments over the next 5 years

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:

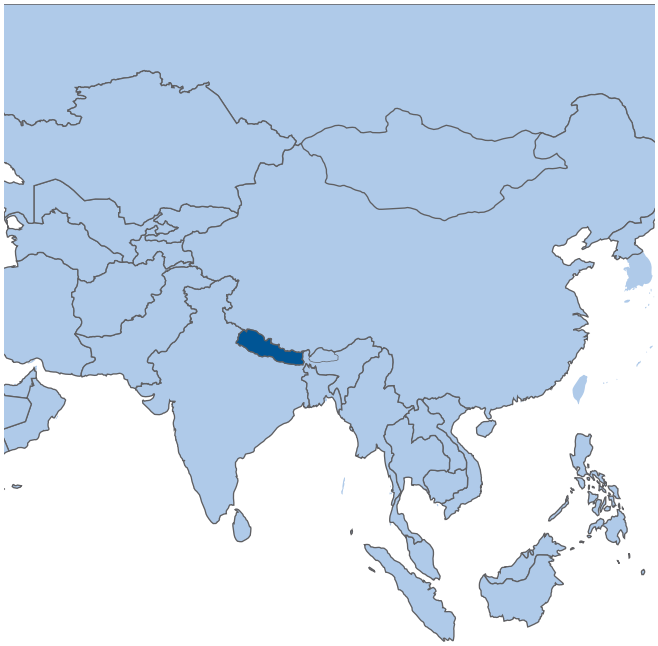
- Continued support to advocacy and promoting good governance and management of basic human services
- Focused technical assistance on improving key clinical services in the public and private sector – emergency obstetric and neonatal care, increased access to effective management of obstetric complications (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.

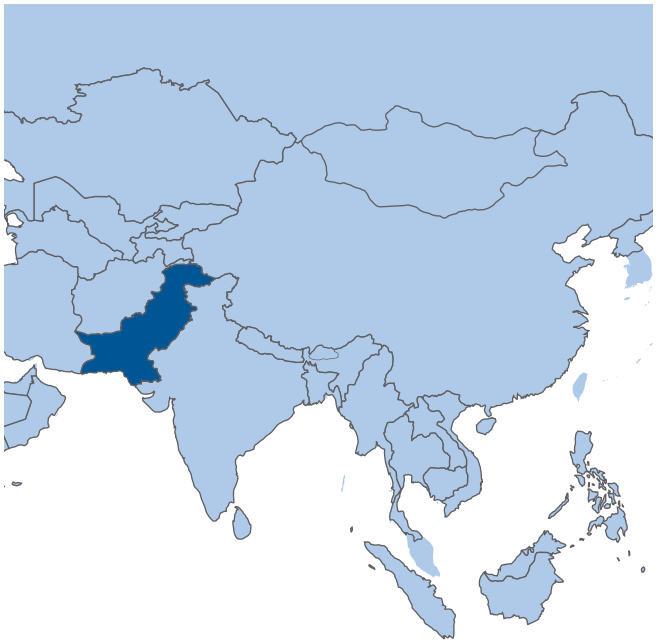
Planned results for the Mission's MCH investments over the next 5 years

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)