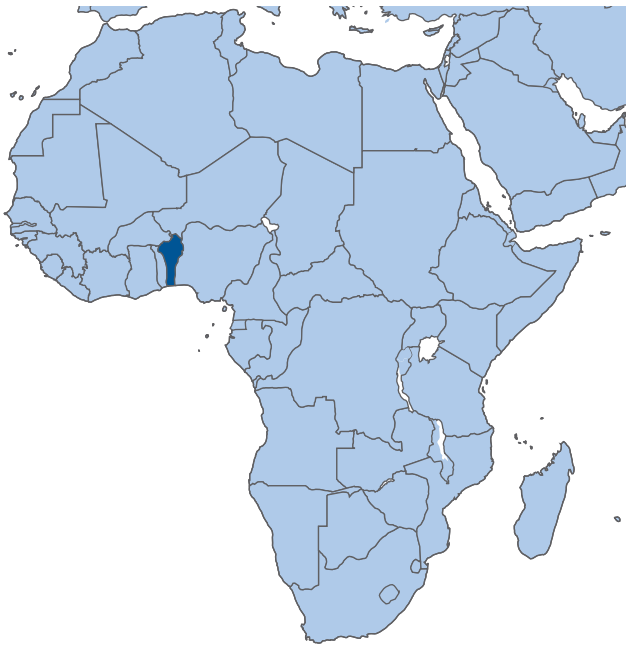
Benin MCH Program Description



Overall MCH and health sector situation

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

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

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

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

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

MCH interventions at the Mission level

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

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

Delivery approaches and mechanisms supporting expanded coverage/use of interventions

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

Specific actions supported as part of the MCH approach

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

The USAID program's geographic focus

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

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

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

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

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

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

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

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

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

Investments and initiatives of other donors and international organizations

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

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

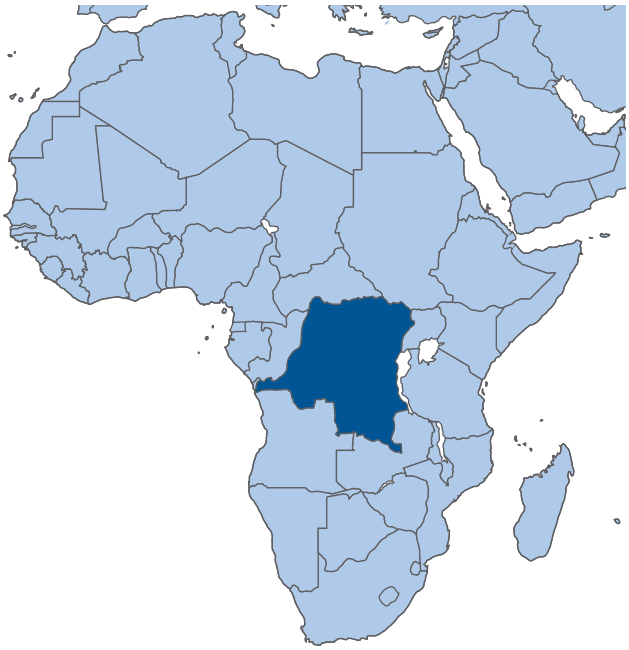
Planned results for the Mission's MCH investments over the next 5 years

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

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

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

Democratic Republic of the Congo MCH Program Description



Overall MCH and health sector situation

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

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

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

MCH interventions at the Mission level

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

Delivery approaches and mechanisms supporting expanded coverage/use of interventions

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

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

Specific actions supported as part of the MCH approach

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

The USAID program's geographic focus

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

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

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

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

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

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

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

Investments and initiatives of other donors and international organizations

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

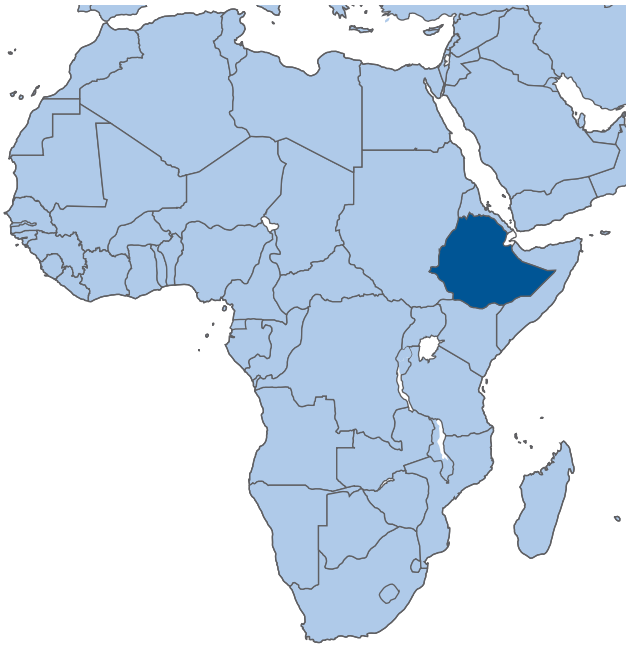
Planned results for the Mission's MCH investments over the next 5 years

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

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

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

Ethiopia MCH Program Description



Overall MCH and health sector situation

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

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

MCH interventions at the Mission level

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

Delivery approaches and mechanisms supporting expanded coverage/use of interventions

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

Specific actions supported as part of the MCH approach

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

The USAID program's geographic focus

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

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

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

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

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

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

Investments and initiatives of other donors and international organizations

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

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

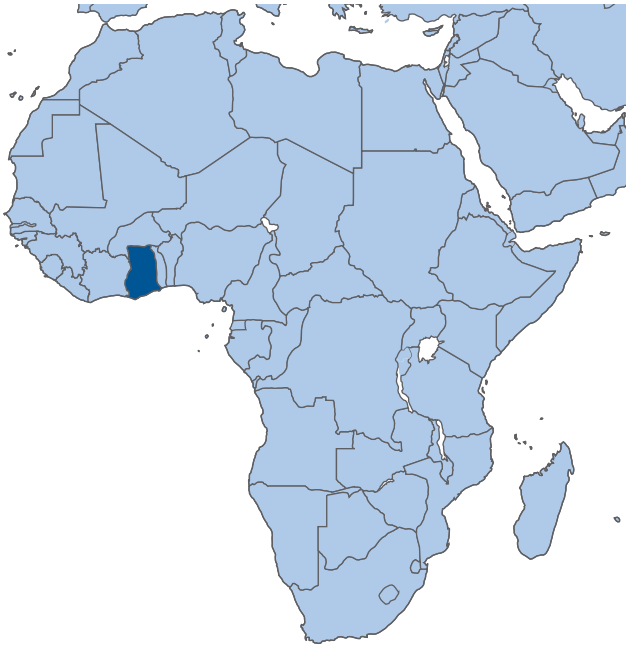
The targets are in line with the Ethiopian Government's Health Sector Development Program III, which aims by the end of the 5-year period to:

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

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

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

Ghana MCH Program Description



Overall MCH and health sector situation

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

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

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

MCH interventions at the Mission level

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

Delivery approaches and mechanisms supporting expanded coverage/use of interventions

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

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

Specific actions supported as part of the MCH approach

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

The USAID program's geographic process

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

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

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

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

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

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

Investments and initiatives of other donors and international organizations

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

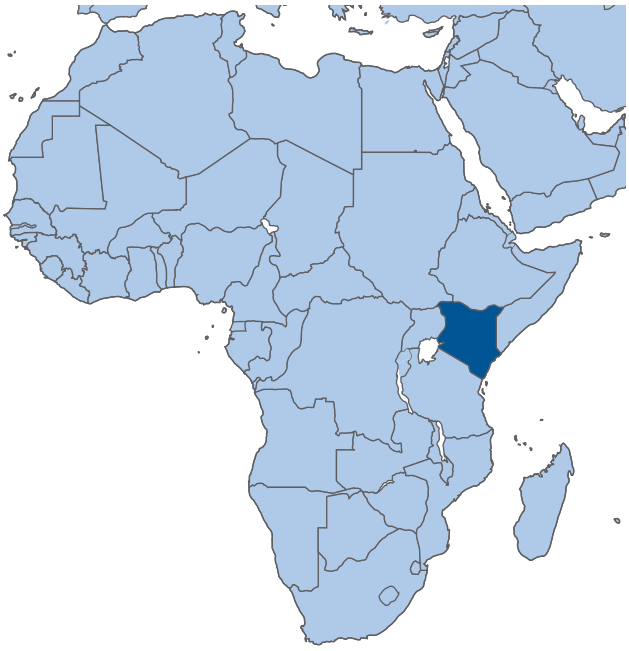
Planned results for the Mission's MCH investments over the next 5 years

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

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

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

Kenya MCH Program Description



Overall MCH and health sector situation

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

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

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

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

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

MCH interventions at the Mission level

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

Delivery approaches and mechanisms supporting expanded coverage/use of interventions

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

Specific actions supported as part of the MCH approach

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

The USAID program's geographic focus

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

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

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

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

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

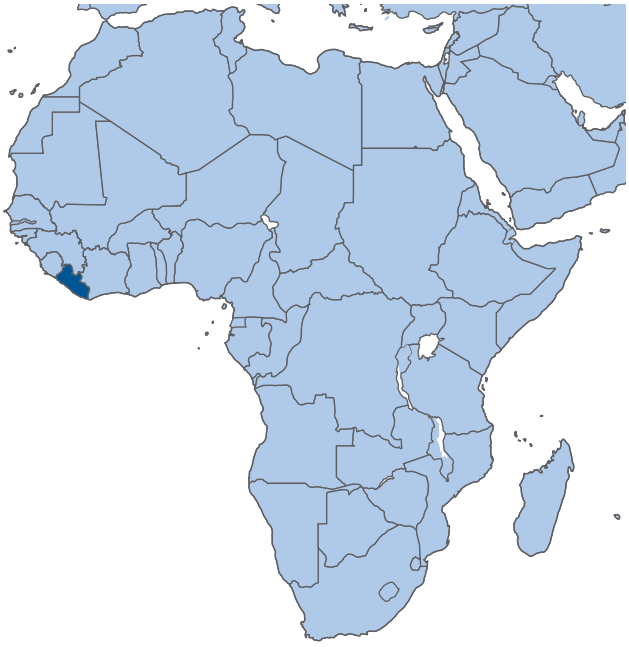
Planned results for the Mission's MCH investments over the next 5 years

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

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

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

Liberia MCH Program Description



Overall MCH and health sector situation

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

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

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

MCH interventions at the Mission level

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

Delivery approaches and mechanisms supporting expanded coverage/use of interventions

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

Specific actions supported as part of the MCH approach

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

The USAID program's geographic focus

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

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

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

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

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

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

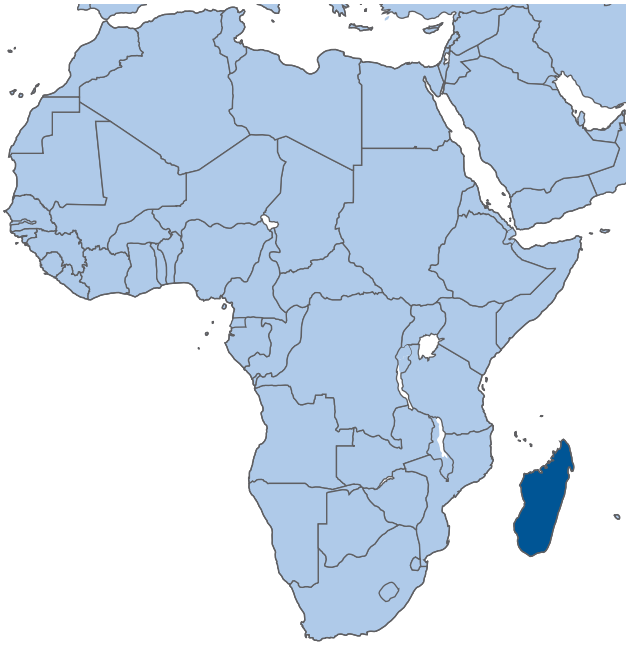
The USG will work with the Liberian Government and other development partners in lowering the MMR of 994/100,000 by 25 percent, increasing the rate of delivery by a skilled birth attendant from 49 to 60 percent, increasing overall childhood vaccination coverage to 75 percent, and providing in-service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

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

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

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

Madagascar MCH Program Description



Overall MCH and health sector situation

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

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

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

MCH interventions at the Mission level

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

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

Delivery approaches and mechanisms supporting expanded coverage/use of interventions

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

Specific actions supported as part of the MCH approach

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

The USAID program's geographic focus

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

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

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

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

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

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

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

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

Investments and initiatives of other donors and international organizations

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

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

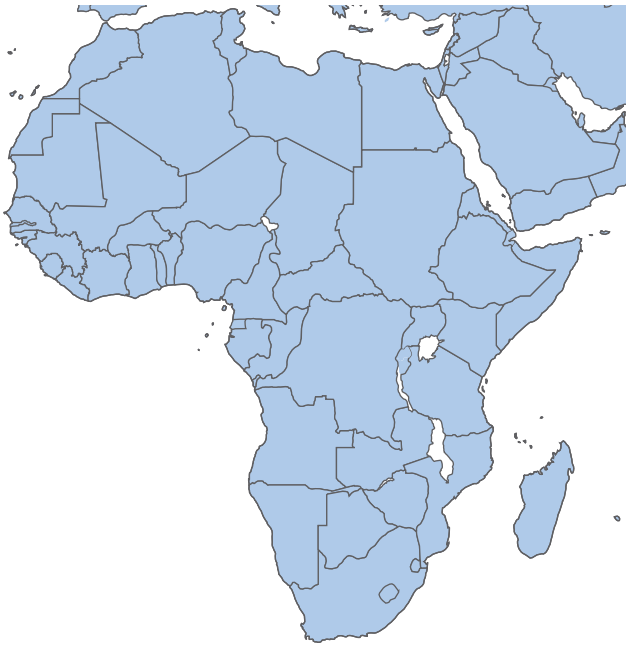
Planned results for the Mission's MCH investments over the next 5 years

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

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

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

Malawi MCH Program Description



Overall MCH and health sector situation

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

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

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

MCH interventions at the Mission level

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

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

Delivery approaches and mechanisms supporting expanded coverage/use of interventions

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

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

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

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

Specific actions supported as part of the MCH approach

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

The USAID program's geographic focus

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

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

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

of Work for the Health Sector Wide Approach 2004–2010 and the Malawi Growth and Development Strategy.

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

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

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

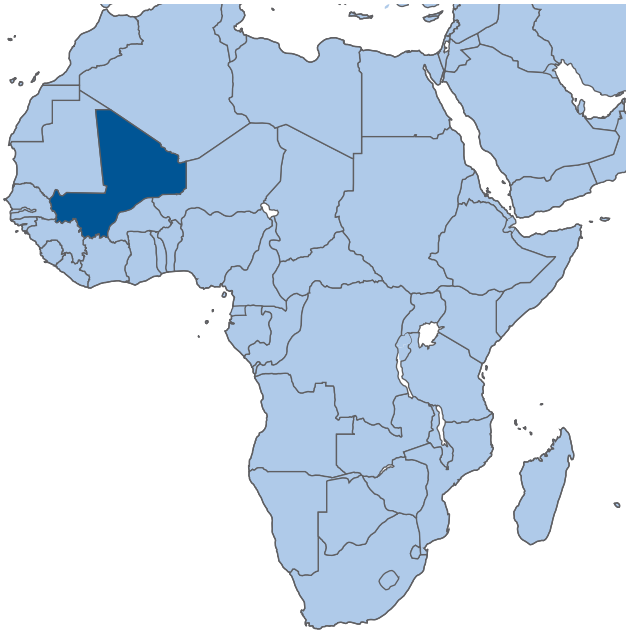
Planned results for the Mission's MCH investments over the next 5 years

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

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

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

Mali MCH Program Description



Overall MCH and health sector situation

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

MCH interventions at the Mission level

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

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

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

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

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

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

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

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

Delivery approaches and mechanisms supporting expanded coverage/use of interventions

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

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

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

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

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

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

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

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

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

Specific actions supported as part of the MCH approach

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

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

The USAID program's geographic focus

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

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

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

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

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

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

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

Initiatives:

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

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

Avian Influenza

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

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

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

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

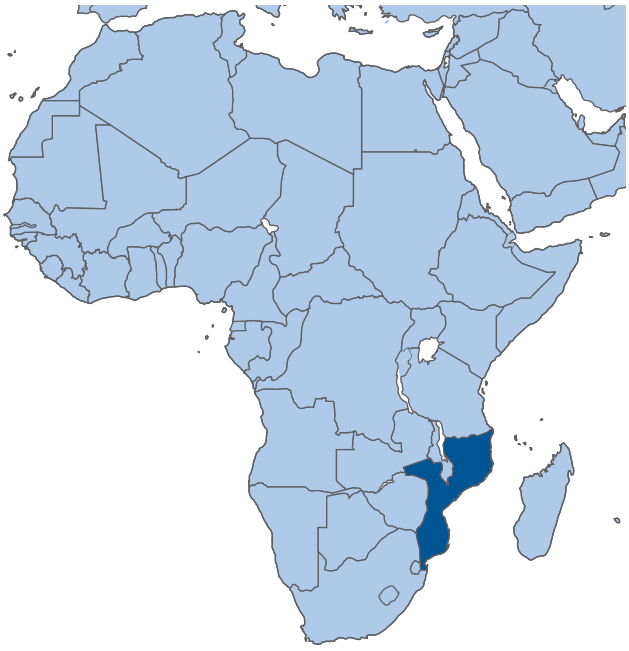
- Increase percentage of women who have completed a pregnancy in the last 2 years who have received two or more doses of IPTp during that pregnancy from 4 percent (2006) to 85 percent in 2011.
- Increase percentage of children 6 to 59 months old receiving vitamin A supplementation from 80 percent (2006)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

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

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

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

Mozambique MCH Program Description



Overall MCH and health sector situation

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

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

MCH interventions at the Mission level

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

Delivery approaches and mechanisms supporting expanded coverage/use of interventions

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

Specific actions supported as part of the MCH approach

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

The USAID program's geographic focus

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

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

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

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

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

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

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

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

Investments and initiatives of other donors and international organizations

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

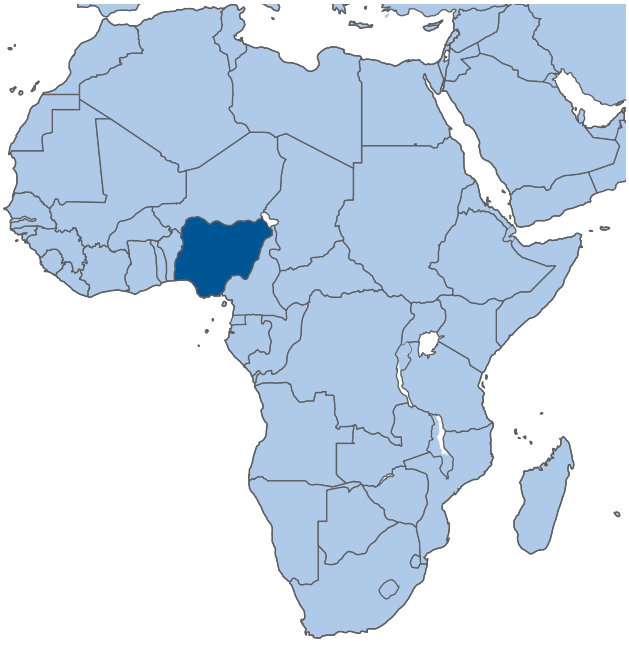
Planned results for the Mission's MCH investments over the next 5 years

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

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

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

Nigeria MCH Program Description



Overall MCH and health sector situation

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

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

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

MCH interventions at the Mission level

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

Delivery approaches and mechanisms supporting expanded coverage/use of interventions

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

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

Specific actions supported as part of the MCH approach

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

The USAID program's geographic focus

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

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

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

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

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

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

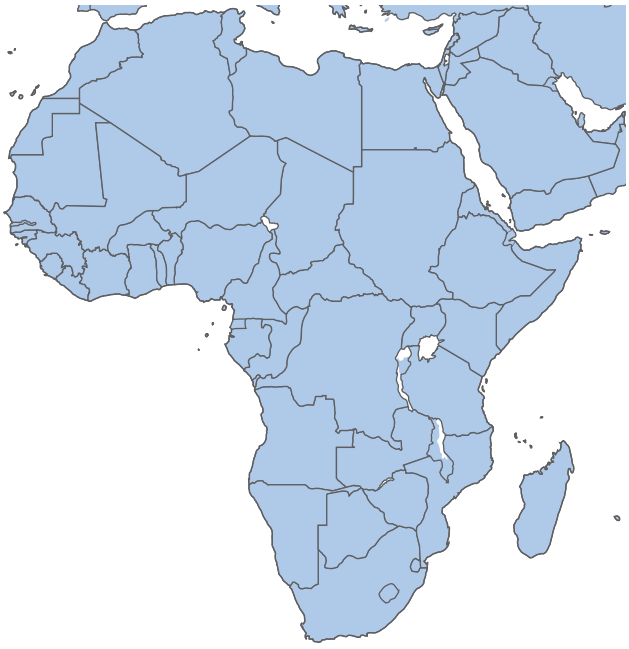
Planned results for the Mission's MCH investments over the next 5 years

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

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

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

Rwanda MCH Program Description



Overall MCH and health sector situation

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

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

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

MCH interventions at the Mission level

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

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

Specific actions supported as part of the MCH approach

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

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

The USAID program's geographic focus

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

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

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

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

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

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

Investments and initiatives of other donors and international organizations

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

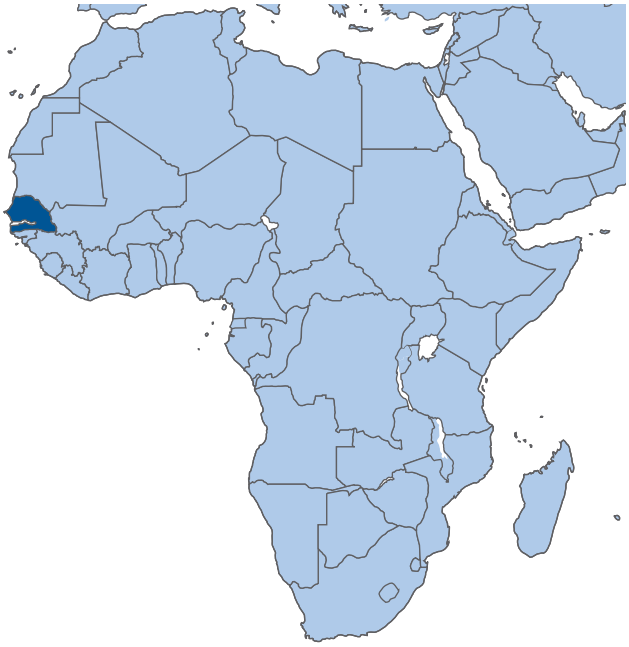
Planned results for the Mission's MCH investments over the next 5 years

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

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

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

Senegal MCH Program Description



Overall MCH and health sector situation

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

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

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

MCH interventions at the Mission level

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

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

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

Delivery approaches and mechanisms supporting expanded coverage/use of interventions

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

Specific actions supported as part of the MCH approach

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

The USAID program's geographic focus

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

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

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

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

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

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

Investments and initiatives of other donors and international organizations

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

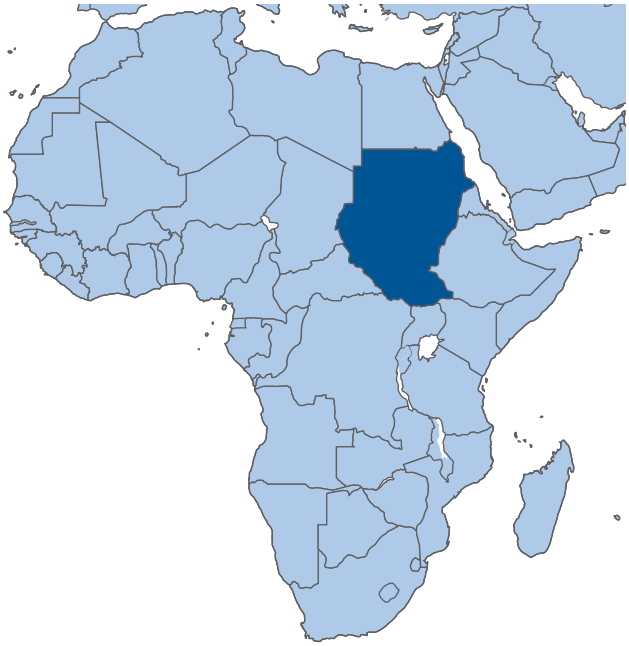
Planned results for the Mission's MCH investments over the next 5 years

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

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

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

Sudan MCH Program Description



Overall MCH and health sector situation

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

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

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

MCH interventions at the Mission level

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

Delivery approaches and mechanisms supporting expanded coverage/use of interventions

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

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

Specific actions supported as part of the MCH approach

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

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

The USAID program's geographic focus

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

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

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

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

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

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

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

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

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

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

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

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

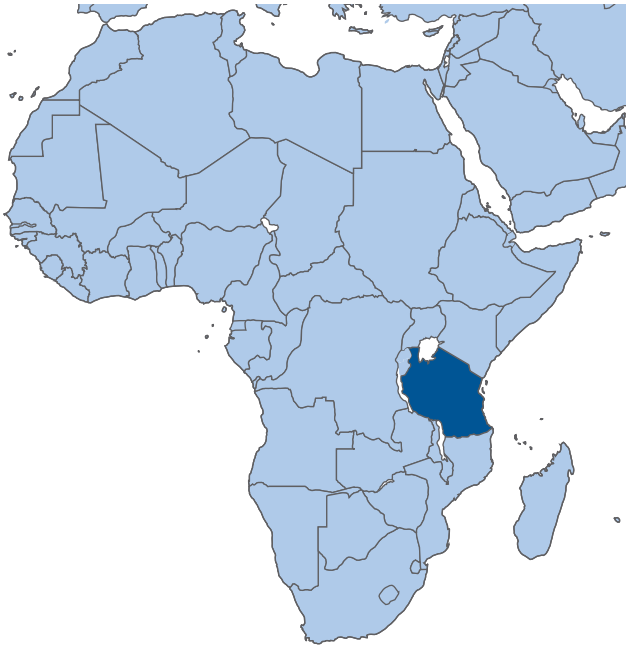
Planned results for the Mission's MCH investments over the next 5 years

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

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

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

Tanzania MCH Program Description



Overall MCH and health sector situation

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

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

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

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

MCH interventions at the Mission level

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

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

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

Delivery approaches and mechanisms supporting expanded coverage/use of interventions

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

Specific actions supported as part of the MCH approach

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

The USAID program's geographic focus

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

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

The Mission supports the MOHSW health sector strategies listed above.

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

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

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

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

Investments and initiatives of other donors and international organizations

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

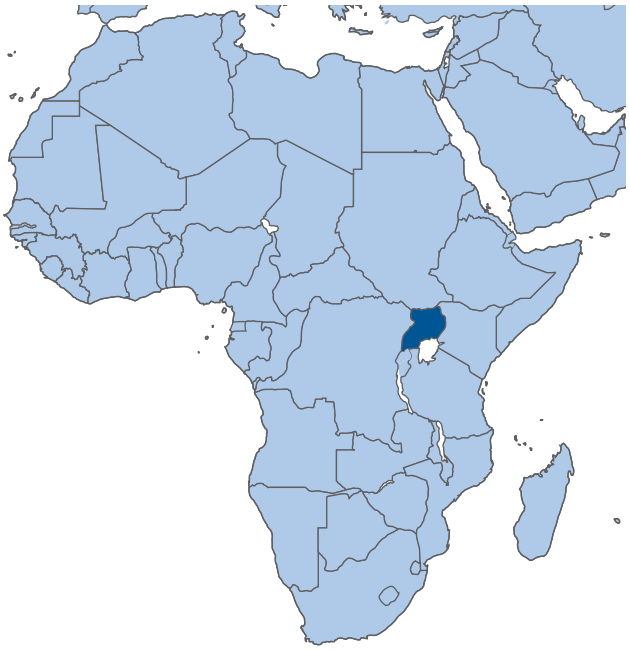
Planned results for the Mission's MCH investments over the next 5 years

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

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

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

Uganda MCH Program Description



Overall MCH and health sector situation

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

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

MCH interventions at the Mission level

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

Delivery approaches and mechanisms supporting expanded coverage/use of interventions

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

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

Specific actions supported as part of the MCH approach

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

The USAID program's geographic focus

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

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

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

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

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

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

Investments and initiatives of other donors and international organizations

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

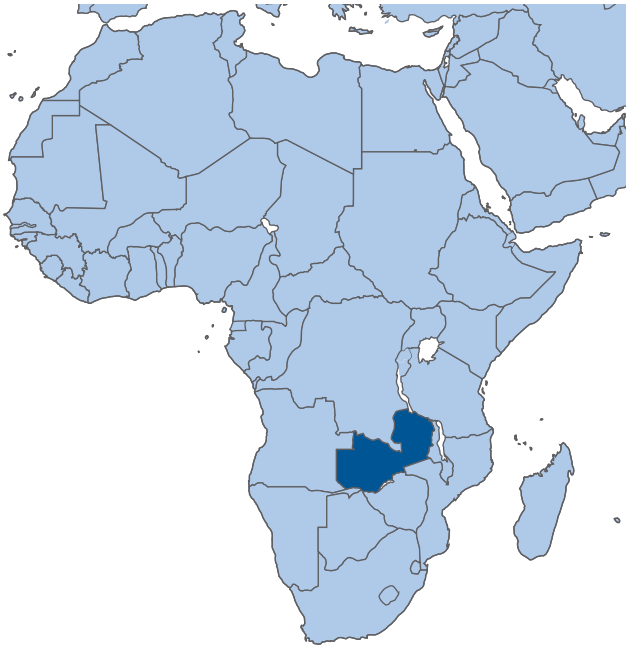
Planned results for the Mission's MCH investments over the next 5 years

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

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

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

Zambia MCH Program Description



Overall MCH and health sector situation

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

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

MCH interventions at the Mission level

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

Delivery approaches and mechanisms supporting expanded coverage/use of interventions

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

Specific actions supported as part of the MCH approach

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

The USAID program's geographic focus

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

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

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

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

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

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

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

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

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

Investments and initiatives of other donors and international organizations

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

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

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

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

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

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