



**USAID**  
FROM THE AMERICAN PEOPLE

**BASICS**

# USAID/BASICS ANNUAL REPORT

## PROJECT YEAR THREE

(OCTOBER 1, 2006 - SEPTEMBER 30, 2007)





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## PROGRAM OVERVIEW

In FY07 (Project Year 3), USAID/BASICS provided technical assistance to 14 countries in Africa, 3 in Asia, and 4 in South America. The project completed country programs in India and Swaziland, and initiated new activities in 5 countries: Malawi, Liberia, Afghanistan, Southern Sudan, and Benin. USAID/BASICS also provided short term technical assistance for the Partnership for Maternal, Newborn, and Child Health and UNICEF in Ghana, and initiated plans for Tanzania. The project visited and identified potential activities in South Africa. In addition, USAID/BASICS participated in 3 regional networks: newborn in LAC, Diarrhea/zinc in Eastern Africa, and newborn in ANE.

Overall, USAID/BASICS is *on target* in terms of its achieving its work plans and USAID pathway targets. In three technical focus areas—Diarrheal Diseases, Nutrition, and Newborn Health—the project has exceeded performance expectations. In its Pneumonia, Malaria, and Healthy Timing and Spacing of Pregnancy programs, USAID/BASICS is performing as anticipated. Only in the area of Pediatric HIV and in private sector Malaria initiatives is the project lagging. Nonetheless, in these areas, with funding in PMI and PEPFAR, improvement is anticipated during the next program year cycle.

## **Status of Country Programs**

### Active

- Cambodia
- Democratic Republic of the Congo
- Dominican Republic (through the LAC Regional initiative)
- El Salvador (through the LAC Regional initiative)
- Honduras (through the LAC Regional initiative)
- Indonesia (new in 2007)
- Kenya (through the East Africa Regional initiative)
- Liberia (new in 2007)
- Madagascar
- Malawi
- Nicaragua (through Save the Children)
- Nigeria
- Rwanda
- Senegal
- Southern Sudan (new in 2007)
- Tanzania
- Timor-Leste (in collaboration with IMMUNIZATIONbasics)
- Uganda (through the East Africa Regional initiative)

### Preliminary steps taken in FY07 for program start-up in FY08

- Afghanistan
- Mali

### Completed

- Bolivia (September 2006)
- India (December 2007)
- Iraq (2006)
- Swaziland (September 2007)

### Staff and long term consultants engaged in PY3

- Headquarters—Dr. Ciro Franco was hired as Malaria Advisor in June 2007, replacing Dr. Larry Barat, who joined USAID.
- Democratic Republic of the Congo—Finance and Administrative Manager, Newborn Advisor, and Community Case Management Advisor hired.
- Indonesia—60 in-country staff hired.
- LAC—3 in-country coordinators (Dominican Republic, El Salvador, Honduras) hired.
- Madagascar—Finance and Administrative Manager and Nutrition Advisor identified.
- Malawi—PMTCT advisor hired.
- Rwanda—Finance and Administrative Manager and HIV/AIDS advisor hired.

### Technical Focus Areas

Acute Respiratory Infections (Pneumonia)
<p><u>End-of-project Objective</u></p> <ul style="list-style-type: none"><li>• Facilitate implementation of community-based interventions for pneumonia in 10 countries, with at least 4 in expansion.</li></ul>
<p><u>Status: On target</u></p> <ul style="list-style-type: none"><li>• 4 countries in introduction phase (Madagascar, Rwanda, Nicaragua, and Tanzania).</li><li>• 2 countries in expansion phase (DR Congo and Senegal).</li><li>• 3 countries supported via technical exchange (Benin, Niger, and Togo).</li></ul>
<p><u>Illustrative Country Highlights</u></p> <ul style="list-style-type: none"><li>• Madagascar—Implemented community case management (CCM), including pneumonia, in 12 districts across 9 regions.</li><li>• Senegal—Following termination of activities spanning 19 districts in 6 regions in September 2006 (when a new USAID bilateral project assumed work on child survival scale up activities in Senegal), initiated a new activity with multi-donor financing in 6 districts of the Fatick region, whose under-five population of 122,983 is 7% of the national under-five population.</li><li>• DR Congo—Operationalized 170 new CCM sites in 23 health zones through the training of 324 community health workers (expanding from 54 sites operationalized in 7 health zones in FY06), attaining a total thus far of 224 sites in 30 health zones.</li></ul>

## Diarrheal Diseases

### End-of-project Objectives

- Introduce zinc for the treatment of diarrheal diseases in 6 countries, including 2 countries at the community level and 4 in expansion phase.
- Incorporate oral rehydration therapy into community-based treatment programs in at least 6 countries, and into facility-based IMCI in at least 3 countries.
- Implement strategies to increase oral rehydration therapy use in 3-4 African countries.

### Status: Surpassed target

- 5 countries (DR Congo, Madagascar, Rwanda, Timor-Leste, and Indonesia) introduced zinc and are revitalizing ORT at the facility and/or community levels through USAID/BASICS' direct involvement.
- 2 new countries (Kenya and Uganda) introduced zinc and are revitalizing ORT at the facility and/or community through the East Africa Regional Initiative, which also includes DR Congo and Madagascar.

### Illustrative Country Highlights

- Indonesia—Led a national readiness assessment for the introduction of zinc and revitalization of ORT. Based on recommendations from the assessment, developed an action plan for USAID/Indonesia and received Mission funding for PY4.
- East Africa Regional Initiative—Conducted country-level stakeholder meetings in Uganda, Rwanda, DR Congo, and Kenya, and held a regional meeting where 30 MOH and partner representatives from each country developed implementation plans to revitalize diarrhea case management and introduce zinc, and established a network for horizontal exchange.
- Madagascar, Senegal, Rwanda and DR Congo—Supported CCM activities, including ORT revitalization and introduction of zinc.
- Timor-Leste, Cambodia and Afghanistan—Conducted successful advocacy for the introduction of zinc.

## Healthy Timing and Spacing of Pregnancy (HTSP)

### End-of-project Objective

- Develop and implement strategies and operational approaches to integrate HTSP with routine postpartum, infant and/or child care in 6 countries.

### Status: On target

- Conducted advocacy for HTSP in 3 countries (Rwanda, Timor-Leste and Cambodia).
- Introduced HTSP within child health or newborn service in 2 countries (Swaziland, Rwanda).

### Illustrative Highlights

- Global—Finalized the *Training Manual for the Integration of Healthy Timing and Spacing of Pregnancy into Newborn and Child Health Activities*.
- Rwanda—Incorporated HTSP into the IMCI training module that is currently being rolled out in 9 districts. Twenty-five district-level supervisors and 85 health workers have thus far been trained using the module. Result monitoring is in process.

## Humanitarian Assistance and Fragile States

### Illustrative Country Highlights

- Liberia—Provided technical assistance for the development of national health policy and plan, including the Basic Package of Health Services (BPHS); undertook a transition assessment (assessing the transition from relief funding to development assistance) and initiated county-level plans for implementing the BPHS, which includes key newborn and child health interventions.
- Southern Sudan—Began providing technical support for a transition assessment (for OFDA) and for facilitation of a stakeholder transition workshop in early FY08.

## Nutrition for Infants and Children

### End-of-project Objectives

- Introduce and scale up early breastfeeding, IYCF, ENA, and/or CBGP at the national and regional levels in 6-8 countries.

### Status: Surpassed Target

- 2 completed countries (Senegal, India) with activities at scale and documented results.
- 5 current countries (Cambodia, Madagascar, Nigeria, Rwanda, and Timor-Leste) with ENA, IYCF or CBGP.

### Illustrative Country Highlights

- Cambodia—Created an 8-year national strategic plan for nutrition and held a consensus building workshop for operational priorities in the coming years.
- Timor-Leste—Held a successful IYCF workshop in January 2007, effectively elevating the importance of nutrition for infants and children on the MOH agenda.
- Nigeria—In collaboration with Food Basket International, implemented GMP and HEARTH interventions in 6 communities, including nutrition and hygiene education. Produced counseling cards, including the importance of exclusive breastfeeding. Trained community focal points and 48 community volunteers in counseling card use and general ENA principles.

## Malaria

### End-of-project Objectives

- Facilitate the implementation of CCM or home-based management of fever (HBMF) for malaria in 6 countries, with at least 3 at scale.
- Facilitate the use of private medicine sellers to improve delivery and quality of treatment for malaria and, where feasible, pneumonia in children under 5, in 6 countries, with at least 3 at scale.

### Status: On target for CCM; behind target in private sector interventions

- 5 countries (Rwanda, Madagascar, DR Congo, Senegal, Timor-Leste) strengthening case management of malaria.
- 5 countries (Rwanda, Madagascar, DR Congo, Senegal, Tanzania – private sector) introducing home-based management of fever (i.e., CCM of Malaria).
- 1 country (Tanzania) introducing private sector/drug vendor CBT of malaria.

### Illustrative Country Highlights

- Rwanda—Evaluated the Integrated National Malaria Program's home-based management of malaria intervention and made recommendations for scale-up, including guidelines for the introduction of coartem for CBT and expansion of the home-based treatment intervention. Based on findings, successfully advocated for CCM pneumonia.
- Tanzania—Conducted formative research on care-seeking for sick children to strengthen the country's private sector model (ADDO); led development of training modules for child health and a community mobilization strategy to support increasing use of drug outlets. Conducted journalist workshops for the development of 8 radio spots, available for nation-wide transmission, on malaria prevention, where to go for treatment and the transition to ACTs.
- Timor-Leste—Implemented an innovative behavior change model for bed net distribution. Since December 2005, a total of 55,034 LLINs (long-lasting insecticide treated bednets) have been distributed to target families, benefiting 81,032 children. An additional 22,376 nets have been distributed to residents of IDP camps in Dili. Rapid surveys amongst target families in two districts show 80-94% appropriate use.

## Newborn Health

### End-of-project Objectives

- Introduce and implement essential newborn care (ENC) in 5 countries, with scale-up in 2 countries.
- Integrate ENC with IMCI in 1-2 countries.
- Integrate ENC, with an emphasis on postnatal care, with at least 2 PMTCT country programs

### Status: Surpassed Target

- 10 countries (Cambodia, Rwanda, DR Congo, Madagascar, Senegal, Swaziland, Timor-Leste and LAC Regional – Dominican Republic, El Salvador, and Honduras) introducing and implementing ENC
- 1 country (Rwanda) integrated ENC with IMCI.
- 1 country (Swaziland) integrated ENC with PMTCT.

### Illustrative Country Highlights

- Swaziland—Completed operations research on integrating MNH services into PMTCT—carried out in partnership with EGPAF and Population Council—to promote early and effective postpartum visits in the first week, with emphasis on the first three days. Trained 132 supervisors, health care providers, and trainers, covering 7 facilities in the country's most highly populated region, Manzini (approx. 7,500 in-facility deliveries annually), as well as one facility in Hhohho (approx. 3,760 in-facility deliveries annually). Results showed improvement in health provider skills, such as those related to the pre-discharge package (baseline = 52%, end-line = 87%) and during the early post-natal visits (increase from 75% to 96%). The utilization of early postnatal services increased 20-fold for visits within the first 3 days, 6-fold for visits between days 4-7, and 4-fold for visits 2-6 weeks after delivery. These favorable results led the MOH to express interest in rolling out the intervention nationally. Submitted a proposal to PEPFAR for funding to support expanding the intervention.
- LAC Regional Initiative—Through distance learning and in-country support, facilitated a process of identifying gaps and implementing solutions in the prevention and treatment of neonatal sepsis at the facility level (in El Salvador and the Dominican Republic; covering 60,000 combined deliveries) and at the community level (in Honduras; covering 300 communities in 17 municipalities). After 6 months of program implementation, results showed a reduction in cases of suspected newborn sepsis in three hospitals in El Salvador (2 by 30% and one by 56%) and in two regional hospitals in Dominican Republic (by 20%) .
- Rwanda—Provided technical assistance to incorporate newborn health in the IMNCl strategy at the facility and community levels. Facilitated monthly IMNCl strategy group meetings. IMNCl is now implemented in 42 health centers in 9 districts by Twbakane, UNICEF, EIP, EGPAF and Cooperation Suisse. These centers cover an under five population of 177,000 (12% of the country's children under 5). Led development of community IMCI materials for newborn elements.
- Senegal—Activities, results and lessons learned in the expansion phase with CCF Canah and Africare in 19 districts documented. Program extended to the Fatick region (122,983 U5s; 7% of national population). A rapid baseline evaluation was carried out which showed that only 8% of the region's newborns received thermal protection and less than 12% received skin-to skin contact with the mother after delivery.

## Pediatric HIV/AIDS

### End-of-project Objectives

- Facilitate establishment or strengthening of policies, plans and guidelines to expand child survival services to include detection, care (including cotrimoxazole prophylaxis) and referral of suspected and diagnosed pediatric HIV cases in 4 countries.
- Strengthen community level detection, care, and referral of pediatric HIV cases in at least 4 countries.
- Expand capacity building, supportive supervision, and implementation of systems and referral strategies to increase early diagnosis of HIV in infants, cotrimoxazole prophylaxis for all infected children, and referral for ART from lowest levels of care in at least 4 countries.

### Status: Behind target

- 4 countries (Malawi, Swaziland, Tanzania and Rwanda) with activities addressing earlier diagnosis and continuity of infant care following PMTCT program exit, including prophylaxis or policy and guidelines development.

### Illustrative Country Highlights

- Global—Sponsored “A Chance for Children,” at the Global Health Council’s annual meeting, attended by 80 participants.
- Rwanda—Conducted a workshop for 100 stakeholders aimed at developing a framework and action plans to address missed opportunities for access to pediatric HIV care and treatment at all entry points in the health system.
- Tanzania—Published the “Report of a Pediatric HIV/AIDS Care and Treatment Assessment in the Kilimanjaro, Iringa, and Mbeya Regions of Tanzania.” The assessment identified: missed opportunities to identify HIV-infected children through MCH and PMTCT programs, on pediatric wards, and other entry points; low levels of HIV identification among infants due to delays in testing; low numbers of health personnel trained in pediatric HIV care and treatment; and weak mechanisms for referral, follow-up, tracking, and monitoring.
- Swaziland—See Newborn (integration of ENC within PMTCT program).

# **TECHNICAL FOCUS AREAS**

## **ACUTE RESPIRATORY INFECTIONS (PNEUMONIA)**

USAID/BASICS supports the introduction and expansion of community-based treatment for childhood pneumonia to achieve documented improvement in access and treatment of pneumonia in children under 5 years of age. In those countries where malaria is endemic—especially PMI countries—the project’s approach is to opportunistically build on the platform created by home-based malaria treatment, adding pneumonia treatment; or when appropriate, adding malaria treatment to community case management (CCM) of pneumonia.

The project is also developing system-strengthening components that are essential for sustaining effective community-based treatment, such as pharmaceutical management, data management, supportive supervision and quality assurance. With CORE and based on country experiences, USAID/BASICS is refining program operational materials, including scale-up approaches, and compiling program guidelines for community-based treatment and CCM of pneumonia.

USAID/BASICS is currently providing technical assistance to strengthen and expand case management of pneumonia through IMCI in 2 countries (Rwanda and Timor-Leste). The project is also providing technical support for the introduction or expansion of community-based treatment of pneumonia in 5 countries. Of these, DR Congo and Senegal are in the expansion phase and Madagascar, Rwanda, and Nicaragua are in early implementation. The project is actively advocating for CCM of pneumonia in Cambodia and Timor-Leste.

## Objectives

End-of-project Objectives	FY07 Interim Objectives
<b>ARI PATHWAY— INTRODUCTION OF COMMUNITY-BASED TREATMENT (CBT) OF PNEUMONIA (ADVOCACY, PLANNING, AND START-UP) AND EXPANSION OF CBT OF PNEUMONIA (BEYOND START-UP DISTRICTS)</b>	
<p>Through direct engagement or technical influence, facilitate implementation of community-based interventions for pneumonia, either stand-alone or integrated with malaria, diarrhea and/or, essential nutrition in 10 countries, with at least 4 of them in expansion or scale up phase (over 20% coverage of eligible communities).</p>	<ul style="list-style-type: none"> <li>• Assist 10 countries in the implementation of CBT of pneumonia:               <ul style="list-style-type: none"> <li>— 1-2 in the advocacy/planning stage</li> <li>— 5-6 in the early implementation phase</li> <li>— 2 in the expansion phase</li> </ul> </li> </ul>
<p>Refine the CBT/CCM program guide (with emphasis on hard- to-reach areas) for pneumonia, malaria and diarrhea, leading to evaluation and use by key implementing parties.</p>	<ul style="list-style-type: none"> <li>• Incorporate field interventions and experiences into the CCM program guide.</li> <li>• Develop country implementation guides in new countries.</li> </ul>
<p>Adapt and use a data management application in 4 CBT programs.</p>	<ul style="list-style-type: none"> <li>• Refine the data management application.</li> <li>• Use the application in 4 countries: DR Congo, Madagascar, Rwanda and Nicaragua.</li> </ul>
<p>Integrate quality assurance methods and indicators within at least 6 CBT programs.</p>	<ul style="list-style-type: none"> <li>• Refine QA methods and materials</li> <li>• Include QA methods in the expansion model in Senegal and in intervention designs in Rwanda.</li> </ul>
<p>In partnership with RPM Plus, adapt a district assessment and implementation guide to improve drug management for common childhood illnesses and introduce it in 4 countries, with at least 3 countries extending it to cover CBT activities.</p>	<ul style="list-style-type: none"> <li>• Refine and implement drug management for childhood illness (DMCI) in DR Congo.</li> </ul>
<p>Develop a costing package for CBT and apply it in 3 countries as part of expansion.</p>	<ul style="list-style-type: none"> <li>• Develop a zonal costing package in DR Congo and apply in planning for scale up.</li> </ul>

### Status: On target

- 4 countries in introduction phase (Madagascar, Rwanda, Nicaragua, and Tanzania).
- 2 countries in expansion phase (DR Congo and Senegal).
- 3 countries supported via technical exchange (Benin, Niger, and Togo).

## Results and Achievements

### *Introduction of CBT of Pneumonia (Advocacy, Planning, And Start-Up) and Expansion of CBT of Pneumonia (Beyond Start-Up Districts)*

- Assisted 9 countries in the implementation of CCM/CBT of pneumonia:
  - 4 countries in the introduction phase: Madagascar, Rwanda, Nicaragua, and Tanzania;
  - 2 countries in expansion phase: DR Congo and Senegal; and
  - 3 countries supported via technical exchange (Benin, Niger, and Togo).
- Incorporated field experiences from DR Congo into the CCM/CBT program guide.
- CCM/CBT country implementation guides developed for Rwanda.
- Testing of a data management computer application for entering information from CCM treatment forms began in DR Congo (see below) and development of a companion computer program for automated analysis of CCM data was also completed.
- A data management computer application was tested and used in DR Congo in 2 zones, though extension to other UNICEF districts was postponed due to funding delays, which are expected to be resolved shortly. Still, nearly 5,200 individual forms were entered at the central level and, where the application could be used, zonal data entry agents noted that the interface was user friendly. Data management application use in Madagascar and Rwanda did not occur this year as activities progressed slower than expected.
- Direct observation methods have been maintained in intervention countries. Additionally, a manual analytical form designed to monitor the completeness of reporting forms and quality of case management was introduced in DR Congo and Madagascar. The form was shared with other countries, including Benin, and will be used in Rwanda in FY08.
- In DR Congo, tools for DMCI used at the health facility level were introduced at the community level. After initial use showed that community health workers had difficulty quantifying drug needs, it was decided that community health workers would only track consumption, and forecasting would be undertaken at the facility level.
- Planning for the zonal costing package in DR Congo is complete, a consultant has been identified, and draft tools developed. Tools will be finalized in FY08.

### **Year 4—Planned activities**

- Assist 10 countries in the implementing CBT of pneumonia, including 4 in introduction (Cambodia, Malawi, Nicaragua, and Rwanda), 3 in expansion (DR Congo, Madagascar, and Senegal), and 3 via technical exchange (Benin, Niger, and Togo).

## **DIARRHEAL DISEASES**

USAID/BASICS' work plan directly addresses USAID's pathway for the introduction and expansion of zinc use, as well as the agency's pathway for revitalizing oral rehydration therapy (ORT). In as far as these efforts are synergistic, activities to strengthen case management of diarrhea in public and private health systems commonly include both ORT and zinc. In addition, in those countries implementing CCM, USAID/BASICS commonly supports the inclusion of diarrhea.

USAID/BASICS is currently providing technical assistance to increase coverage and improve case management of diarrheal diseases (including the introduction and expansion of zinc) in 6 African countries (DR Congo, Madagascar, Rwanda, Senegal, Tanzania and Kenya), as well as 2 Asian countries (Indonesia and Timor-Leste). In Cambodia, USAID/BASICS is working at the national and provincial levels to implement the Cambodian Child Survival Strategy, which includes expanding coverage of ORT.

## Objectives

End-of-project Objectives	FY07 Interim Objectives
<b>ZINC PATHWAY—INTRODUCE AND EXPAND ZINC USE IN DIARRHEA PROGRAMS IN PUBLIC AND PRIVATE HEALTH SYSTEMS</b>	
Introduce zinc for the treatment of diarrheal diseases in 6 countries at the facility level and 2 countries at the community level.	<ul style="list-style-type: none"> <li>• Conduct zinc assessments in 3-4 countries.</li> <li>• Introduce or improve treatment of diarrhea with zinc in 2 new countries at the facility and community levels.</li> </ul>
Expand zinc use in diarrhea programs in 4 countries, attaining at least 20% coverage in implementation areas.	<ul style="list-style-type: none"> <li>• Expand implementation in Madagascar.</li> </ul>
<b>ORT PATHWAY— REVITALIZE ORAL REHYDRATION THERAPY USE IN THE MANAGEMENT OF DIARRHEA</b>	
Advocate for the revitalization of ORT in 6 countries, and increase commitment and resources in at least 3 countries.	<ul style="list-style-type: none"> <li>• Deliver ORT and zinc training to health workers in Madagascar.</li> <li>• Advocate for zinc and ORT in 3 countries.</li> </ul>
Implement strategies to increase ORT use in 3-4 African countries, attaining at least a 20% increase in 2 countries.	<ul style="list-style-type: none"> <li>• Conduct formative research in Madagascar and DR Congo.</li> <li>• Analyze factors associated with ORT decline in 3-4 East African countries.</li> </ul>
Incorporate ORT into CBT programs in at least 6 countries, and into facility-based IMCI in at least 3 countries.	<ul style="list-style-type: none"> <li>• Incorporate oral rehydration therapy into CBT programs in DR Congo.</li> <li>• Include zinc and ORT training in Madagascar at the community level.</li> <li>• Introduce ORT revitalization strategies in 3 East African countries.</li> </ul>
Implement DMCI to improve ORS stock management in at least 5 countries.	<ul style="list-style-type: none"> <li>• Improve DMCI for oral rehydration solution supplies in DR Congo.</li> <li>• Introduce DMCI in 1 new country.</li> </ul>
<b>OTHER</b>	
Incorporate feeding recommendations into facility-based and community-based diarrhea case management programs.	<ul style="list-style-type: none"> <li>• Incorporate feeding recommendations into facility-based and community-based diarrhea case management programs in Rwanda and Cambodia, with documented improvement in caretaker knowledge in at least 1 country.</li> </ul>

### Status: Surpassed target

- 5 countries (DR Congo, Madagascar, Rwanda, Timor-Leste, and Indonesia) introduced zinc and are revitalizing ORT at the facility and/or community levels through USAID/BASICS' direct involvement.
- 2 new countries (Kenya and Uganda) introduced zinc and are revitalizing ORT at the facility and/or community through the East Africa Regional Initiative, which also includes DR Congo and Madagascar.

## Results and Achievements

### *Introduce and Expand Zinc Use in Diarrhea Programs in Public and Private Health Systems*

- Conducted assessments of diarrhea case management and the feasibility of introducing zinc therapy for treatment in Indonesia and Madagascar. As part of an assessment on zinc use and diarrheal disease management, a literature review was conducted in DR Congo in June 2007 to identify data collection needs. Collection of the elements for which data is lacking is planned for FY08.
- Implemented CCM pneumonia, diarrhea (including zinc treatment and low osmolarity ORS), and malaria in 117 out of 168 planned sites (5/12 districts; 4/9 regions) in Madagascar through the training of 250 of 314 planned community health workers. Initial data for the period between October 2006 and July 2007 comprise average monthly reporting from 43 sites, where a total monthly average of 110 childhood diarrhea cases were treated.

### *Revitalize Oral Rehydration Therapy Use in the Management of Diarrhea*

- Introduced zinc and low-osmolarity ORS for the revitalization of facility-based diarrhea treatment in 9 districts of Madagascar through the training of 37 program managers and 223 service providers.
- In collaboration with the Regional Centre for Quality of Health Care (RCQHC, Makerere University), conducted country-level stakeholder meetings in Uganda, Rwanda, DR Congo, and Kenya and held an East Africa regional workshop in Nairobi from June 27 to June 29, where 30 MOH and partner representatives from each of the four participating countries developed implementation plans to revitalize diarrhea case management and established a network for cross-border support. Advocacy activities for the introduction of zinc and new low-osmolarity ORS were also undertaken in Cambodia, Timor-Leste, and Senegal.
- Assessment activities on the revitalization of diarrheal treatment began in May 2007 in DR Congo, however the focus was on the introduction of zinc to build momentum and utilize the zinc product already in country before it expired. Planning for formative research on ORT did occur, including a literature review in June 2007 to identify data collection needs. The assessment is due to start in October 2007 (Q1, FY08). Due to constraints in timing and staffing, formative research on ORT use in Madagascar was postponed until FY08.
- Next steps and country implementation plans developed by Uganda, Rwanda, DR Congo, and Kenya at the East Africa regional workshop in Nairobi include analyzing factors associated with ORT decline. Some limited analysis was done in FY07, and a partner is conducting formative research that will further inform the analysis. As mentioned above, formative research on ORT use is scheduled for DR Congo in October 2007.
- In DR Congo, zinc and low-osmolarity ORS for the revitalization of diarrhea treatment were introduced at the facility and community levels through the training of 39 trainers and 71 nurses for facility-level introduction, and to 91 CHWs from 66 CCM sites (spanning 9 health zones).
- In Madagascar, implemented CCM pneumonia, diarrhea (including zinc treatment and low osmolarity ORS), and malaria in 117 out of 168 planned sites (5/12 districts; 4/9 regions) through the training of 250 of 314 planned community health workers.

- Tools for DMCI used at the health facility level were introduced at the community level in DR Congo. After initial use showed that community health workers had difficulty quantifying drug needs, it was decided that community health workers would only track consumption, and forecasting would be undertaken at the facility level.
- DMCI was introduced in Madagascar and is under consideration for Rwanda.
- In Rwanda, the focus of feeding the sick child was introduced in the context of CCM. USAID/BASICS is working to introduce LQAS in order to monitor the results.

#### **Year 4—Planned activities**

- Expand zinc use in 3 countries (Madagascar, DR Congo, and Rwanda), and facilitate increases of at least 10% in ORT use in 6 countries (DR Congo, Madagascar, Rwanda, Senegal, Malawi, Cambodia, and TBD).

# HEALTHY TIMING AND SPACING OF PREGNANCY

USAID/BASICS' strategy for integration of Healthy Timing and Spacing of Pregnancy (HTSP) into newborn and child health programs is composed of two major components: an evidence-based advocacy component to raise awareness and increase commitment for HTSP among decision makers, and a programmatic component aimed at developing and integrating HTSP educational messages and activities into child health services.

USAID/BASICS is currently providing technical assistance for healthy pregnancy spacing in Rwanda, Swaziland, and Timor-Leste. Advocacy efforts have begun in Cambodia and the project is exploring the introduction of HTSP integration activities in DR Congo and Madagascar.

## Objectives

End-of-project Objectives	FY07 Interim Objectives
Conduct advocacy HTSP in 6 countries, as well as in the PMNCH.	<ul style="list-style-type: none"> <li>Adapt ESD advocacy materials for HTSP, incorporate within newborn and child health programs, and use in 2 countries.</li> </ul>
Introduce HTSP within routine newborn and child health services in 6 countries.	<ul style="list-style-type: none"> <li>Finalize HTSP materials.</li> <li>Introduce and incorporate HTSP materials within IMCI in Rwanda.</li> <li>Introduce materials within IMCI training module and postpartum programs in Timor-Leste.</li> </ul>
Through the ANE regional network, incorporate HTSP within the postpartum care package in 4 countries.	<ul style="list-style-type: none"> <li>Assist 2 Asian countries (Cambodia and Timor-Leste) in adopting HTSP within the post-partum package.</li> </ul>
Implement a monitoring and evaluation framework and document results in 6 countries.	<ul style="list-style-type: none"> <li>Finalize indicators and undertake a baseline assessment in Rwanda, Timor-Leste, and Cambodia.</li> </ul>

### Status: On target

- Conducted advocacy for HTSP in 3 countries (Rwanda, Timor-Leste and Cambodia).
- Introduced HTSP within child health or newborn service in 2 countries (Swaziland, Rwanda).

## Results and Achievements

### *Advocacy*

- ESD project advocacy materials adapted and used in Rwanda, Timor-Leste, Cambodia, and Swaziland to advocate for the incorporation of HTSP into newborn and child health programs.

### *Introduction of HTSP within routine newborn and child health services*

- Finalized the *Training Manual for the Integration of Healthy Timing and Spacing of Pregnancy into Newborn and Child Health Activities*.
- Incorporated HTSP into the IMCI training module that is currently being rolled out in 14 districts in Rwanda. Twenty-five district-level supervisors and 85 health workers have thus far been trained using the module. Integrated IMNCI-HIV is being rolled out in 46% of Rwanda's health districts (14/30) covering 470,000 under five children (31% of national population).
- In collaboration with ACCESS and Twubakane, conducted a workshop for 150 participants on religious leaders' contributions to maternal and newborn mortality reduction (40% of health centers in Rwanda are religiously affiliated), through promotion of birth spacing.
- In Timor-Leste, HTSP had been integrated into Essential Newborn Care (ENC) and postnatal care. Sixteen health care providers have been trained. Activities were implemented at a slower pace due to several organizational changes in the MOH and amongst implementing partners.

### *Incorporation of HTSP within postpartum care packages*

- Collaborated with the MOH, UNICEF, WHO, and other stakeholders to develop Cambodia's first post-partum visit package, including HTSP. Further HTSP activities in Cambodia are pending USAID Mission approval.

### *Implementation of a monitoring and evaluation framework*

- HTSP indicators for both global and country reporting were finalized. Rwanda DHS 2005 was used as a proxy for baseline documentation of an HTSP profile in the country. Baselines will be carried out for HTSP integration in countries without recent DHS reports.

## Year 4—Planned activities

- Incorporate HTSP within newborn and child health in 3 new countries (Madagascar, DR Congo and Malawi), and expand in Timor-Leste and Rwanda.

# MALARIA

USAID/BASICS maximizes the coverage of CBT of malaria, integrating home-based management of fever within CCM of other common childhood illnesses (i.e., diarrhea and pneumonia) as appropriate. USAID/BASICS' community-based treatment strategy also targets private sector practitioners (especially local drug sellers) to improve the quality of drugs and case management provided to children with malaria. In addition, the project supports improved and expanded coverage of rapid treatment for fever through its work to strengthen IMCI provision in select countries where Missions have requested it.

USAID/BASICS is also active in promoting and expanding the prevention of malaria through the distribution of insecticide treated bed nets (ITNs) and behavior change communication strategies to expand the use of ITNs by children under 5 years old and pregnant women. If Intermittent Preventive Treatment in infants (IPTi) is officially adopted by WHO, USAID/BASICS plans to support its introduction. Additionally, the project is collaborating closely with Roll Back Malaria (RBM) and the President's Malaria Initiative (PMI) to examine the role of rapid diagnostic tests (RDTs) in the cost-effective treatment of patients with ACTs, and provides technical support to Ministries and implementing partners to efficiently make the change to ACTs for malaria treatment.

Technical assistance for malaria programs is ongoing in 6 countries: DR Congo, Madagascar, Rwanda, Senegal, Tanzania, and Timor-Leste.

## Objectives

End-of-project Objectives	FY07 Interim Objectives
<b>PRESIDENT'S MALARIA INITIATIVE— ARTEMISININ-BASED COMBINATION THERAPIES</b>	
<p>Through USAID/BASICS' direct engagement or influence, 6 countries will implement CBT of malaria, integrated with pneumonia, and/or diarrhea when appropriate, and delivered by community health workers, with at least 3 of the countries at scale.</p>	<ul style="list-style-type: none"> <li>• Conduct advocacy in 1-2 new countries.</li> <li>• Advocate, plan for and, if possible introduce CBT in 1 additional PMI country.</li> <li>• Start implementation in Madagascar.</li> <li>• Continue to support implementation of CBT/CCM in DR Congo.</li> <li>• Expand CBT of malaria through PMI in Rwanda.</li> <li>• After receiving approval from USAID/Senegal, continue scale-up, including ACTS, by expanding into non-USAID districts.</li> </ul>
<p>Through USAID/BASICS' direct engagement or influence, 6 countries will begin using private medicine sellers to improve delivery and quality of treatment for malaria and, where feasible, pneumonia in children under 5, with at least 3 countries at scale.</p>	<ul style="list-style-type: none"> <li>• Advocate for the addition of a private sector component to the Cambodia work plan.</li> <li>• Implement pharmacy/ADDO child interventions in Tanzania.</li> <li>• Use the Private Medicine Sellers Resource Package to advocate for and guide selection of context-appropriate private sector malaria interventions in 2 countries in which CBT/CCM are already being implemented.</li> <li>• Provide technical assistance in Nigeria, to expand and strengthen quality assurance and sustainability of private medicine sellers intervention. Document key program elements, including costs to form the basis for scale-up through the World Bank Booster Program.</li> </ul>
<p>Facilitate adoption by RBM, WHO, and other international partners of strategies to maximize the role of private medicine sellers in home management of malaria.</p>	<ul style="list-style-type: none"> <li>• Develop a private medicine sellers resource package to guide decision-makers.</li> <li>• Using the package, advocate for integration of private sector interventions into broader framework on community-based management of malaria in 2 countries.</li> </ul>
<b>PRESIDENT'S MALARIA INITIATIVE— PREVENTION OF MALARIA IN CHILDREN</b>	
<p>If officially adopted by WHO, support policy development and planning towards implementation of Intermittent Preventive Treatment in infants (IPTi) in 4 countries.</p>	<ul style="list-style-type: none"> <li>• With USAID/PMI, WHO, CDC, identify and conduct operational research that will guide implementation of IPTi in 1-2 countries.</li> </ul>

End-of-project Objectives	FY07 Interim Objectives
OTHER	
<p>In conjunction with CDC, USAID/PMI, assist in the assessment of RDTs for children under 5 in various endemic settings in 3 countries.</p>	<ul style="list-style-type: none"> <li>• Establish a quality assurance system for malaria diagnosis in Timor-Leste.</li> <li>• Complete an assessment of RDTs and provide sound evidence on RDTs to inform policy decisions on their use.</li> <li>• Design the role of diagnostic testing for malaria formative research, focusing on operational issues regarding provider use and feasibility of broader application of diagnostic testing, including CBT context.</li> </ul>
<p>Facilitate adoption and promotion of strategies for integrated community-based treatment of pneumonia, malaria and diarrhea using CHWs by RBM, WHO, and other international partners.</p>	<ul style="list-style-type: none"> <li>• Facilitate consensus on appropriate approaches to community-based malaria management, including both public and private sector interventions.</li> <li>• Obtain supplementary funding to convene a meeting of experts towards building a broad policy consensus.</li> </ul>
<p>Facilitate the adoption by CORE partners of CBT of malaria in all countries with CS or malaria programs globally (where an MOH policy allows it).</p>	<ul style="list-style-type: none"> <li>• Complete a first draft of the CCM Manual, which includes CBT of malaria.</li> <li>• Assist in the use of the draft by NGOs in 3 or more countries.</li> </ul>

Status: On target for CCM; behind target in private sector interventions

- 5 countries (Rwanda, Madagascar, DR Congo, Senegal, Timor-Leste) strengthening case management of malaria.
- 5 countries (Rwanda, Madagascar, DR Congo, Senegal, Tanzania – private sector) introducing home-based management of fever (i.e., CCM of Malaria).
- 1 country (Tanzania) introducing private sector/drug vendor CBT of malaria.

## Results and Achievements

- In June 2007, USAID/BASICS appointed Dr. Ciro Franco as Malaria Technical Officer. He succeeds Dr. Larry Barat, who joined the President's Malaria Initiative team at USAID.

### *Artemisinin-Based Combination Therapies*

- Evaluated the Integrated National Malaria Program's home-based management of malaria intervention in Rwanda and made recommendations for scale-up, including advocating for guidelines for the introduction of coartem for CBT. The evaluation final report is available on the malaria page of [www.basics.org](http://www.basics.org).
- Signed a 4-year task order in September 2007 for Malawi to support reductions in child morbidity and mortality by improving MOH child health service delivery in 8 targeted districts, including increasing the correct use of bed nets by families and pregnant women; improving awareness and acceptance of the country's change to coartem as the first-line drug for malaria; and raising the number of children who received malaria treatment within 24 hours of the onset of fever.
- Madagascar: Implemented CCM pneumonia, diarrhea, and malaria in 117 out of 168 planned sites (5/12 districts; 4/9 regions) through the training of 250 of 314 planned community health workers. Initial data for the period between March and September 2007 comprise average monthly reporting from 20 sites, where a total monthly average of 110 childhood malaria cases were treated.
- DR Congo: Operationalized 170 new CCM sites in 23 health zones through the training of 324 community health workers. (Since FY05, a total of 224 CCM sites have been operationalized in 30 health zones, and 421 CHWs have been trained). Initial data for the period between Oct 06 and Jul 07 comprise average monthly reporting from 43 sites, where a total monthly average of 306 childhood malaria cases were treated.
- USAID/BASICS did not receive PMI funds in Rwanda for FY07; however CBT of malaria, pneumonia, and diarrheal diseases is being expanding to 14 districts.
- Senegal: Initiated CCM, including malaria, in the Fatick region (a non-USAID region). Among other results, a baseline survey showed only 19% of children with fever were brought for care within 24 hours of onset and 31% do not seek care at all. Conducted training of trainers in CCM of ARI, malaria, and diarrhea in the Fatick region in August 2007 for 20 trainers (primarily supervisors and doctors) and for 21 trainers in newborn health in September 2007.
- Advocated unsuccessfully for the addition of a private sector component to the Cambodia work plan.
- Tanzania: Conducted formative research on the ADDO program to inform USAID/BASICS-led development of training modules, behavior change communication tools, and a community mobilization strategy in support of the program, including malaria prevention and treatment. Conducted journalist workshops (April and May 2007) for the development of 8 radio spots, available for nation-wide transmission, on malaria prevention.
- Though a private medicine sellers resource package was not developed this year, USAID/BASICS advocated for private sector malaria interventions in 2 countries. In Madagascar, planning began with PSI to improve *depot de pharmacy* agents' ability to identify and refer children with general danger signs in to health facilities. In Tanzania, finalized the Centre for Enhancement of Effective Malaria Interventions' (CEEMI) 2006 formative study, whose overall goal was to inform integration of a child health component into the Accredited Drug Dispenser Outlet (ADDO) program.

### *Prevention of Malaria in Children*

- Adoption of IPTi is still pending approval by WHO and USAID. In anticipation of its approval, USAID/BASICS authored a road map, called “Going from Research to Implementation,” to outline the necessary country-level steps.

### *Other*

- Developed an initial concept paper for improving compliance with RDT outcomes. It is applicable to Timor-Leste, as well as Madagascar and Tanzania.
- Met with other stakeholders to discuss operational issues of RDTs and refine the diagnostics.
- To facilitate adoption and promotion of strategies for integrated CBT of pneumonia, malaria, and diarrhea, USAID/BASICS presented its experiences at several knowledge sharing events, including organizing a regional workshop on CCM in DR Congo designed to showcase the country’s experience with CCM and allow countries to exchange experiences on CCM. The workshop is scheduled for October 2007.
- In collaboration with partners, completed a first draft of the CCM manual, including CBT of malaria. Field testing of the manual has been rescheduled for FY08.
- Provided technical exchange with PISAF (bilateral in Benin) on CCM of malaria, specifically on the follow-up of sick children.

### **Year 4—Planned activities**

- Continue implementation of CBT/CCM of malaria in DR Congo and Senegal (non-USAID districts); initiate in Madagascar, and expand (through PMI) in Rwanda. Introduction in one new country (Malawi and/or Tanzania) and conduct advocacy in 1-2 new countries (Timor-Leste, Cambodia, Afghanistan, Mozambique or Uganda).

# NUTRITION FOR CHILDREN AND INFANTS

USAID/BASICS developed the Essential Nutrition Actions (ENA), a set of proven interventions that improve the growth and micronutrient status of infants and children, and reduce child deaths due to malnutrition. The "ENA Approach" championed by USAID/BASICS has three main programmatic thrusts: (1) incorporating ENA into maternal and child health services, and expanding community outreach, especially in underserved areas; (2) building capacity at the community level for delivering ENA interventions through community workers, organizations, and volunteers; and (3) using multiple communications channels to inform, sensitize, and motivate key audiences.

USAID/BASICS promotes ENA at the community level through a variety of approaches, such as community-based growth promotion (CBGP), positive deviance inquiry coupled with hearth-based nutritional rehabilitation, mother support groups, and nutritionally-appropriate case management of childhood illness.

The project is currently providing technical assistance for nutritional interventions in 3 Asian countries (Cambodia, India, and Timor-Leste) and 5 African countries (Madagascar, Malawi, Nigeria, Rwanda, and Senegal).

## Objectives

End-of-project Objectives	FY07 Interim Objectives
<b>NUTRITION PATHWAY — PREVENT ANEMIA IN CHILDREN DURING WELL/SICK VISITS, CHILD HEALTH WEEKS, AND HOME-BASED FOOD APPROACHES</b>	
<p>Integrate and implement micronutrient and other anemia reduction interventions with malaria activities in 2 countries.</p>	<p><i>ASSUMPTION: WHO issues guidelines for IPTi with EPI</i></p> <ul style="list-style-type: none"> <li>• Initiate operational large-scale pilot (possibly in Timor-Leste) for iron supplementation in conjunction with infant IPTi/EPI (RCT incorporated into pilot)</li> <li>• Prepare for operational large-scale pilot in 1 African country for iron supplementation in conjunction with IPTi/EPI</li> </ul>
<b>NUTRITION PATHWAY — INTRODUCTION AND SCALE-UP OF EBF, IYCF, ENA, CBGP</b>	
<p>In 6-8 countries, strengthen the performance of ENA through implementation of case management of childhood illness-linked nutrition protocols at facilities, outreach and promotion for micronutrients in the community, and extension of breastfeeding support groups.</p>	<ul style="list-style-type: none"> <li>• Expand ENA implementation through case management of childhood illnesses.</li> <li>• Monitor and improve performance actions using QA and other approaches.</li> <li>• Introduce breastfeeding support groups in Timor-Leste</li> <li>• Facilitate local adaptation of IMCI feeding assessment and counseling protocols in Rwanda.</li> <li>• Introduce GMP and PD/Hearth in Nigeria.</li> <li>• Develop micronutrient guidelines for Rwanda.</li> <li>• Build capacity for ENA in collaboration with UNICEF, WHO and NGOs.</li> <li>• Implement district situation analysis in Cambodia, and integrate ENA into health monitoring.</li> <li>• Develop (or improve) national IYCF Strategies in Timor-Leste, Rwanda, and Cambodia.</li> </ul>
<p>Scale up growth promotion and community-based growth promotion (CBGP) in 4 countries, with minimum weight gain (proxy for growth) used as a composite indicator to guide government and NGO child health programs.</p>	<ul style="list-style-type: none"> <li>• In Senegal and Madagascar, expand CBGP with USAID/BASICS technical support, WB-financial support and implementation through Ministry of Health/NGO partners.</li> <li>• Introduce CBGP in Rwanda and Cambodia in collaboration with their respective MOHs.</li> </ul>

End-of-project Objectives	FY07 Interim Objectives
NUTRITION PATHWAY — INTRODUCTION AND SCALE-UP OF EBF, IYCF, ENA, CBGP (cont.)	
Develop strategies for complementary implementation of various approaches for child nutrition.	<ul style="list-style-type: none"> <li>• Develop collaboration with CORE group for implementation.</li> <li>• Develop complementary implementation algorithm.</li> <li>• Select implementation country.</li> <li>• Develop strategic plan based on the algorithm.</li> <li>• Organize implementation partners (PVOs) and develop a consensus.</li> </ul>
OTHER	
Incorporate prenatal nutrition, IYCF and micronutrients into PMTCT programs in 2-3 countries.	<ul style="list-style-type: none"> <li>• Integrate infant feeding guidelines into PMTCT programs focusing on AFASS assessment for replacement feeding and early cessation of breastfeeding.</li> </ul>
Produce global guidelines for programming nutrition in fragile states.	<ul style="list-style-type: none"> <li>• Initiate intensive documentation of nutrition programming in recovering states.</li> </ul>
Introduce CBGP, mothers support and health system strengthening (USAID/BASICS urban nutrition package) in 2 major urban centers.	<ul style="list-style-type: none"> <li>• Produce working paper for urban nutrition package defining targeting criteria.</li> <li>• Introduce ENA/CBGP/CDD/ARI in slum areas in Dili, Timor-Leste.</li> </ul>

Status: Surpassed Target

- 2 completed countries (Senegal, India) with activities at scale and documented results.
- 5 current countries (Cambodia, Madagascar, Nigeria, Rwanda, and Timor-Leste) with ENA, IYCF or CBGP.

## Results and Achievements

### *Prevention of Anemia in Children during Well/Sick Visits, Child Health Weeks, and Home-Based Food Approaches*

- IPTi guidelines were issued late in FY07, and will enable activities in FY08.

### *Introduction and Scale-Up of EBF, IYCF, ENA, CBGP*

- Expanded ENA through IMCI in Timor-Leste, Cambodia, and Rwanda. In Nigeria, 48 community volunteers trained in general ENA principles.
- In Timor-Leste, the 4-phase continuous coverage and quality improvement (CCQI) model reached its third stage (information analysis and decision-making) in the Manatuto regio. Through the ICDS program in India, used annual RAPS surveys to assess weakness and plan for improvements.
- Breastfeeding support groups were not initiated in Timor-Leste due to the security situation and competing priorities. Now planned for FY08.
- In Rwanda, created a local adaptation of the IMCI chart book for recommendations based on commonly available local foods.
- In collaboration with Food Basket International, implemented GMP and hearth interventions in 6 communities of Nigeria. GMP implementation in Nassarawa State resulted in consistent reduction in underweight and equally consistent increases in the percentage of infants/children showing positive growth trends; obstacles in Akwa-Ibom state, (e.g. higher impoverishment and more civil disturbance) resulted in minimal impact on nutritional status and growth. Similar implementation differences were seen between states for the PD/Hearth interventions— in Nassarawa, with over 100 caregiver-child pairs enrolled each month and average weight gains of around 400g achieved in both; Hearth sessions have not been held in Akwa-Ibom as the community members have been unwilling to contribute the necessary “positive deviance foods.”
- Due to a shift in priorities at the USAID Mission in Rwanda and based on an assessment by USAID/BASICS’ Nutrition Technical Officer, micronutrient guidelines will not be developed for the country, and, due to competing priorities, capacity building for ENA was delayed until FY08. The activity will result in the training of 60 nutritionists from the MOH in ENA, as part of nutritionist qualification organized by the Rwanda MOH.
- As the current strategic direction of the Cambodia program focuses on other activities, it has been decided to remove plans to implement district situational analysis and integration of ENA into health monitoring from the USAID/BASICS Cambodia work plan.
- Held a successful infant and young child feeding (IYCF) workshop in Timor-Leste in January 2007, effectively elevating the importance of nutrition for infants and children on the MOH agenda. In Cambodia, in partnership with MOH, USAID, UNICEF, WHO, other UN agencies, and NGOs, created an 8-year national strategic plan for nutrition and held a consensus building workshop for operational priorities in the coming years. Due to priority placed on nutrition linked with HIV and PMTCT by the mission, national IYCF strategies were not developed in Rwanda.
- Funding constraints did not allow for the expansion of CBGP in Senegal. However, CBGP expansion is in its initial stages in Madagascar; a local coordinator is being hired to provide technical assistance to the national community nutrition project in FY08.
- CBGP will not be introduced in Cambodia as the current strategic direction of the program focuses on other activities. In FY08, CBGP will be done in collaboration with RPM Plus’ national networks of people living with HIV and AIDS.

#### **Year 4—Planned activities**

Introduce breastfeeding support groups in Timor-Leste; incorporate ENA into facility-based case management of childhood illnesses in Malawi, and community-based management of childhood illnesses in Malawi and Madagascar; introduce CBGP in Timor-Leste and Rwanda; and integrate infant feeding guidelines into PMTCT programs in Rwanda, Cambodia, and Malawi.

## **NEWBORN SURVIVAL AND HEALTH**

USAID/BASICS promotes the application of the essential newborn care (ENC) package for newborn health, emphasizing the need to integrate newborn health into a full range of existing programs, such as maternal and reproductive health, HIV/AIDS and PMTCT, integrated management of childhood illnesses, and nutrition. In addition to integration, the project works to support the continuity of care by linking care settings. These include maternal, newborn, and child health; household, community, and facility care; and preventive and curative care.

USAID/BASICS is currently providing technical assistance for newborn health interventions in 11 countries: Cambodia, DR Congo, Latin America and the Caribbean (a regional initiative including Dominican Republic, El Salvador, and Honduras), Madagascar, Rwanda, Senegal, Swaziland, and Timor-Leste, and has developed a new activity for Mali.

## Objectives

End-of-project Objectives	FY07 Interim Objectives
<b>NEWBORN HEALTH PATHWAY – TECHNICAL LEADERSHIP</b>	
<p>Develop, disseminate, and apply advocacy and technical guidelines for home/community-based care, home-to-hospital continuum of care, feeding of the low birth weight infant and an e-learning module on neonatal sepsis with partners such as ACCESS, WHO, and UNICEF.</p>	<ul style="list-style-type: none"> <li>• Develop an e-learning module on neonatal sepsis.</li> <li>• Support the development of a UN/USAID/PMNCH joint statement on community-based interventions for the newborn.</li> <li>• Continue support in completing and disseminating the advocacy/policy document, “Opportunities for the Newborn in Africa.”</li> </ul>
<b>NEWBORN HEALTH PATHWAY – INTRODUCTION AND EXPANSION OF NEWBORN CARE</b>	
<p>Through regional activities (Africa, Asia, and Latin America and the Caribbean), promote essential care at country level influencing directly, or through partners.</p>	<ul style="list-style-type: none"> <li>• Continue to provide support to countries through the regional umbrella.</li> <li>• Provide specific assistance provided to at least 2 countries in each region to promote newborn health within the framework of MCH care.</li> <li>• Develop regional action plans in the LAC region with the Inter Agency Working Group.</li> <li>• Provide support at country level on the prevention and treatment of neonatal infections.</li> </ul>
<p>Introduce and implement ENC, including identification and care seeking for danger signs, in 5 countries and expanded/scaled up in 2 countries.</p> <p>Document improved household behaviors and facility performance in countries where USAID/BASICS has direct engagement in newborn health.</p>	<ul style="list-style-type: none"> <li>• Continue to support ENC in Senegal, India, and Timor-Leste.</li> <li>• Explore USAID/BASICS’ involvement in another country in Africa.</li> </ul>
<p>Integrate ENC, with an emphasis on postnatal care, with at least 2 PMTCT country programs, through collaboration with partners.</p>	<ul style="list-style-type: none"> <li>• Complete implementation and evaluation of Swaziland program and share results with stakeholders.</li> <li>• Incorporate newborn health and selected aspects related to HIV/AIDS-PMTCT within the IMCI strategy in Rwanda.</li> </ul>
<p>Integrate ENC with IMCI in 1-2 countries and introduce at peripheral health facilities and community level.</p>	<ul style="list-style-type: none"> <li>• Expand IMNCl implementation in Rwanda.</li> </ul>

### Status: Surpassed Target

- 10 countries (Cambodia, Rwanda, DR Congo, Madagascar, Senegal, Swaziland, Timor-Leste and LAC Regional – Dominican Republic, El Salvador, and Honduras) introducing and implementing ENC
- 1 country (Rwanda) integrated ENC with IMCI.
- 1 country (Swaziland) integrated ENC with PMTCT.

## Results and Achievements

### *Technical Leadership*

- Initial draft of an e-learning module on neonatal sepsis completed, with finalization expected during the first quarter of FY08. Delays occurred due to the priority given to programmatic activities in new countries (Madagascar and DR Congo). Moreover, the upcoming neonatal sepsis research group meeting in London (October 2007) will inform additional inputs.
- To support the development of a UN/USAID/PMNCH joint statement on community-based interventions for the newborn, USAID/BASICS provided inputs at various USAID meetings.
- The advocacy/policy document, *Opportunities for the Newborn in Africa*, was completed. It is an important component of country-level advocacy and has been used in both DR Congo and Madagascar to advocate for activities in newborn health.

### *Introduction and Expansion of Newborn Care*

- Provided support to the Latin America and Caribbean region as a key member of the LAC Newborn Health Alliance and through USAID/BASICS LAC Regional Initiative on preventing and treating neonatal sepsis. Regional support for the newborn was provided in Asia through exchange of SOTA information through contributions to the MotherNewborNet and at the ANE regional meeting (450 participants from 18 countries) in September 2007, where USAID/BASICS organized practical demonstrations on newborn resuscitation and a panel on integrating PMTCT with treatment for HIV/AIDS, improved quality of maternal and newborn health, and family planning.
- During FY07, USAID/BASICS provided specific assistance to 3 countries in Asia (Cambodia, India, and Timor-Leste), 5 in Africa (DR Congo, Madagascar, Rwanda, Senegal, and Swaziland), and 3 in Latin America and the Caribbean (Dominican Republic, El Salvador, and Honduras).
- As a key member of the Inter-agency LAC Alliance for Newborn Health contributed to finalization of the regional strategy for newborn health (launched Jun 07) and development of a regional action plan (Aug 07 workshop in Paraguay).
- LAC Regional Initiative: Through distance learning and in-country support, facilitated a quality improvement process of identifying gaps and implementing solutions in the prevention and treatment of neonatal sepsis at the facility level (in El Salvador and the Dominican Republic; covering 60,000 combined deliveries) and at the community level (in Honduras; covering 300 communities in 17 municipalities). After 6 months of program implementation results showed a reduction in cases of suspected newborn sepsis in three hospitals in El Salvador (2 by 30% and one by 56%) and in two regional hospitals in Dominican Republic (by 20%).
- ENC was supported in Senegal, India, and Timor-Leste; Bolivia's program ended after the first quarter of PY3 due to end of funding and changes in MOH policies and priorities in child health. In Senegal, initiated introduction of ENC in the Fatick region (122,983 U5s; 7% of national population) and conducted a training of trainers for ENC at the facility level in September 2007 for 21 midwives, RH supervisors, and doctors. Program activities in India in support of CARE/RACHNA completed and draft report of key results and lessons learned relevant to newborn health developed. For most newborn care practices, significant changes were registered between baseline and end-line, or between intervention and control areas, including receipt of iron tablets during pregnancy and practice of the "five cleans." In Timor-Leste, in partnership with HAI and WHO, trained 115 midwives in ENC.
- Trips were taken to Mali, DR Congo, and Madagascar to explore USAID/BASICS' support of newborn health.

- Swaziland: completed operations research integrating MNH services into PMTCT—in partnership with EGPAF and Population Council/Horizons—to promote early quality postpartum visits in the first week with emphasis on the first three days. Trained 132 supervisors, health care providers, and trainers, covering 7 facilities in the country’s most highly populated region, Manzini (approx. 7,500 in-facility deliveries annually), as well as one facility in Hhohho (approx. 3,760 in-facility deliveries annually). Results showed improvement in health provider skills, such as those related to the pre-discharge package (baseline = 52%, end-line = 87%) and during the early post-natal visits (increase from 75% to 96%). The utilization of early postnatal services increased 20-fold for visits within the first 3 days, 6-fold for visits between days 4-7, and 4-fold for visits 2-6 weeks after delivery. These favorable results led the MOH to express interest in rolling out the intervention nationally.
- Rwanda: trained 16 district-level supervisors, 36 national trainers, and 275 health workers in facility-level IMNCI-HIV (pneumonia, diarrhea, malaria, HIV, sick newborn care, and HTSP). IMNCI-HIV is being rolled out in 46% of Rwanda’s health districts (14/30) covering 470,000 under five children (31% of national population).

*Other*

- Cambodia: National Newborn Health Working Group established in collaboration with the MOH, UNICEF, WHO, ACCESS, and other stakeholders. Focus initially will be on the much neglected postpartum care taking into account that the large majority of deliveries occur at home in a village (85% of Cambodians are rural). Package definition, expected by end 2007.

**Year 4—Planned activities**

- Extend newborn health program activities to 10 countries, providing support for strengthening policies in 2 (Cambodia and Rwanda), TA for implementation in 9 directly or with support through a regional umbrella (DR Congo, Madagascar, Senegal, El Salvador, Honduras, Dominican Republic, India and Timor-Leste).

## **PEDIATRIC HIV/AIDS**

USAID/BASICS collaborates with and shares information with child health and PEPFAR partners, USAID, host country governments and implementing partners about the needs of HIV exposed and infected children and programmatic approaches to scaling up their early identification and access to cotrimoxazole prophylaxis, antiretroviral therapy, and other critical care and support services.

At the country level, the project is currently providing technical assistance for pediatric HIV/AIDS interventions in Malawi and Rwanda. In Malawi, USAID/BASICS PMTCT and HIV/AIDS Advisors provided support to the MOH to strengthen and scale up PMTCT and HIV guidelines, policies, and services.

In Rwanda, a USAID/BASICS MCH advisor and pediatric HIV and AIDS technical consultant provided support to TRAC, the MCH task force of the MOH, and the Pediatric Technical Working Group of the USG PEPFAR program. The project has provided technical support and capacity building to strengthen policies and district action planning on pediatric HIV, increase early identification and access to care and treatment through training in IMCI-HIV, and the development of pediatric HIV job aids and tools. USAID/BASICS' strategy is built on a foundation that integrates child health, HIV, and MCH services.

## Objectives

End-of-project Objectives	FY07 Interim Objectives
<b>PEDIATRIC HIV/AIDS PATHWAY - REDUCE INFANT AND CHILDHOOD MORTALITY CAUSED BY HIV/AIDS THROUGH INTRODUCTION, EXPANSION, AND STRENGTHENING CHILD SURVIVAL SERVICES.</b>	
Strengthen community level detection, care, and referral of pediatric HIV cases in at least 4 countries.	<ul style="list-style-type: none"> <li>• Conduct formative research on community perception, knowledge, attitudes, and practices towards pediatric HIV/AIDS in 1 country.</li> <li>• Increase detection, care, and referral of infants and children with pediatric HIV by reaching out to communities in 2 countries with education and mobilization activities.</li> <li>• Implement pediatric HIV activities at the community level in designated districts in Rwanda and 1 other country.</li> </ul>
Expand capacity building, supportive supervision, and implementation of systems and referral strategies to increase early diagnosis of HIV in infants, cotrimoxazole prophylaxis for all infected children, and referral for ART from lowest levels of care in at least 4 countries.	<ul style="list-style-type: none"> <li>• Establish supervision, mentorship, and clinical consultation systems for pediatric HIV case management in 3 countries.</li> <li>• Improve referral linkages between child health services and pediatric HIV care and treatment services in 3 countries.</li> <li>• Implement improved advocacy, training, supply, and systems for provision of CTX prophylaxis in 3 countries.</li> </ul>
Continue implementation in countries and districts to expand and strengthen child survival services to increase detection, care, and referral of suspected and known pediatric HIV cases.	<ul style="list-style-type: none"> <li>• Implement facility-based IMCI-HIV in six districts in Rwanda and one other country.</li> <li>• Provide technical support to assess and improve referral systems and communications within and between facilities and communities around pediatric HIV care and treatment services in 3 countries.</li> <li>• Introduce and facilitate use of tools and job aids for identification, referral, and care and treatment of infants and children with pediatric HIV at multiple entry points to care in 3 countries.</li> <li>• Provide assistance to national level efforts to improve capacity of providers of pediatric HIV services.</li> <li>• Enhance pre-service and in-service education in pediatric HIV care and treatment in two countries.</li> </ul>

End-of-project Objectives	FY07 Interim Objectives
<p>PEDIATRIC HIV/AIDS PATHWAY - REDUCE INFANT AND CHILDHOOD MORTALITY CAUSED BY HIV/AIDS THROUGH INTRODUCTION, EXPANSION, AND STRENGTHENING CHILD SURVIVAL SERVICES.</p>	
<p>Facilitate establishment or strengthening of policies, plans and guidelines to expand child survival services to include detection, care (including cotrimoxazole prophylaxis), and referral of suspected and diagnosed pediatric HIV cases in four countries.</p>	<ul style="list-style-type: none"> <li>• Make national level assessment and planning technical assistance visits aimed at expansion of child survival services to include detection, care, cotrimoxazole prophylaxis, and referral of pediatric HIV cases to 2 countries.</li> <li>• Continue to provide technical support for the production of global level guidelines and tools, including the WHO Pocketbook HIV/AIDS supplement, the UNICEF Programming Guide, and other IMAI materials under development by WHO.</li> <li>• Host global and regional level strategic meetings held to share technical approaches and lessons in strengthening child survival services to including early detection, care, cotrimoxazole prophylaxis, and referral of pediatric HIV cases.</li> </ul>

Status: Behind target

- 4 countries (Malawi, Swaziland, Tanzania and Rwanda) with activities addressing earlier diagnosis and continuity of infant care following PMTCT program exit, including prophylaxis or policy and guidelines development.

## Results and Achievements

### *Reduce Infant and Childhood Mortality Caused by HIV and AIDS through the Introduction, Expansion, and Strengthening of Child Survival Services*

- Organized and participated in numerous high-visibility events and meetings to raise awareness, and improve global and country level responses to the needs of children affected by HIV and AIDS; highlighted by sponsorship of “A Chance for Children,” at the Global Health Council’s annual meeting, as well as the National Church’s Concerted Response on HIV and AIDS (India), PATH MNCH meeting (USA), Expanded Interagency Task Team on PMTCT and Pediatric HIV Care and Treatment/Pediatric HIV Working Group Meeting (USA), and the steering group for the development of an operational guide on HIV testing and counseling of children for countries of the Africa Region (Congo/Brazzaville).
- Provided technical assistance to develop global level guidelines including the WHO Pocketbook on HIV and AIDS and the UNICEF Programming Guide. Led a team as a part of WHO/UNICEF effort to develop a background paper and assessment and advocacy approach to scale up cotrimoxazole prophylaxis.
- Provided assistance to national level efforts to improve capacity of providers for delivery of pediatric HIV care and support services through training of trainers on IMNCI-HIV, pediatric HIV and PMTCT services in Rwanda and Malawi.
- Strengthened pediatric the HIV component of care in the pre-service Nursing curriculum in Rwanda and Malawi (with integration into PMTCT training curriculum)
- Developed tools for identification, referral and care and treatment of infants and children with pediatric HIV at multiple entry points to care in Rwanda. These can be adapted for use in other countries.
- In Rwanda, conducted a rapid assessment of missed opportunities for diagnosing and treating pediatric HIV/AIDS. In Tanzania, undertook an assessment of the current status of pediatric HIV care and treatment services at the facility and community levels in three regions, including missed opportunities for identification and care and treatment of HIV-exposed and/or infected infants and children. The final report is available on the Tanzania page of [www.basics.org](http://www.basics.org).
- In Rwanda, trained 16 district-level supervisors, 36 national trainers, and 275 health workers in facility-level IMNCI-HIV (pneumonia, diarrhea, malaria, HIV, sick newborn care, HTSP). IMNCI-HIV is being rolled out in 46% of Rwanda’s health districts (14/30) covering 470,000 under five children (31% of national population).
- Led (and continues to lead) collaborative efforts with UNICEF to develop a concept paper for the scale-up of cotrimoxazole prophylaxis for HIV-exposed and -infected children at the country level. It is anticipated that this will be followed by building capacity of national governments to effectively roll out the use of cotrimoxazole prophylaxis for eligible children.
- Developed a comprehensive referral tool for use in Rwanda, and to be adapted for use in two other countries in FY08.
- Supervision and mentorship is on-going in Rwanda and Malawi. A consultative system for pediatric HIV case management is still pending for Rwanda and will probably commence with the employment of a pediatric HIV Technical Officer for Rwanda.
- Assessed community-facility linkages and approaches to early identification of children under 5 with HIV exposure or infection in Kenya, as well as conducted interviews with village health committees and community dialogue groups in several communities to assess knowledge, attitudes, and perceptions of HIV in children. Tools were developed for both the facility and community assessments.
- Pediatric HIV has been incorporated into the community-IMCI trainings in Rwanda and Malawi and pediatric HIV messages have been developed. The impact has yet to be measured, but determining the increase in detection, care, and referral for pediatric HIV patients is a priority activity for the upcoming year.

- Partnering with TRAC in Rwanda, trained 150 local trainers in case management and addressing missed opportunities to identify and treat or refer children in need of HIV care.

*Other*

- Malawi: USAID/BASICS' PMTCT Advisor, appointed in March 2007, played a lead role in finalizing a PMTCT training package and revising related guidelines to address the country's approximately 83,000 new mother-to-child HIV infections each year, and delivered training to 270 service providers from 21 Christian Health Association of Malawi sites. A 4-year task order was signed in September 2007 to support reductions in child morbidity and mortality by improving MOH child health service delivery in 8 targeted districts, including increased utilization of PMTCT and child health services linked to pediatric HIV/AIDS, as well as greater male and community involvement in PMTCT programs.
- Rwanda: In collaboration with TRAC, MCH, and EGPAF, conducted a workshop for 117 stakeholders aimed at developing a framework and action plans to address missed opportunities for access to pediatric HIV care and treatment at all entry points in the health system. As a follow up to the recommendation of the stakeholders' workshop, 153 healthcare workers from 66 health facilities in 5 districts developed action plans for pediatric HIV care and support for health facilities in the districts. Implementing partners are currently being mobilized for the roll out of the action planning in the remaining districts in the country and to support identified activities. Pediatric HIV job aids and tools were developed to facilitate the ability of healthcare providers to identify, care, and refer children who are exposed or infected with HIV to appropriate care.

**Year 4—Planned activities**

- Co-host a regional meeting in sub-Saharan Africa and other meetings as possible to increase local capacity in the early identification and referral of HIV exposed and infected children under 5 for pediatric HIV care and treatment services; conduct national-level assessment and planning technical assistance visits aimed at expanding pediatric HIV/AIDS services in 2-4 countries (Malawi, Kenya, Nigeria and DR Congo). Lead the pediatric working group in the development of an approach to cotrimoxazole prophylaxis scale up. Contribute to the finalization of the WHO/AFRO Operational Guide on Counseling and Testing of Children. Continue to participate in the Pediatric Technical Working Group of the IATT (UNICEF/WHO)

# **PARTNERSHIP FOR MATERNAL, NEWBORN, AND CHILD HEALTH (PMNCH)**

At the recommendation of USAID, no formal work plan was developed for PY3. Instead, based on the evolution of the PMNCH strategy, working groups and work plans, BASICS has responded to specific requests from the PMNCH and USAID Global Bureau.

## **Results and Achievements**

### *Provide technical support to the transition Secretariat*

- Participated in a WHO-led working group on resource tracking, which culminated in the production of a manual on child health resource tracking.
- Two BASICS core staff members attended PMNCH's first-ever global assembly, held April 2007 in Tanzania.

### *Provide technical assistance to countries*

- Supported PMNCH representative's travel to and participation in Senegal's national Countdown Symposium and also participated directly.
- In Ghana, participated in the SwaP Health Sector Review, focusing on the child health component, and finalized the report for dissemination.
- In Cambodia, in conjunction with WHO, BASICS completed and disseminated costing study linked to the nation's Child Survival Strategy.

## **Year 4—Planned activities**

USAID/BASICS has been requested to assist the PMNCH/Tanzania to integrate child health within its maternal and newborn roadmap. The activity was originally expected to occur during quarter 4 of FY07; it is now expected to happen in November 2007.

# **COUNTRY PROGRAMS**

# DEMOCRATIC REPUBLIC OF THE CONGO

USAID/BASICS is a principle partner in the introduction of CBT of pneumonia, diarrheal diseases, and malaria in DR Congo. At this stage, focus is being placed on building provincial capacities so that each province can expand with limited input from central level, based on a CBT expansion model used by USAID/BASICS in a number of client countries. The model includes four basic steps:

1. Establish a pool of trainers and conduct training-of-trainers in each province/region.
2. Use one or more zones/health districts within the implementing province/region as a *practical training ground* for all trainers.
3. Involve the entire pool of trainers in follow-up of trainees in the *practical training ground zone/health district*.
4. Expand training to the remaining zones/health districts in the province/region.

In addition, and as a direct result of USAID/BASICS-led advocacy activities, the Ministry of Health has now begun planning for revitalization of diarrheal disease management, including the use of zinc and new low osmolarity oral rehydration salts for treatment, and through reorientation training for health workers.

## Objectives

End-of-project Objectives	FY07 Interim Objectives
<b>REVITALIZATION OF ORT</b>	
<p>Revitalize the use of ORT through incorporation CBT programs and with facility-based IMCI.</p>	<ul style="list-style-type: none"> <li>• Conduct formative research on ORT use, and develop and implement strategies and guidelines to improve ORT and zinc use.</li> <li>• Conduct training on ORT and zinc for health workers.</li> <li>• Simplify C-DMCI (community drug management for childhood illnesses) tools at community level and use results in improved management of ORS supplies.</li> <li>• Integrate feeding during illness recommendations within facility treatment programs for diarrhea.</li> </ul>
<b>INTRODUCTION AND EXPANSION OF ZINC</b>	
<p>Introduce zinc in the treatment of diarrhea disease at facility level in public and/or private health systems, and possibly in the private sector, expanding to attain 20% coverage of zinc use in program areas.</p>	<ul style="list-style-type: none"> <li>• Conduct an assessment for zinc introduction.</li> <li>• Introduce operational approaches for facility-based treatment using zinc and begin implementation.</li> </ul>
<b>COMMUNITY CASE MANAGEMENT</b>	
<p>Integrate CBT for pneumonia with malaria, diarrhea, and essential nutrition at scale, in at least 20% of health zones (districts), covering 20% of eligible communities.</p>	<ul style="list-style-type: none"> <li>• Support expansion within initial districts to cover at least 50% of eligible communities identified by districts.</li> <li>• Introduce CBT of pneumonia, malaria, and diarrhea in up to 25 of the country's 515 health zones, using the expansion model in about half of the 11 provinces.</li> </ul>
<p>Refine, use, and evaluate the community case management program guide (with emphasis on hard- to-reach areas) for pneumonia, malaria, and diarrhea with all MOH implementing partners.</p>	<ul style="list-style-type: none"> <li>• Improve guidelines, training approaches, and materials by incorporating feedback from field experience.</li> <li>• Refine and further use the expansion model, particularly in USAID- and World Bank-funded areas.</li> <li>• Finalize BCC materials and include them in the training materials.</li> </ul>
<p>Integrate a data management application for CBT of pneumonia, malaria, and diarrheal disease in all districts that are equipped with computers and that are implementing community case management.</p>	<ul style="list-style-type: none"> <li>• Develop the data management application for individual patient forms and community health worker performance follow-up and begin using in early districts.</li> </ul>
<p>Integrate quality assurance methods and indicators within the CBT program guide and materials.</p>	<ul style="list-style-type: none"> <li>• Introduce performance/quality improvement methods and test and finalize manual analytic forms for key quality indicators for use at peripheral levels to improve community health worker performance.</li> </ul>

## Results and Achievements

### *Revitalization of ORT*

- Training on ORT and zinc was begun in September 2007. Training, including both ORT and zinc, was delivered to 39 trainers and 71 nurses for facility-level introduction, and to 91 CHWs from 66 CCM (spanning 9 health zones).
- Tools for DMCI used at the health-facility level were introduced at the community level. After initial use showed that community health workers had difficulty quantifying drug needs, it was decided that community health workers would only track consumption, and forecasting would be undertaken at the facility level.
- To integrate counseling on feeding children during illness into facility programs for diarrhea treatment, feeding recommendations were included in all materials developed for ORT and zinc training. Particular emphasis was placed on this key behavior during training sessions, as well as during follow-up.
- Given the Mission's preference for AXxes (the USAID bilateral) to commence activities before partners undertake ORT and zinc activities, formative research on ORT and the development of strategies and guidelines to improve use were not undertaken during FY07. The research activity is now planned for October 2007 (Q1, FY08).

### *Introduction and expansion of zinc*

- As part of an assessment on zinc use and diarrheal disease management, a literature review was conducted in June 2007 to identify data collection needs. It was determined that a catalog of communications materials, information of health worker practices, and the etiology of diarrheal disease and disease prevalence exists. Lacking is data on the logistics (availability and stock management) of ORS, as well as sufficient information on care-seeking behaviors. Collection of these elements is planned for FY08.
- To introduce an operational approach for facility-based diarrhea treatment using zinc, USAID/BASICS and its partners developed an implementation guide that outlines product logistics for making zinc available in facilities (including costing), training for different categories of personnel (i.e., those trained in IMCI and those not yet trained), and reporting on the number of cases treated and product consumption.
- As noted above, training was conducted for the introduction of zinc at the facility and community levels in conjunction with ORT.

### *Community case management*

- With the goal of establishing CBT sites in at least 50% of eligible communities (i.e., those more than 5km from a health facility or with obstacles to reaching health facilities) in initial implementation districts, USAID/BASICS and its partners operationalized 170 new CCM sites in 23 health zones through the training of 324 community health workers in FY07. Since FY05, a total of 224 CCM sites have been operationalized in 30 health zones, and 421 community health workers have been trained. In FY07 over 6000 cases of illness in children under 5 years old were seen by community health workers.

- With over 60% (3,749 cases) of available data analyzed, there were 2472 cases of malaria diagnosed, of which 75% (1,853) were correctly treated by the CHW. There were 929 cases of simple diarrhea diagnosed, of which 87% (809) were correctly treated, and 691 cases of pneumonia diagnosed, of which 86% (592) were correctly treated. Of 215 cases with danger signs that required referral, only 24% (52) were correctly referred to a health center.
- A manual analytical form designed to monitor the completeness of reporting forms and quality of case management was first introduced in implementing districts and later added to the training of new health zones as part of the implementation package. Following difficulties observed on drug management by CHWs, it was agreed to further simplify CHWs role in drug management and assign more responsibilities to nurses supervising CHWs. As part of the expansion model, the regional team in Kinshasa province independently conducted CHW trainings with little support from the central level. Other pools did not have training opportunities due to funding. No BCC materials have yet been developed because USAID authorization to move ahead with a diarrheal disease country assessment (including formative research to support material development) was given in May. Since then, the DD activities have been fast-tracked.
- Testing of a computer application for entering information from CCM treatment forms began in two zones during the third quarter of FY07, but was affected by mechanical and power supply problems. Extension to other UNICEF districts was postponed due to funding delays, which are expected to be resolved shortly. Still, approximately 5,200 individual forms from FY06 and FY07 were entered at the central level and, where and when the application could be used, zonal data entry agents noted that the interface was user friendly.
- Development of a companion computer program for automated analysis of CCM data (e.g., agreement between signs and classification, between classifications and treatment, and between treatment dose and age) was also completed.
- A data management computer program was developed and tested in health zones around Kinshasa. Significant progress was made on the automated analysis. Feedback from the program showed some improvement in completeness of reporting and analysis. Modifications have been introduced in the data collection form, and an automated report will soon be completed.

*Other: Newborn health*

- A TDY for presenting experiences, gathering information and partnership building (AXxes, WHO, UNICEF, and others) was conducted in July 2007. It was agreed that the focus of follow-on technical assistance will be on an integrated package of AMSTL, newborn care, and post-partum/natal care of the mother and newborn.
- Facilitated the establishment of the newly formed National Working Group on Newborn Health.
- Adapted tools for capacity building and supervision of facility and community level workers, and for monitoring and evaluation. Hired an in-country coordinator.

#### **Year 4 planned activities**

- CCM of diarrhea, malaria, and pneumonia will be scaled up to at least 10% of health zones in more than half of provinces through training of trainers, quality assurance visits, revision of the implementation guide, improved drug management, and development of BCC materials.
- Data management in CCM will be improved through the development of a computer program with automated forms. Teams from the provinces, zones, and districts will be trained in the program and the necessary equipment and support will be procured. The CCM data management program will be linked with the HMIS in health facilities.
- Diarrhea disease case management will be improved at both the facility and community levels through the revitalization of ORT use and the introduction of zinc use in treatment. Formative research on care-seeking and case management for diarrhea and zinc will be carried out, and the results will inform the development of BCC materials for the promotion of zinc, ORT and feeding. Training of trainers and training of CHWs in the use of zinc and the IMCI form will be conducted.

# EAST AFRICA REGIONAL INITIATIVE

Since 2006, USAID/BASICS has worked in close collaboration with the Regional Center for Quality of Health Care (RCQHC) of Makerere University to support the development of an East Africa Initiative to revitalize diarrheal disease case management, introduce low osmolarity oral rehydration solution (ORS) and zinc, and foster consensus among countries through the establishment of a regional strategy. With input from RCQHC and USAID's East Africa Office, 4 countries were selected to participate in the initiative: Uganda, Rwanda, Democratic Republic of the Congo, and Kenya.

## Results and Achievements

- Conducted stakeholder meetings in Uganda, Rwanda, DR Congo, and Kenya to advocate for the initiative, followed by a regional workshop in Nairobi from June 27 to June 29. Thirty participants from each of the four countries—including MOH officials (diarrheal disease, IMCI, child health experts) and partner representatives from UNICEF, RPM Plus, HKI, A2Z, NGOs, and RCQHC—developed country implementation plans and agreed on next steps. These included conducting country-level assessments, developing capacity in areas of diarrheal disease case management and zinc, and identifying zinc supply sources. Through this meeting, participants also reached consensus on the need to organize a regional network focused on child survival and establish technical-specific working groups in the areas of diarrheal disease case management and the introduction of zinc. Network exchanges will be conducted through distance learning technology, such as Elluminate.

## Year 4—Planned activities

- Support country-level implementation plans in the DR Congo and Rwanda through existing country programs.
- Provide distance-based technical assistance to RCQHC to support initiation of regional networks.

# LIBERIA

USAID/BASICS is supporting the Liberian Ministry of Health and Social Welfare (MOHSW) in the development of Liberia's National Health Policy and Plan. The plan includes a basic package of health services, which emphasizes maternal and child health care, and focuses on county-level delivery of services.

In conjunction with local and international stakeholders, the project is also assisting the MOHSW to develop plans to ensure the continuity of health service delivery as Liberia transitions from humanitarian to long-term development assistance. For example, USAID/BASICS contributed to the identification of the post-conflict transition gap. In October 2006, the project found that, of 389 functioning health facilities in the entire country, 300 (77%) were supported by NGOs, and were scheduled for funding discontinuation from current sources (mostly humanitarian assistance) at various times between July 2006 and December 2008, as part of the transition to development assistance.

## Results and Achievements

- Worked closely with the MOHSW to develop the National Health Policy and Plan, which set forth the GoL's priorities and policies in terms of decentralized service delivery and implementation of the Basic Package of Health Services (BPHS). These documents were finalized in January 2007.
- Liberia's BPHS, which was authored through technical assistance from USAID/BASICS, was finalized and approved by the MOHSW in April 2007, forming the foundation for county-level transition planning.
- Assisted the World Bank and USAID in organizing a donor's forum in February 2007, which resulted in additional development funding committed to support the health sector.
- Commissioned by USAID's Office for Foreign Disaster Assistance (OFDA), USAID/BASICS designed and tested the first-ever, evidenced-based approach to support coordinated relief to develop transition efforts and donor strategic planning in post-conflict Liberia. Known as the Facility Impact Assessment Tool (FIAT), the approach examines the "relative public health significance" of health service delivery points, based on standards for access and catchment areas, epidemiology, staffing patterns, infrastructure, and operating budgets. Development of the FIAT and companion assessment activities emphasized establishing a common process to be used in other post-conflict transition situations. Results of FIAT application in 5 counties enabled USAID/BASICS to make recommendations to OFDA and the U.S. State Department's Bureau of Population, Refugees, and Migration (BPRM), on the allocation of reduced FY07 funding to maximize public health impact, minimize loss of health services, and support the implementation of the National Health Plan, which emphasizes maternal and child health, and develop a common process to be used in other post-conflict transition situations. The assessment team also gathered qualitative information through a series of five workshops in each county supported by OFDA funding, Grand Gedeh, Lofa, Nimba, Bomi, and Grand Cape Mount. Information gathered through these workshops highlighted the negative impact of decreased funding on the health of the Liberian people and provided an opportunity to introduce the GoL's vision of a decentralized health system to local health officials and community members and build the capacity of local officials to fulfill new roles and responsibilities outlined under the National Health Plan and Policy. As a result, a transition funding plan was agreed to by OFDA, and development donors including USAID and Dfid. This ensured uninterrupted operation of more than 300 clinics, the majority of whose services are maternal, antenatal, and

child health interventions. Finally, the transition assessment resulted in a generic transition process toolkit (which will assist in the application of this method in other post-conflict situations). The toolkit details the transition assessment process and presents concrete examples of each element such as the data collection tool, workshop session guide, mapping process, and the country-level transition plan template.

- In June 2007, USAID/BASICS and the MOHSW facilitated a workshop in Monrovia for MOHSW central-level staff and county health officials to develop initial county and facility level transition plans. Through this workshop, the MOHSW defined the need for an accreditation system to track the progress of counties towards fulfillment of transition goals.
- Since the June 2007 visit, which laid the foundation for county health planning, USAID/BASICS has continued to support MOH efforts to develop year-long county health implementation plans in all 15 counties in Liberia. USAID/BASICS reviewed and provided input to county plans, trained county health planning teams, and participated in one county planning workshop to strengthen the county planning methodology and mentor the health planning team. In addition, USAID/BASICS contributed to a finalized facility-level BPHS implementation accreditation system. All counties in Liberia will have finalized year-long implementation plans by December 2007.

#### **Year 4—Planned activities**

- USAID/BASICS expects to receive a Task Order from USAID/Liberia to support health systems strengthening to ensure quality BPHS implementation. USAID/BASICS' field-based team will be actively supported by a core short-term technical assistance team. Activities will include strengthening BPHS capacity, incorporating community-based workers into the existing system, developing BPHS implementation guidelines and protocols, contributing to the development of an HMIS system to track improvements in health indicators, supporting on-going planning to ensure standardized BPHS implementation at the county level, and on-going efforts to monitor and track the health transition funding gap.

## **MADAGASCAR**

A main element of USAID/BASICS' technical assistance program in Madagascar is providing support for the introduction of zinc for treating diarrhea and CBT of pneumonia. The zinc initiative represents a key opportunity to revitalize diarrheal disease management in the country. Zinc efforts are also providing a point-of-entry for support to improve integrated CCM of pneumonia and malaria. Nutrition and newborn activities are being developed as a part of the portfolio as well. These include providing technical support to the National Office of Nutrition and the MOH's newborn health partners to refine nutrition programs and develop a community based newborn program.

## Objectives

End-of-project Objectives	FY07 Interim Objectives
<b>DIARRHEA</b>	
<p>Improve facility-based treatment of diarrheal diseases, including zinc, in at least 65% of the country's 111 health districts.</p>	<ul style="list-style-type: none"> <li>• Improve BCC materials.</li> <li>• Update health worker training materials with new directives.</li> <li>• Train health workers in all health facilities of 11 initial implementation districts.</li> </ul>
<b>COMMUNITY CASE MANAGEMENT (OF DIARRHEA, PNEUMONIA, AND MALARIA)</b>	
<p>In at least 65% of the country's 111 health districts, provide access to childhood treatment of pneumonia, malaria, and diarrheal diseases through CCM for one or more hard-to-reach communities within half of health center zones.</p>	<ul style="list-style-type: none"> <li>• Integrate malaria, pneumonia, and diarrhea in to CCMt training materials.</li> <li>• Train community health workers in at least 1 community from half of the health facilities in 11 initial implementation districts.</li> <li>• Harmonize geographic delineation of "Champion Communities" in all USAID-supported districts implementing both CCM and Champion Communities.</li> </ul>
<p>Develop, refine, and facilitate the use of CCM implementation guidelines (for malaria, pneumonia, and diarrhea diseases) by the MOH and its partners, emphasizing hard-to-reach areas.</p>	<ul style="list-style-type: none"> <li>• Develop a draft of CCM implementation guidelines.</li> <li>• Test the expansion model in at least 1 region.</li> </ul>
<p>Adapt and introduce a district assessment and implementation guide for improving drug management in the treatment of common childhood illnesses, including CBT activities and resulting in:</p> <p>(1) Drug management training for staff in all health centers implementing CCM in at least 65% of the country's 111 districts.</p> <p>(2) Proper drug storage, dispensing, and stock management in at least 90% of CCM sites</p>	<ul style="list-style-type: none"> <li>• Incorporate methods for DMCI into CCM training materials.</li> <li>• Train health center staff in DMCI methods in health centers in 11 districts implementing community case management</li> <li>• Carry out a Community DMCI assessment.</li> </ul>

End-of-project Objectives	FY07 Interim Objectives
<b>COMMUNITY CASE MANAGEMENT (OF DIARRHEA, PNEUMONIA, AND MALARIA) (cont.)</b>	
Adapt an application to manage CCM data and facilitate a process to integrate data into the formal health system information management system.	<ul style="list-style-type: none"> <li>• Begin adaptation of the computer application.</li> <li>• Build Ministry of Health capacity to use data for program monitoring.</li> </ul>
Develop, update, and facilitate the use of protocols and training materials for pharmacy depot agents, providing training and support to at least half of agents in at least 45% of the country's 111 districts.	Develop protocols and training materials, and test them in 2 districts.
Improve the delivery and quality of treatment for malaria and pneumonia (where feasible) for children under age 5 through private medicine sellers.	Develop a private medicine seller resource package, using it to guide selection of context- appropriate private sector malaria interventions.
<b>NUTRITION</b>	
Link ONN/ SEECALINE Community Nutrition Workers with CCM of malaria, pneumonia and diarrhea (including zinc treatment).	Introduce the proposed linkage model in a limited "learning area" (one district), including community mobilization and health education.
Improve the effectiveness of growth promotion activities.	Develop and introduce (into refresher and introductory training curricula) new job aids and counseling materials.

## Results and Achievements

### *Community Case Management*

- Implemented community case management of pneumonia, diarrhea, and malaria in 117 out of 168 planned sites (5/12 districts; 4/9 regions) through the training of 250 of 314 planned community health workers. Initial, partial data suggest that community sites are treating a rough monthly average of 2 cases of childhood pneumonia, 6 cases of malaria, and 3 cases of diarrhea.
- Planning was begun with PSI to improve *depot de pharmacy* agents' ability to identify and refer children with general danger signs in to health facilities. PSI's focus is primarily on product quality, with USAID/BASICS providing technical assistance to integrate the recognition of danger signs, nutrition counseling for sick children, and links with local health facilities to enhance referral.

### *Diarrhea*

- Introduced zinc and low osmolairty ORS for the revitalization of facility-based diarrhea treatment in 9 districts through the training of 37 program managers and 223 service providers. With an FY07 goal of expansion to 12 districts (spanning 6 regions), insufficient supplies of zinc caused program planners opting to scale-back the expansion calendar to avoid product stock-outs in implementation areas.
- As noted below, CCM, including diarrhea, was implemented in 117 out of 168 planned sites, with initial data suggesting that each site treats an average of 3 cases of childhood diarrhea per month.

### *Nutrition*

- In April, USAID/BASICS' Nutrition Technical Officer traveled to Madagascar and established a work plan for nutrition. This includes improving counseling for recuperative feeding in the context of CCM, improving counseling and support for exclusive breastfeeding through mothers' support groups, supporting the National Office of Nutrition to target and coordinate various actors for nutrition and their various intervention approaches, and collaborating with implementing partners (primarily the MOH, ONN, and Title II-funded NGOs) to introduce and scale-up community-based management of acute malnutrition (CMAM). In discussion with partners better information about the geographic and seasonal distribution of acute malnutrition was identified as a primary need for CMAM. In June, USAID/BASICS started collecting data on this issue from a variety of sources such as the Government of Madagascar, UN agencies, NGOs, and vulnerability early warning projects.

## **MALAWI**

USAID/BASICS is supporting the expansion of Malawi's national program for the prevention of mother-to-child transmission of HIV (PMTCT) through an in-country advisor who works full-time in the Ministry of Health's HIV/AIDS Unit. The advisor, Dr. Peggy Chibuye, was appointed in March 2007 and is primarily responsible for mentoring the Ministry's PMTCT Coordinator, and teaming up with the Unit's head to facilitate effective collaboration with other Ministry departments and implementing agencies. This includes active roles in policy and guideline development; capacity building and training; planning, implementation, and scale-up; and monitoring and evaluation.

USAID/BASICS assistance to Malawi will vastly expand in FY08 through a three-year technical assistance agreement with the Malawi Ministry of Health to improve the effectiveness, quality, and accessibility of child health services.

## Objectives

End-of-project Objectives	FY07 Interim Objectives
<p>Improve the capacity of providers of pediatric HIV services through implementation of activities using the UNICEF/WHO Programming Guide, WHO Pocketbook and IMAI (Integrated Management of Adolescent and Adult Illness) approach.</p>	<ul style="list-style-type: none"> <li>• Provide technical input to WHO and UNICEF for the revision of materials.</li> <li>• Collaborate with WHO on IMAI training.</li> </ul>
<p>Provide technical support at the national level to refine guidelines, and improve systems and programming to increase access to pediatric HIV services for children under 5 years of age.</p>	<ul style="list-style-type: none"> <li>• Conduct an assessment to document current opportunities and barriers to early identification, referral to care and treatment services, and follow up for HIV-exposed and -infected infants and children.</li> <li>• Review national guidelines in PMTCT, HIV counseling and testing, and ART to assess gaps and technical issues in addressing the needs of infants and children with HIV.</li> <li>• Provide ongoing technical assistance on pediatric HIV/AIDS through seconded positions to the MOH or other mechanisms.</li> <li>• Conduct facility reviews and exercises to revise systems of referral within facilities, between facilities, and between facilities and communities to increase access of exposed and infected infants and children to pediatric HIV care and treatment services.</li> </ul>
<p>Disseminate job aids and tools to address approaches to missed opportunities for pediatric HIV identified during assessments of pediatric HIV/AIDS care.</p>	<ul style="list-style-type: none"> <li>• Conduct an inventory of existing job aids and tools on pediatric HIV/AIDS care and treatment, and identify what is needed to improve identification, referral and management along the continuum of care.</li> <li>• Develop, pre-test, refine, produce and disseminate tools and job aids.</li> </ul>
<p>Provide technical assistance and training support for integration of pediatric HIV into pre-service and in-service curricula, materials, and training; with particular focus on IMCI.</p>	<ul style="list-style-type: none"> <li>• Develop and implement pediatric HIV orientation modules.</li> </ul>
<p>Provide support for supervision, mentorship and ongoing clinical consultations for community and facility health care workers.</p>	<ul style="list-style-type: none"> <li>• Provide supportive supervision, mentorship, and ongoing clinical consultations for community and facility health care workers providing services.</li> </ul>

## Results and Achievements

- Since her appointment in March 2007, USAID/BASICS in-country advisor, Dr. Peggy Chibuye, has become fully engaged in providing technical support to the Malawian Ministry of Health, playing an instrumental role in finalizing the PMTCT training package and revising related guidelines. Furthermore, in an effort to improve the monitoring and management of PMTCT data, registers (ANC, maternity, postnatal, and under-five) and “health passports” have been revised to include HIV information.
- Delivered training on PMTCT to 52 service providers from 21 Christian Health Association of Malawi sites, and oriented 40 national PMTCT trainers on the adapted training package (addition of combination ARV prophylaxis for MTCT).
- Several challenges have impeded the implementation of PMTCT activities outlined in the 07 COP. These challenges have made it difficult to fully integrate PMTCT into maternal and child health services, effectively collaborate with health sector partners, increase couple testing and counseling in PMTCT services, and establish a sustainable monitoring system for HIV prevention, care and treatment. Challenges include:
  - Slow disbursement of funds
  - Competing HIV capacity building activities in the MOH have prevented the rapid expansion of the PMTCT program
  - Few HIV-positive pregnant women, exposed infants, and infected children access care and treatment
  - Staff shortages at all levels
  - Lack of Standard Operational Procedures (SOP)

## Year 4—Planned activities

- USAID/BASICS assistance to Malawi will vastly expand in FY08 through a three-year technical assistance agreement with the Malawi Ministry of Health to improve the effectiveness, quality, and accessibility of child health services. These objectives will be directly achieved by implementing the *National Strategic Plan for Accelerated Child Survival and Development in Malawi*, strengthening community-based malaria interventions through mobilization of local NGOs, and building capacity for the prevention and treatment of pediatric HIV/AIDS. Of 28 districts in Malawi, the program targets the eight districts with the highest rates of child mortality and morbidity, These include Balaka, Chikwawa, Kasungu, Mangochi, Mzimba Nsanje, Salima, and Zomba; comprising 30% of the country’s population of children under the age of five.

# NIGERIA

In partnership with Food Basket Foundation International, a local NGO, USAID/BASICS is introducing growth monitoring and promotion (GMP), and hearth-based rehabilitation of malnourished children, developed through positive deviance inquiry. The intervention is being implemented in 3 communities in the Nassarawa State (Gunki, Wache and Pawa/Mallam) and 3 communities in the Akwa-Ibom State (Afaha-Adiene, Itak-Ikot, and Nung-Ukim).

GMP and hearth-based rehabilitation are helping to improve infant and young child feeding, and are essential components of the Gender Integrated Nutrition and Agricultural (GINA) project, a USAID/Africa Bureau multi-sectoral initiative to reduce food insecurity.

## Objectives

End-of-project Objectives	FY07 Interim Objectives
<p>Implement interventions in 9 communities to reduce infant and child malnutrition through improved feeding practices, better use of household food resources to maximize nutritional benefit, and strengthened linkages with health services. These activities will contribute to the Gender Integrated Nutrition and Agricultural (GINA) project's overall objective of reducing malnutrition by 10% in children under the age of five.</p>	<ul style="list-style-type: none"> <li>• Undertake nutrition education programs in ENA and create awareness on the importance of food and environmental hygiene at the household level (including PD/Hearth).</li> <li>• Strengthen community-based growth monitoring centers in all 9 GINA project communities</li> <li>• Facilitate the establishment of a community based information system to track GINA at the community, LGA, and state levels.</li> <li>• Develop an action plan for integrating and linking GINA components into preexisting local health centers, local government agric departments, agri-business institutions, USAID, and all other donors.</li> </ul>

## Results and Achievements

- Produced counseling cards, including the importance of exclusive breastfeeding. Subsequently trained community focal points and 48 community volunteers in counseling card use, as well as general principles related to essential nutrition actions.
- As detailed in the chart on the next page, GMP implementation in Nassarawa State has been more successful and more effective than in Akwa-Ibom state, resulting in consistent reduction in underweight and equally consistent increases in the percentage of infants/children showing positive growth trends. Implementation in Akwa-Ibom state, which is much poorer and experiences more civil disturbance, has faced many difficulties with participation and has shown minimal impact on nutritional status and growth.
- Similar implementation differences were seen between states for the PD/Hearth interventions. While two sets of Hearth sessions were held in Nassarawa, with over 100 caregiver-child pairs enrolled each month and average weight gains of around 400g achieved in both; Hearth sessions have not been held in Akwa-Ibom as the community members have been unwilling to contribute the necessary “positive deviance foods.” Efforts to improve coverage of GMP and to successfully introduce Hearth sessions in Akwa-Ibom are ongoing.

*Results from Growth Monitoring and Promotion, and Health-based Rehabilitation in Nassarawa State and Akwa-Ibom State, Nigeria*

		Nassarawa State	Akwa-Ibom State
Growth Monitoring and Promotion	<i>Nutritional Surveillance</i>	In June, 11.1% of children were moderately/severely underweight, an increase of 2 percentage points over May. Severe underweight prevalence increased from none in May to 1.7% in June. In July, overall underweight prevalence fell to 7.4%, reflecting a nearly 4 percentage point drop in moderate underweight with essentially no change in the prevalence of severe underweight. In August, only 2.4% of the children weighed in Nasarawa State were underweight.	In June, 19% of children weighed were moderately/severely underweight, roughly a 4% increase over the previous month, with nearly all the increase seen in the percentage of moderately malnourished children. In July moderate/severe underweight increased 10% over the June figures. Due to implementation difficulties, GMP was conducted in only one of the 3 communities during August.
	<i>Growth Promotion</i>	Of those children for whom a growth trend could be measured in June ( <i>i.e.</i> , children with 2 consecutive weighings), only 7.0% had a positive slope in their growth curve. The percentage with a positive slope increased to 13.5% in July, and to 30% in August. Most of the increase in percentage with a positive growth trend was seen from a decrease in children with “flat” growth curves, with the percentage losing weight (negative slope growth curve) remaining essentially constant except for a small reduction in August.	In June, 11.4% of children for whom a growth trend was available showed a positive growth curve, and 25% showed negative growth. While the percentage of children with positive growth was roughly the same in July, the percentage with negative growth fell by 11%.
	<i>Referral to Health Services</i>	On average, 5 children from Nassarawa State were referred to health services from GMP each month due to identified illness.	Twenty-eight children were referred to health services in June, but only 12 were referred in July.
Hearth-based Rehabilitation		133 caregiver-child pairs participated in PD/Hearth sessions in July, and the enrolled children showed an average weight gain of 416g over the course of the Hearth sessions. 143 caregiver-child pairs participated in July, and average weight gain was 387g for these sessions.	USAID/BASICS’ implementation partner has been experiencing difficulties in implementing PD/Hearth in Akwa-Ibom state, primarily because of caregivers’ reluctance to contribute the essential “positive deviance foods”. Efforts to motivate the community to participate are ongoing.

**Year 4 planned activities**

- USAID/BASICS’ FY08 work plan continues through June of 2008. In collaboration with Food Basket Foundation International, the project will continue to implement monthly growth monitoring and promotion sessions and Hearth interventions as needed. In addition to continued supervision of these ongoing activities, USAID/BASICS will complete the development of a community-based information system (CBIS) and coordinated Local Government-level planning for multi-sectoral nutrition and agriculture in the remaining project months. The CBIS will incorporate GMP data along with relevant data collected for other development activities (as determined by a previous USAID/BASICS/FBFI census of local development organizations and activities). Reports from the CBIS will be used to inform the Local Government planning for multi-sectoral activities.

## **RWANDA**

USAID/BASICS is helping the Rwandan Ministry of Health improve newborn and child health, and decrease preventable deaths through a number of activities: advocating for increased government and donor funding; developing and strengthening the capacity of the maternal and child health unit within the Ministry of Health to provide technical leadership in newborn and child health services; planning and harmonizing activities across districts and implementing partners to achieve the maximum impact in reducing mortality; and improving access to and the quality of preventative and treatment services.

A key role for USAID/BASICS in Rwanda is as organizer of the IMCI working group, including facility-based IMNCI-HIV and community-IMCI.

## Objectives

End-of-project Objectives	FY07 Interim Objectives
<b>DIARRHEA</b>	
Revitalize ORT use through incorporation within community-based treatment programs in 15/30 districts and with facility-based IMCI in 20/30 districts.	<ul style="list-style-type: none"> <li>Implement integrated diarrheal disease management programs in 9/30 districts for facility-based IMCI and 3/30 districts for CCM.</li> </ul>
<b>COMMUNITY CASE MANAGEMENT (OF DIARRHEA, PNEUMONIA, AND MALARIA)</b>	
Implement community-based treatment of pneumonia in 15/30 districts.	<ul style="list-style-type: none"> <li>Pilot community-based treatment of pneumonia in 3/30 districts.</li> </ul>
<b>FACILITY-BASED IMCI</b>	
Implement facility-based IMCI in 20/30 (or 66% of total) districts.	<ul style="list-style-type: none"> <li>Introduce facility-based IMCI in 9/30 districts.</li> </ul>
<b>MALARIA</b>	
Implement integrated community-based interventions (including pneumonia and/or diarrhea) in 15/30 districts.	<ul style="list-style-type: none"> <li>Implement the home-based management of malaria strategy in 5/30 districts, integrating pneumonia and/or diarrhea when possible.</li> </ul>
Implement an antenatal care (ANC) service package that includes IPT and ITN.	<ul style="list-style-type: none"> <li>Update antenatal care standards to include birth preparedness and complication readiness, IPT, ITN, PMTCT, anemia.</li> </ul>
Highlight the role of the private sector in child health and conduct advocacy for policies that utilize private drug sellers to deliver prompt, appropriate malaria treatment to children under 5.	<ul style="list-style-type: none"> <li>Analyze private drug sellers' contribution in malaria treatment and make recommendations for next steps.</li> </ul>
<b>NUTRITION</b>	
Implement Essential Nutrition Actions (ENA) at the facility and community levels.	<ul style="list-style-type: none"> <li>Validate and disseminate the updated infant and young children feeding (IYCF) policy and implementation strategy.</li> <li>Scale up Community Based Nutrition Programme (CBNP)/ Community Based Growth Program (CBGP) activities, including ENA.</li> </ul>
Incorporate prenatal nutrition, IYCF and micronutrients in neonatal health and PMTCT programs.	<ul style="list-style-type: none"> <li>Facilitate adoption of a national law to protect breastfeeding.</li> <li>Develop an integrated strategy and guidelines for micronutrient supplementation (Children 6-59 months, mothers during pregnancy and post partum).</li> </ul>

End-of-project Objectives	FY07 Interim Objectives
<b>NEWBORN SURVIVAL AND HEALTH</b>	
<p>Incorporate newborn health into IMCI, and implement in 12 districts, sharing best practices, results and lessons learned with partners to promote and further expand/scale up within Rwanda and other countries in the region.</p>	<ul style="list-style-type: none"> <li>• Incorporate newborn health into facility and community based IMCI strategy/algorithm and implement in six districts.</li> <li>• Provide technical assistance to MOH to strengthen newborn health implementation at facility and community level in six districts.</li> </ul>
<p>Incorporate newborn health into national level policies and pre-service educational curriculum.</p>	<ul style="list-style-type: none"> <li>• Strengthen the newborn health component at national level policies related to MCH care.</li> <li>• Provide advocacy to strengthen newborn health in pre-service educational curriculum in collaboration with ACCESS and other partners.</li> </ul>
<b>PEDIATRIC HIV/AIDS</b>	
<p>Strengthen pediatric HIV/AIDS policy guidelines, protocols, plans and health care worker capacity.</p>	<ul style="list-style-type: none"> <li>• Develop and harmonize tools, job aids and manuals to support early identification, care, treatment, follow-up and referral to pediatric HIV services at facilities and communities.</li> <li>• Implement facility-based IMCI-HIV in 9/30 districts.</li> </ul>
<p>Expand the capacity of districts to provide Pediatric HIV/AIDS diagnosis, care and treatment services.</p>	<ul style="list-style-type: none"> <li>• Develop action plans in 30/30 districts to address missed opportunities for children at risk for HIV</li> </ul>
<p>Strengthen capacity of community health workers to support early identification, care, support and referral for HIV exposed/infected infants and children.</p>	<ul style="list-style-type: none"> <li>• Implement community IMCI-HIV in 3/30 districts</li> </ul>
<b>HEALTHY TIMING AND SPACING OF PREGNANCY (HTSP)</b>	
<p>Introduce HTSP within routine newborn and child health activities.</p>	<ul style="list-style-type: none"> <li>• Incorporate HTSP in newborn and child health policies and guidelines.</li> <li>• Incorporate HTSP within facility IMCI in 9/30 districts.</li> <li>• Conduct advocacy with the Family Planning working group.</li> </ul>

## Results and Achievements

### *Community case management*

- Organized (during the first quarter of FY07) an advocacy meeting with the MOH and its child survival partners that resulted in consensus on integrating community-based treatment of pneumonia into C-IMCI in pilot districts. Subsequently, in collaboration with EIP and Twubakane, trained 72 district-level trainers from 2 of 30 districts on C-IMCI and community case management of pneumonia, diarrhea, and malaria. By the end of year 5, 15/30, of all districts will be covered.

### *Diarrhea*

- Though USAID/BASICS advocacy efforts contributed to the addition of zinc to the national essential drugs list, the product was not available at the facility level throughout the country, and available in only 1 of 30 districts at the community level.
- As noted below, roll-out of facility IMNCI-HIV, including diarrhea, has been initiated and will reach in 14 districts. Similarly, training towards C-IMCI roll-out was begun in FY07, as well.

### *Facility-based IMCI*

- Developed materials and trained 16 district-level supervisors, 36 national trainers, and 275 health workers in facility-level IMNCI-HIV (pneumonia, diarrhea, malaria, HIV, sick newborn care, and HTSP). IMNCI-HIV is being rolled out in 46% of Rwanda's health districts (14/30) covering 470,000 under five children (31% of national population).

### *Malaria*

- In 2004, Rwanda's Integrated National Malaria Control Program (INMCP) developed a strategy for home-based management of fever, primarily to increase the percentage of children under the age of five who receive correct treatment within 24 hours of the onset of malaria symptoms, including through the participation of private drug sellers. After two years of implementation in six districts, the program requested technical assistance from USAID/BASICS and USAID/RPM Plus to conduct an evaluation of the program to gauge its impact on case management, care-seeking, and overall malaria control, and to inform program scale-up. The contribution of private drug sellers to malaria treatment was also analyzed during the assessment. Data collection for this assessment was carried out from October to November 2006, with findings and recommendation presented to the INMCP and key stakeholders in November 2006. The final report, published in February 2007, is available on the Rwanda page of [www.basics.org](http://www.basics.org).
- The home-based management of malaria strategy was implemented through integration of malaria, pneumonia, diarrhea and malnutrition in CCM materials, which USAID/BASICS, in collaboration with partners, developed and tested. Training of trainers in CCM was conducted for 72 trainers in 2 of 30 districts; the training of CHWs will be the next step.
- Refocused antenatal care, integrating birth preparedness and complication readiness, IPT, ITN, PMTCT, and anaemia, was rolled out in each health facility in the country.

### *Nutrition*

- Created a local adaptation of the IMCI chart book for recommendations based on commonly available local foods.
- ENA was implemented at the facility level through the training of 275 health care workers in facility IMCI, integrating ENA. Facility IMCI was rolled out in 123 health facilities of 459 in the country (27%), and 14 of 30 districts are providing IMCI services to 470,000 targeted under five children (31%).
- ENA (checking for malnutrition, management of light malnutrition, counseling on continued feeding, etc.) was also implemented at the community level through integration into C-IMCI materials.

### *Newborn survival and health*

- As noted above, roll-out of facility IMNCHI-HIV, including sick newborn care, has been initiated and will reach 14 districts.
- National level policies related to MCH care were strengthened by updating newborn health in the revised national norms and protocols.

### *Pediatric HIV/AIDS*

- As noted above, roll-out of facility IMNCHI-HIV, including pediatric HIV, has been initiated and will reach 14 districts.
- In collaboration with TRAC, MCH, and EGPAF, conducted a workshop for 100 stakeholders aimed at developing a framework and action plans to address missed opportunities for access to pediatric HIV care and treatment at all entry points in the health system. Partnering with TRAC, trained 150 local trainers in case management and addressing missed opportunities to early identify and treat or refer children in need of HIV care.

### *Healthy timing and spacing of pregnancy*

- Incorporated HTSP into the IMCI training module that is currently being rolled out in 9 districts in Rwanda. Twenty-five district-level supervisors and 85 health workers have thus far been trained using the module.
- In collaboration with ACCESS and Twubakane, conducted a workshop for 150 participants on Religious leaders' contributions to maternal and newborn mortality reduction (40% of health centers in Rwanda are religiously affiliated), including through promotion of birth spacing.

## Year 4—Planned activities

- Support the expansion of community-based treatment of malaria, including its integration with other community based treatments as appropriate like pneumonia and diarrheal disease. In conjunction with partners and NGOs, USAID/BASICS will support the development of tools and the implementation of facility based and community IMCI including malaria case management.
- Provide technical assistance to the MOH and partners like EIP, Twubakane, and UNICEF to help introduce ARI management at community level.
- With the MOH and partners, focus on revitalizing ORT by promoting interventions to increase use through facilities, community, and private providers' channels.
- Assist the MOH and PMI implementing partners to assess the introduction of ACTs at the community level and define strategies to deliver relevant malaria interventions at the community level in conjunction with acute respiratory infection and diarrheal disease interventions (integrated community case management).
- Assist the MOH to finalize CCM materials, which include nutrition, and introduce them in collaboration with child survival partners in 10 districts. ENA will be introduced as part of PMTCT and newborn strategies. Community-based nutrition programs will be supported, primarily through the GOR-affiliated RRP+ network of associations of PLWHA, with special emphasis for management of HIV and infant feeding issues and nutritional support for HIV-infected infants/children.
- Advocate for and assist essential newborn care integration into the national maternal and child health norms and protocols. Facility-based IMCI already includes newborn and HIV; community IMCI also will integrate newborn health and HIV. USAID/BASICS and its partners will develop the newborn and child health program performance indicators for monitoring at all levels.
- Assist the MOH and its partners to increase early identification and management/referral of HIV-infected infants through the integration of pediatric HIV in all entry points to care. This will be done through follow-up support for implementation of the steps outlined in the national stakeholders meeting on missed opportunities in pediatric HIV co-sponsored by USAID/BASICS in June of 2007. In addition, USAID/BASICS will pilot a pediatric orientation module for facility and community health workers to broaden awareness of pediatric HIV and early identification and referral of HIV exposed and infected infants among those who encounter infants in the hospital and in the community. Ongoing technical support to TRAC will continue around referral systems, district support, policies and guideline development and in the work of the USG Technical Working Groups on PMTCT and pediatric HIV, MCH and, in the future, nutrition.
- Continue to collaborate with partners like IntraHealth/Twubakane and the CAPACITY Project to develop country-specific advocacy materials on healthy timing and spacing of pregnancy, operationalize its integration into child health activities, and provide TA to assist the MOH and other implementing partners, including USAID funded bilaterals, to introduce and expand coverage of HTSP within existing newborn and child health services.

# SENEGAL

USAID/BASICS significantly scaled back its activities in Senegal in September 2006, when a new USAID bilateral project assumed work on child survival activities in the country. However, during the second quarter of Project Year 3, USAID and USAID/Senegal agreed that USAID/BASICS would continue to work in the country to support the roll-out of neonatal, nutrition, and community case management interventions in Fatick, a non-USAID-sponsored region. Fatick has an under-5 population of 122,983, equivalent to 7% of the national population. In this effort, USAID/BASICS is a principle organizer of a partnership that includes:

- The communities and leadership of Fatick
- UNICEF
- PRN (a World Bank program)
- The African Development BANK (ADB)
- Local NGOs
- Action for Community Development (ACDEV/ Action pour le Développement Communautaire),
- Christian Childrens Fund (CCF)
- World Vision International (WVI)
- The Fatick Regional Farmers' Association (ARAF/Association Régionale des Agriculteurs de Fatick), The Belgium Cooperation

## Results and Achievements

### *Community case management*

- Initiated community case management of ARI, malaria, and diarrhea in the Fatick region in August 2007 through the training of 20 trainers (primarily supervisors and doctors). Program implementation began following implementation of a baseline study—designed and implemented by USAID/BASICS, in partnership with the Fatick Regional Health Team— that showed, among other results:
  - 39% of under-5s with cough or fast/difficult breathing are taken to an appropriate care provider.
  - 17% of children with diarrhea are treated with ORS and 42% receive no treatment whatsoever.
  - 19% of children with fever a brought for malaria care within 24 hours of onset and 31% do not seek care at all.

### *Newborn health*

- Conducted training of 21 trainers in facility-based essential newborn health in September 2007, following implementation of a baseline study that showed, among other results, only 8% of the newborns received thermal protection and less than 12% received skin-to skin contact with the mother after delivery.

## *Diarrhea*

- Stemming directly from advocacy efforts undertaken by USAID/BASICS, UNICEF, and CCF, the MOH committed itself to the revitalization of diarrhea case management using low osmolarity oral rehydration solution and zinc.

### **Year 4 planned activities**

- Provide technical assistance to the MOH and partners like ACDEV, CCF/PSSC and UNICEF to help introduce ARI management at community level, integrated with malaria and diarrhea disease.
- With the MOH and partners, focus on revitalizing ORT use by promoting interventions to increase use through facilities, community and private providers' channels. Fatick has been selected to conduct the initial phase of zinc introduction, with the primary support of USAID/BASICS and CCF. USAID/BASICS will participate in advocacy and design (SOW, tools development, work planning, budgeting) of a country assessment for zinc and ORT implementation.
- Provide leadership to the group of partners introducing newborn health at the facility level in Fatick through training and supervision. USAID/BASICS will coordinate with partners to ensure all facilities in the region are provided with the essential equipment for basic newborn care. All levels of the health system in Fatick will receive key messages about newborn health via a health communication campaign which USAID/BASICS, coordinating with partners, will design and disseminate.
- Continue to provide technical support to the MOH as a member of the Partnership for Maternal, Newborn and Child Health to develop a national Child Survival Strategy and prepare the MOH to present Senegal as a successful case study at the next international PMNCH meeting.

# SWAZILAND

From June 2005 to July 2007, USAID/BASICS supported a facility-based operational research project, *Repositioning Postnatal Care in a High HIV Environment*, implemented by the Population Council and the Elizabeth Glaser Pediatric AIDS Foundation. The country is home to one of the world's highest rates of HIV infection. The objective was to improve care of all mothers and newborns and improve follow-up and care of HIV-positive mothers and their infants (with emphasis on the first three days following delivery) by integrating maternal and newborn health services into PMTCT programming.

The operational research covered 7 facilities in the country's most highly populated region, Manzini, where approximately 7,500 in-facility deliveries occur annually; as well as one facility in Hhohho where roughly 3,760 in-facility deliveries are registered each year.

USAID/BASICS specifically participated as an implementing party by training supervisors and health providers in essential post-natal, maternal, and newborn care, integrated into PMTCT; also reinforcing selected aspects of antenatal, labor, and delivery care. The project also helped to facilitated organizational changes and provided supportive supervision.

## Objectives

End-of-project Objectives	FY07 Interim Objectives
Integrate ENC and postnatal care with the PMTCT country program through collaboration with partners and with emphasis on post-partum care.	<ul style="list-style-type: none"> <li>• Complete operational research implementation and evaluation.</li> <li>• Document lessons learned and make recommendations to the MOH.</li> </ul>

## Results and Achievements

- Training, finalized in March 2007, was provided to 132 health supervisors, staff trainers (from the MOH and the 3 main nursing schools in the country), nurses, midwives, physicians, and trainers for “rural health motivators”. Desired completion of training had been November 2006, but the MOH postponed a number of sessions, mainly due to competing priorities. Moreover, while training of all relevant staff in the 7 intervention sites had been desired, the MOH opted for a mix of staff from those sites and staff from other sites. Although about 50% of staff from the interventions sites were trained, a significant amount of spontaneous exchange occurred with untrained staff, resulting in a level of roughly 77% of staff who understood and performed the targeted behaviors.
- With USAID/BASICS’ support and as a result of the project’s advocacy, every intervention facility established a specific postnatal care area, allocated staff to provide post-natal services, and procured necessary equipment (“facilitation of systems processes and of organizational changes”).

- An evaluation conducted by the Population Council after 8 months of implementation showed significant improvements in client uptake and provider performance. A 12-fold increase was observed in the utilization of services within the first week after birth (20-fold within the first 3 days). Among providers, knowledge of newborn temperature maintenance at birth increased by 25% and of danger signs by 50%. Use of infant cotrimoxazole prophylaxis increased by 24%, and mixed feeding for HIV-exposed newborns decreased from 17% to 6%. However, maternal knowledge of key aspects of care was deficient (e.g. only about 15% cited 2 danger signs in the newborn), suggesting inadequate or inappropriate counseling.
- After preliminary results of the final evaluation were presented at a stakeholders' meeting in July 2007 in Swaziland, the MOH expressed its interest in rolling out the intervention nationwide (4 regions). This would involve the training of 600 nurse midwives and nurses, roughly 2000 rural health motivators, and 70 trainers/supervisors (teachers from academic institutions, regional supervisors, and senior physicians, and central MOH staff).
- The processes and materials that USAID/BASICS developed and adapted for this initiative are being applied in Rwanda and Malawi.

# TANZANIA

Ways to significantly improve community access to information and medicine that save lives and improve child health are at the heart of USAID/BASICS' work in Tanzania. Private sector initiatives focused on improving community mobilization and child health through the Accredited Drug Dispenser Outlet (ADDO) approach with RPM Plus have allowed USAID/BASICS an excellent opportunity to demonstrate how community leaders, radio journalists, and MOHSW staff can work together to analyze key child health problems and produce meaningful radio programs on child health that have relevance not only for their particular geographic area, but for the country. It is expected that other innovations for community mobilization and radio with local participation will build on this positive experience and, pending funding, expand to other areas of the country. The platform for all of USAID/BASICS' work in Tanzania is a strong understanding of what communities understand about child health and what motivates or influences them to do the things they do when a child becomes ill. Opportunities to introduce alternative models for community- case management (CCM) of childhood illness in the future can build on this positive experience of engaging local participation to design, adapt and implement programs and activities for child health, as well as become as integral part of the national ADDO program role out.

## Objectives

End-of-project Objectives	FY07 Interim Objectives
<b>Private Sector Initiatives</b>	
<p>Enhance C-IMCI through private/public initiatives, primarily by establishing child health as an integral component of the ADDO Program.</p> <p>Significantly broaden community-level access to new treatments for pediatric HIV/AIDS (cotrimoxazole prophylaxis) and malaria (ACTS) through private drug sellers, as well as other initiatives.</p>	<ul style="list-style-type: none"> <li>• Through CEEMI, complete analysis of qualitative and quantitative information gathered in 2006, and disseminate results.</li> <li>• In collaboration with USAID/RPM Plus, develop and implement a strategy for community mobilization and behavior change to support child health through the ADDOs.</li> <li>• Develop, test, and initiate use of training manuals on child health in support of the ADDO Program.</li> </ul>
<p>Facilitate program planners' use of in-depth information on child health care seeking behaviors and treatment to improve curative and preventive strategies addressing malaria, pneumonia, diarrhea, and, as appropriate, pediatric HIV/AIDS.</p>	<ul style="list-style-type: none"> <li>• Contribute to a follow-on survey with USAID/RPM Plus to evaluate the impact of the child health ADDO component after approximately one year of implementation.</li> <li>• Carry out a qualitative assessment of health seeking behaviors and treatment in other areas of the country with high need to explore other opportunities and models for private/public initiatives outside the ADDO Program.</li> </ul>
<b>Pediatric HIV/AIDS</b>	
<p>Facilitate adoption of Pediatric HIV by the MOH as an integral part of Reproductive and Child Health Services, as well as development of a national policy.</p>	<ul style="list-style-type: none"> <li>• Pending funding, draft and pretest a pediatric HIV orientation module based on formative research and a pilot of the module with MCH and other staff.</li> <li>• Adapt and harmonize job aids for pediatric HIV identification.</li> </ul>
<p>Expand and significantly improve PMTCT service coverage.</p>	<ul style="list-style-type: none"> <li>• Pending funding, support the roll out of Integrated Management of Adolescent and Adult Illness (IMAI), which includes IMCI and IMCI-HIV.</li> </ul>

## Results and Achievements

### *Private sector initiatives*

- Finalized the Centre for Enhancement of Effective Malaria Interventions' (CEEMI) 2006 formative study (conducted at the request of USAID/BASICS and USAID/RPM Plus), whose overall goal was to inform integration of a child health component into the Accredited Drug Dispenser Outlet (ADDO) program. Two large-scale meetings were held during the third quarter of the year to disseminate results to in-country stakeholders, including the ADDO professional association, community representatives, and the media. Report recommendations are summarized in the table below.

Recommendations to the MOHSW	Situational Analysis
<ul style="list-style-type: none"> <li>• Develop a strategy for community mobilization to engage communities and disseminate accurate information on how malaria, diarrhea, and pneumonia can be prevented.</li> <li>• Provide outreach on child health issues to other family members and community gatekeepers beyond mothers and caretakers (i.e. fathers and grandmothers).</li> <li>• Continue to train ADDO dispensers on child health issues and promote their role as reliable and locally available resources for information and services.</li> <li>• Encourage the involvement of community health management teams in ADDOs to build public-private partnerships that broaden community access to quality drugs and child health services.</li> <li>• Develop and disseminate a comprehensive training package for ADDO dispensers that includes child health.</li> <li>• Build stronger referral links between the ADDOs and the health facilities.</li> </ul>	<ul style="list-style-type: none"> <li>• Treatment seeking is often delayed due to lack of money, distance, household dynamics or preferences for traditional medicine (particularly convulsions).</li> <li>• Caretakers will stop giving treatment if the child resumes playing and is believed to be better.</li> <li>• Many families purchase medicine “in stages” or buy only what they can afford; storing medicine for “the next time the child gets ill” is common.</li> <li>• Grandmothers and fathers have the potential to positively influence improved care seeking and prevention practices and want to be more actively involved.</li> <li>• Flagyl and antibiotics are preferred treatments for diarrhea; ORS is not a big seller.</li> <li>• Fathers report that traditional medicine is a preferred treatment for pneumonia and convulsions</li> <li>• Radio, health workers, family, and friends are important sources of information on child health</li> <li>• Grandmothers have heard that there is medicine that can help children that may have HIV/AIDS; they are eager to find out how/where to get it</li> </ul>

- As noted in the situational analysis of the CEEMI report, men and grandmothers are important “household gatekeepers” on care seeking practices and child health and opportunities to more fully engage their interest and enthusiasm needed to be tapped. This finding formed the basis for USAID/BASICS-organized workshops in April and May 2007) to train 22 radio journalists, community leaders, and MOH representatives in the development of radio spots on malaria prevention, ultimately resulting in the production of 8 spots available for nation-wide transmission. Seven of the 8 spots were scripted to enable nationwide broadcast, even in areas where no ADDOs operate. Since then, the spots have been aired on 2 radio stations in Rvuma.

#### *Pediatric HIV/AIDS*

- Assessed entry points to care for HIV exposed children and proposed a series of recommendations and tools that have been used in other countries. However, USAID/BASICS never received COP funds to implement the recommendations.

#### **Year 4 planned activities**

- Conduct a final participatory radio production workshop in Morogoro using the same approach used to develop the spots for malaria, but this time focused on ARI, diarrheal diseases, and danger signs.
- Finalize simple guidelines on community mobilization that facilitate the promotion of child health through the ADDO networks with input from regions and the MOHSW. The guidelines will become an integral part of the national ADDO rollout plan.
- Contribute to the final baseline with RPM Plus on child health and the ADDOs. Particular attention will be given to the influence of the radio spots on malaria, diarrhea, ARI and recognition of danger signs on care seeking behaviors.

# CAMBODIA

USAID/BASICS' primary focus in Cambodia is supporting implementation of the new Cambodian Child Survival Strategy, specifically by helping to strengthen the institutional capacity of the country's Child Survival Management Committee. The committee is responsible for managing the nationwide scale-up of 12 child survival scorecard interventions identified in the Child Survival Strategy, including reaching the following targets by 2010 (the baseline percentages are taken from the 2005 Cambodia Demographic and Health Survey and the target percentages for 2010 were selected by the relevant national programs):

- increasing early initiation of breastfeeding from 35% to 60%
- increasing exclusive breastfeeding from 60% to 80%
- increasing complementary feeding from 82% to 95%
- increasing Vitamin A coverage from 35%<sup>1</sup> to 85%
- increasing measles vaccine coverage from 77% to 92%
- increasing tetanus toxoid coverage from 54% to 80%
- increasing the use of insecticide-treated nets by families with children under the age of five from 4.2%<sup>2</sup> to 80%
- increasing the use of oral re-hydration therapy from 58% to 85%
- increasing antibiotic treatment for pneumonia from 48% to 75%
- increasing malaria treatment from 0.2%<sup>2</sup> to 95%
- increasing skilled birth attendance from 44% to 70%
- decreasing dengue breeding sites from 181<sup>3</sup> per 100 households to less than 10 per 100 HH

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<sup>1</sup> The 2005 CDHS probably undercounted Vitamin A coverage.

<sup>2</sup> The ITN and malaria treatment baseline coverage levels are artificially low, since the 2005 CDHS did separate the 85% of the population living in non-malarious areas from the 15% of the population at risk.

<sup>3</sup> The baseline is taken from the 2000 CDHS.

## Objectives

End-of-project Objectives	FY07 Interim Objectives
<p>Strengthen the institutional capacity of the Child Survival Management Committee (CSMC) and the Child Survival Steering Committee (CSSC) to manage the successful scale-up of the Child Survival Scorecard interventions throughout the country.</p>	<ul style="list-style-type: none"> <li>• Support funding and implementation of the CSMC work plan through the 7 national programs relevant to child survival.</li> <li>• Facilitate CSMC coordination of Phase I and II of the child survival costing study.</li> <li>• Provide technical assistance towards establishment of the Cambodian Child Survival Strategic Plan 2007-2015</li> </ul>
<p>Assist the CSMC in coordinating and sustaining sub-national (provincial and operational district) implementation of the child survival strategy.</p>	<p>Support the CSMC in:</p> <ul style="list-style-type: none"> <li>• Establishing functional provincial CSMCs</li> <li>• Developing provincial-level and operational district-level plans for scaling up the 12 scorecard interventions and incorporate them into annual CSMC operational plans.</li> <li>• Selecting provinces and operational districts, and begin implementing scale-up plans.</li> </ul>
<p>Improve the newborn and child survival package of interventions in the child survival strategy by introducing operational guidelines and developing optimal service delivery at community and facility levels.</p>	<ul style="list-style-type: none"> <li>• Establish the Newborn Working Group and develop an MOH newborn strategy.</li> <li>• Develop operational guidelines for integrating newborn interventions into existing maternal and child health programs and activities.</li> <li>• Facilitate incorporation of newborn interventions into field service delivery projects sponsored by NGOs and the MOH.</li> </ul>
<p>Introduce child survival interventions and strengthen local capacity in case management of childhood diarrhea, ARI, malaria, as well as young child feeding and essential newborn care.</p>	<ul style="list-style-type: none"> <li>• Implement community-based case management in selected provinces and districts.</li> <li>• Facilitate provincial CSMCs' management and coordination of community-based case management.</li> <li>• Develop plans for assessing community case management and obtaining evidence for presentation to policymakers regarding the appropriate role of trained and supervised village volunteers.</li> <li>• Develop a communications strategy for more effective community case management and submit for adoption by the MOH.</li> </ul>
<p>Implement a monitoring and evaluation framework to report on the child survival scorecard and use reports to strengthen child survival programs and policies.</p>	<ul style="list-style-type: none"> <li>• Facilitate use of a child survival monitoring tool by provinces and operational districts to track performance and coverage, including regular reporting to the central-level CSMC.</li> </ul>

## Year 3 Results and Achievements

### *Institutional Capacity Building*

- Strengthened the capacity of the central-level Child Survival Management Committee (CSMC) to provide leadership in efforts to scale-up the 12 scorecard interventions at the provincial level and below. Given competing priorities of the MOH and partners, the project has noted slow progress in decision-making towards practical steps aimed at increasing coverage. Eighteen provinces (out of 24) have established CSMCs. USAID/BASICS is developing modules that will improve the capacity of these CSMCs to identify constraints to effective scale-up of scorecard interventions, to determine which activities will have the greatest impact on coverage levels, to incorporate those activities into Annual Operational Plans, and to monitor and track coverage levels for all 12 interventions.
- Published a study that estimates the cost of scaling up the scorecard interventions, *Scaling up Child Survival Interventions in Cambodia: The Cost of National Resource Programme Needs* (available on the Cambodia page of [www.basics.org](http://www.basics.org)). The methodology used in the study can serve as a tool for future costing efforts in Cambodia and elsewhere.
- With support from USAID/BASICS, the national Child Survival Management Committee launched the Cambodian Child Survival Strategy in April 2007, with clear targets set for national coverage levels for 2010 for each of the 12 scorecard interventions.
- Assisted in the development of tools for the Child Survival Management Committee to use when visiting provinces (especially an orientation package), as well as terms of reference for both central and provincial CSMCs.

### *Newborn Health*

- Established the National Newborn Health Working Group in collaboration with the MOH, UNICEF, WHO, ACCESS and other stakeholders. Focus initially will be on much-neglected postpartum care, taking into account that the large majority of deliveries occur at home in a village (85% of Cambodians are rural). Package definition is expected by end-2007.

### *Community Case Management*

- USAID/BASICS is actively involved in providing support to the MOH's policy review of the role of community health volunteers in treating diarrhea, pneumonia, and malaria. The current MOH position is that volunteers can provide community case management only in remote villages, though assessments have shown that, even in communities near health facilities, the majority of sick children are not taken to the facility for treatment. In support of the Provincial Health Office in Koh Kong Province, and with the collaboration of CARE, USAID/BASICS is providing technical support for the training, supervision, and supply of Village Health Support Group volunteers in remote villages in the province.

### *Nutrition*

- At the request of UNICEF and in partnership with the MOH, USAID, WHO, other UN agencies, and NGOs, created an 8-year national strategic plan for nutrition and held a consensus building workshop for operational priorities in the coming years.

## Year 4 planned activities

- In FY08, USAID/BASICS will add value by focusing on two primary objectives. The first is to support the scale-up of the 12 CS scorecard interventions to provinces and districts by developing and rolling out practical and concrete modules and procedures to enable effective scale-up. The second objective is to increase the availability and improve the quality of Community Case Management (CCM) of diarrhea and pneumonia, the two leading causes of death among under-5's in Cambodia, as well as increase the availability of a lifesaving package of interventions for newborns, including attention to infant feeding and nutrition essentials.
- The challenge now for scale-up is to empower provincial CSMCs to take these 12 interventions, devise province-specific plans to greatly increase coverage, implement those plans throughout all the ODs in the province so that more children benefit from them, and monitor/track the increase in coverage so that areas of remaining low coverage are dealt with effectively. USAID/BASICS will provide technical support to this roll out by developing simple practical tools (modules and procedures) to make the scaling-up process more efficient and effective.
- In addition, USAID/BASICS will continue to work closely with the MOH and with NGOs supporting networks of village volunteers, to build on existing materials whenever possible, and develop a common CCM training module as well as support systems to improve the quality and to revitalize diarrhea case management, and to strengthen the management of childhood pneumonia, especially at community level. USAID/BASICS will seek to introduce the latter in a phased manner, collaborating with at least 6 USAID-funded NGO implementing partners, once MOH approval is obtained. Initially CCM will be introduced in remote communities or in malaria home treatment pilot areas. When large numbers of health volunteers improve the quality of their diarrhea treatment and start to treat pneumonia in the village, there is real potential to have a major impact on child mortality in Cambodia.
- In support of the objectives, Dr. Solter will be leaving the project in January 2008. A second local-hire senior Cambodian child health specialist will be hired, as well as a local-hire project manager. By focusing on two major objectives in the coming project year, USAID/BASICS believes that it can add value to a greater extent than would be possible if a larger number of key objectives were being implemented. The transition to a new project management team will occur during the first quarter of FY08.

# INDIA

Since 2001, the USAID/BASICS program in India has been mandated almost exclusively to provide assistance in community-based newborn care, essential nutrition, and primary immunization to the RACHNA (Reproductive and Child Health, Nutrition and HIV/AIDS) program. Implemented by the international relief and development organization, CARE, RACHNA includes goals to reduce mortality and malnutrition among children in a program area covering 78 districts in 9 states and a total population of around 100 million.

The INHP (and *Chayan*) components of RACHNA underwent a final evaluation in the first half of 2006, and, after two extensions, that phase of RACHNA ended in March 2007. In the meantime, INHP III was granted and was formally launched by April 2007. The objectives of USAID/BASICS' support to INHP during FY07 were twofold:

- Assist INHP methodically gather and document lessons from INHP II
- Assist INHP II transition to INHP III

By mid-2007, USAID/India had decided to restructure the way it funded technical assistance for child health in India, and consequently announced a rapid phase-out of most current TA mechanisms, including USAID/BASICS. After briefly negotiating possible fresh avenues for continuing to support USAID/India's child survival activities, USAID/BASICS decided to close the India office by September 2007, and discontinue all operations by December 2007. A work plan to this effect was submitted and approved.

The year was marked by substantial numbers of key staff of CARE/INHP headquarters exiting from the project in quick succession, leaving behind a vacuum. In addition, there was downsizing of state and field staff of RACHNA/INHP in response to the limited program funding available. All of this significantly affected the tasks that USAID/BASICS was mandated to assist during the year, causing long delays. As such, the pace of accomplishments was much slower this year than in any previous year. The following is a summary of the accomplishments:

## *Assist INHP in documenting lessons from INHP II*

This effort was, in effect, a continuation of what began with the final evaluation of INHP II in April 2006. By then, a large amount of data was available from about 40 large sample surveys, in addition to many years of implementation experience of over 300 staff from across the 78 districts of the project. INHP III was being planned, and it was clear that lessons must be gathered from INHP II to inform not only INHP III, but also the larger national programs – ICDS and RCH/NRHM – which were looking for evidence based guidance for their strategies. A two-pronged plan was laid out, where a series of technical briefs based largely on available data would be made available to the larger audience, while simultaneously INHP program staff would be involved in a number of internal learning exercises over many months, ultimately emerging with consensus lessons for INHP III and beyond. This latter process was envisaged to include qualitative assessments in each state and possibly in individual districts, and even fresh surveys if need be, to provide a comprehensive picture of what worked and what did not. Since all this was difficult to accomplish together, USAID/BASICS offered to lead the internal learning exercises, and only assist the INHP technical staff in the production of the technical briefs or brief working papers.

Even early in Quarter 1 of the year, it became clear that there was sufficient uncertainty about the continuation of the then current levels of funding to RACHNA/INHP that made an intense internal learning process difficult, and there was considerable pressure to complete working papers to meet the deadline for an INHP II closure national event scheduled for December. Since it was very difficult to do sufficient justice to the papers in time for the event, a series of abstracts was produced, while the team continued to work on the full papers.

Between January and June 2007, virtually the entire writing team at INHP headquarters, including almost all the technical leadership moved out of CARE and on to other assignments. This further seriously delayed the work on hand. An ex-CDC epidemiologist joined the CARE team as Assistant Country Director in charge of the RACHNA program, and took on the responsibility of seeing the papers to completion. All papers that USAID/BASICS was responsible to complete have been completed to advanced draft stage and given to her for review. There is one important paper that USAID/BASICS was assigned responsibility for in late September 2007, which is yet incomplete. The work thus spills over to the next quarter (and year).

USAID specifically requested USAID/BASICS to separately and independently document lessons from the experience of providing TA to CARE/INHP. This has been planned for completion by Dec 2007.

#### *Assist INHP II transition to INHP III*

In February, USAID/BASICS began assisting RACHNA in a three-month process of detailed planning and preparation for transition of its Integrated Nutrition and Health Program (INHP) to the next project phase, notably participating in project design, orienting national and state leadership to the proposed project strategy, and evaluating tools and approaches from the last phase of INHP to inform the next. Implementation of the basic elements in INHP III gained momentum during the third quarter, and a series of design workshops were held involving state team leaders, followed by state level planning and launch of activities.

One of the core elements of INHP III is the building of capacities in the program leadership particularly at district and sub-district levels within the ICDS and health systems. As per the design of INHP III, it is this element (along with a strategy to build community capacities to hold the systems accountable) that will provide sustainability when INHP's inputs eventually phase out in Sep 2009. This is uncharted territory, and therefore expected to require much innovation and careful strategizing. It was anticipated that USAID/BASICS would assist in the development of the detailed operational elements of these strategies over Qtr 3 and 4. The plans included designing and testing a set of processes and tools for the purpose in 1-2 districts in each state before applying them more widely. Unfortunately, due to implementation delays and time lost to documentation, by Sep 2007, these tasks could not be completed. USAID/BASICS did, however, help initiate the process in at least half the states, and will provide more limited help in the next quarter (and year) in parallel to the residual documentation efforts.

Another element that USAID/BASICS had committed to assist was the first of a series of annual surveys of INHP III, scheduled for Sep 07. This was accomplished largely by the CARE M&E team (the only technical specialists in INHP HQ who survived the exodus), who managed most of it on their own, with minimal guidance from USAID/BASICS.

# INDONESIA

In April 2007, USAID/BASICS established a stand-alone project known as the Millennium Challenge Corporation Indonesia/Immunization Project. Funded through a two-year USAID Threshold Grant from the Millennium Challenge Corporation, the project is assisting the government of Indonesia in its efforts to rapidly increase completed diphtheria, tetanus, and pertussis (DPT3) and measles immunization rates nationally. The direct work of the project targets 64 districts in seven provinces (East, Central, and West Java; Banten; Jakarta; South Sulawesi; and North Sumatra), where more than 60% of Indonesian children reside. Reaching the project goal of a national average of 80.5% DPT3 and measles coverage of children below one year of age is a key criterion for Indonesia to become eligible for Millennium Challenge Compact funding.

At the same time, USAID/BASICS is pursuing the introduction of zinc therapy for treating diarrhea, as well as the overall strengthening of diarrheal disease programs in the country. There are an estimated 1.3 yearly episodes of diarrhea per child in Indonesia, resulting in 25-30 million total annual cases and about 40,000 deaths.

## Objectives

End-of-project Objectives	FY07 Interim Objectives
<b>DIARRHEA</b>	
<p>In conjunction with members of the Zinc Working Group and other partners, including A2Z, introduce zinc for the treatment of diarrheal disease in public and/or private health systems (at facility levels) and at the community level (in conjunction with integrated community treatment/case management). Implementation guidelines developed and disseminated; Zinc incorporated within CCM Manual</p>	<ul style="list-style-type: none"> <li>• In concert with local partners, using experience from Madagascar, refine zinc assessment tools and conduct assessments.</li> </ul>
<p>In conjunction with implementing partners, revitalize ORT use through incorporation within community based treatment (CBT) programs, and within facility-based IMCI achieving improved ORT use in treatment of U5 diarrhea [target 20% increase in intervention areas, but will be set depending on baseline in each country].</p>	<ul style="list-style-type: none"> <li>• Use the results of the assessment used to introduce ORT revitalization strategies.</li> </ul>
<b>EPI</b>	
<p>Raise Indonesia's Immunization Coverage indicator, as measured by DPT3 and measles immunization, to 80.5% or higher, by rapidly increasing immunization coverage rates among infants.</p>	<ul style="list-style-type: none"> <li>• Rapid mobilization and start-up of national and provincial activities.</li> <li>• Work with partners to develop an advocacy agenda and plans to increase resources for immunization.</li> <li>• Conduct baseline coverage surveys and select priority districts in consultation with MOH.</li> <li>• Adapt training/planning/monitoring and other materials and start refresher training of trainers on microplanning, monitoring and use of information.</li> <li>• Provide STTA to complete survey of vaccine management (from provincial level to point of use).</li> <li>• Support coverage evaluation surveys with MOH and partners.</li> <li>• Design project monitoring and evaluation strategy and systems.</li> </ul>

## Year 3 Results and Achievements

### *Diarrhea case management*

- In February 2007, conducted an assessment for the introduction of zinc/revitalization of ORT. Based on recommendations from the assessment, developed an action plan for USAID/Indonesia. The objectives of the Action Plan are to establish zinc therapy as the new and definitive treatment for childhood diarrhea and to use its introduction as a means of establishing an improved approach to case management that includes three key elements: oral rehydration, continued breastfeeding, and diet. An additional objective is to reduce the reliance upon antibiotics and antidiarrheals. To achieve these objectives, USAID/BASICS is providing technical assistance to the MOH to incorporate zinc into national policy and guidelines, concurrent to education of both the public and of health professionals awareness. The assessment report is available on the diarrhea page of [www.basics.org](http://www.basics.org).

### *Millennium Challenge Corporation Indonesia/Immunization Project*

- Developed a strategic agenda, annual work plan, and a performance monitoring plan (PMP). Baseline data collection for the PMP was completed by all provinces and used to identify 7 priority provinces and 64 districts.
- Implemented EPI cluster coverage surveys in project provinces in collaboration with WHO, UNICEF, and the University of Indonesia School of Public Health. Independent monitoring of data collection was carried out by Synovate in 3 of the project's provinces.
- Carried out a review of vaccine forecasting and management at provincial and district levels. Significant over-reporting was observed in almost all provinces, leading to under-estimation of wastage and procurement of insufficient quantities of vaccines. Vaccine shortages are anticipated in late 2007 and early 2008. In addition, poor stock control/management was observed at the provincial and district levels.
- Oriented provincial health staff from five provinces and corresponding immunization managers from the respective priority districts oriented on increase immunization coverage, and improve planning, monitoring and supportive supervision. These will focus on (a) how to increase immunization coverage, (b) identification of reasons for low immunization coverage and finding solutions, (c) preparing/updating annual work plans and activity schedules, (d) monitoring and baseline data collection and (d) supportive supervision. These trainers will conduct district level planning and orientation workshops for Puskesmas staff, enhancing skills of district health providers to manage the immunization program.
- Met regularly with MOH on topics including: data collection and the MOH reporting and recording system. Developed a data collection tool for use by the MOH.
- Designed formative research for advocacy and field research conducted through focus group discussions and in-depth interviews. This information will be used as a reference in the development of communications messages.
- To strengthen partnerships committed to supporting and encouraging demand for routine immunization services, developed NGO partnerships (with the Boy Scouts, KUIS, IBI, PKK, IDAI, Muslimat, and Aisyiyah), formed an external advisory committee, and developed media relations and increased mass media coverage of immunization issues.
- Provincial office start-up action plan drafted in partnership with North Sumatra and South Sulawesi Provincial Team Leaders and used this to set up offices for all priority provinces.

- Provincial project launches and press events carried out in five provinces. Project launches fostered dialogue with government for joint planning of interventions and community advocacy activities. As a result of these events, immunization is now successfully increasing in visibility as a critical public health need.
- Provincial level stakeholder meetings held to coordinate activities and review key priorities and critical areas of support.
- Provided critical support to the Multi-antigen measles campaign in South Sulawesi. The MCCI/IP project supported the activity through (a) transport support to one additional kader per posyandu, (b) mobile loudspeakers, (c) orientation of the religious leaders in two districts (Tano Toraja and Makassar), (d) training of additional vaccinators in urban area of Makassar, (e) advocacy meeting for pediatricians and (f) provision of color coded campaign vaccination cards. Lessons learned on provincial injection practices, vaccine distribution, community mobilization and others will be rolled into micro-planning and EPI trainings.

#### **Year 4 planned activities**

- Provide technical assistance to the MOH to incorporate zinc into national policy and guidelines, concurrent to education of both the public and of health professionals awareness.
- Conduct a national project launch with provincial and other stakeholders' participation.
- Work with advocacy partners to implement advocacy plans to increase resources for immunization.
- Form an external advisory committee to support immunization.
- Increase mass media promotion of immunization and community mobilization activities with partners.
- Undertake rapid coverage improvement activities with districts and *puskesmas* staffs, and potential partners.
- Work with Government of Indonesia at all levels to improve the quality and use of immunization and surveillance data (e.g. Vaccine Management and WHO Cluster Survey STTAs, PMP Key Indicators, etc.).
- Complete refresher training to relevant *puskesmas* staff on microplanning, monitoring and use of information and supportive supervision by District and Provincial staff.

## TIMOR-LESTE

USAID/BASICS and IMMUNIZATIONbasics jointly implement TAIS (*Timor-Leste Assistência Integrada Saúde* or Timor-Leste Integrated Maternal and Child Health Care Project). Begun in mid-2005, TAIS provides technical support to the Ministry of Health to expand effective, proven newborn and child health interventions throughout Timor-Leste. Core interventions include malaria prevention and treatment, nutrition and micronutrient care with emphasis in IYCF, pneumonia prevention and treatment, diarrhea prevention and treatment, essential newborn care, and routine immunization for vaccine-preventable childhood diseases.

## Objectives

End-of-project Objectives	FY07 Interim Objectives
<p><b>Improve the delivery of appropriate preventive and curative interventions for priority childhood infectious diseases, nutrition and newborns at all service levels of the MOH, with particular emphasis at the sub-district and community levels.</b></p>	
<p>Increase the proportion of children under age 5 and pregnant women in Timor-Leste who sleep under Long Lasting Insecticide treated bed nets (LLINs) to at least 60%.</p>	<ul style="list-style-type: none"> <li>• Complete distribution of 80,000 long-lasting insecticide-treated bed nets to children under 5 through community volunteers in 6 districts, and evaluate the level of appropriate use.</li> <li>• Plan for LLIN distribution in the country's 4 remaining districts based on a prevalence study and in collaboration with the MOH.</li> </ul>
<p>Enable data-driven policy decision-making on drugs for malaria at the MOH.</p>	<ul style="list-style-type: none"> <li>• Complete a malaria prevalence study and facilitate use of resulting data by the MOH as a basis for policy decisions for malaria prevention and treatment.</li> </ul>
<p>Optimize diagnostics for malaria to achieve the highest quality treatment and effectiveness at all levels.</p>	<ul style="list-style-type: none"> <li>• Complete an assessment of microscopic diagnosis and facilitate use of results to inform an MOH process for establishing an ongoing, strong quality assurance system.</li> <li>• Attain MOH approval for pilot studies on the effectiveness of RDTs at the health center and health post levels.</li> </ul>

End-of-project Objectives	FY07 Interim Objectives
<b>Improve the delivery of appropriate preventive and curative interventions for priority childhood infectious diseases, nutrition and newborns at all service levels of the MOH, with particular emphasis at the sub-district and community levels. (cont.)</b>	
<p>Increase by at least 40% the proportion of peripheral health facilities (clinical health centers and health posts) correctly and consistently using IMCI, EPI, and nutrition interventions<sup>4</sup> to reduce childhood morbidity and mortality.</p> <p>The TAIS model to optimize quality and coverage focuses on limited set of evidence-based interventions, with proven ability to save maximal number of children's lives.</p> <p>Facility improvement will be achieved through application of the continuous coverage and quality improvement (CCQI) model, a 4-phase process of identifying public health and quality gaps and developing solutions. The phases comprise:</p> <p>(1) Introduction of the goals for child health and procedures definition  (2) Information/data collection with a rapid interactive assessment for quality measurements  (3) Analysis, decision-making and priority setting for local solution development  (4) Implementation of solutions, and continuous monitoring and review for continuing or changing actions</p>	<ul style="list-style-type: none"> <li>• Complete stage 2 health center and health post staff mentoring using CCQI.</li> <li>• Begin expansion of stage 3 health center and health post staff mentoring using CCQI in 5 additional districts.</li> <li>• Provide follow-up mentoring using CCQI to maintain high levels of appropriate EPI, IMCI practices and nutrition promotion in 9 districts.</li> </ul>
<p>Ensure that all district-level referral health facilities in Timor-Leste provide appropriate care for severe childhood illnesses (malaria, pneumonia, diarrhea, malnutrition).</p>	<ul style="list-style-type: none"> <li>• Expand improved care in referral facilities to 3 new districts.</li> </ul>
<p>Increase by at least 40% the proportion of peripheral health facilities that routinely and appropriately deliver preventive, curative and nutrition interventions to caregivers to reduce childhood morbidity and mortality.</p>	<ul style="list-style-type: none"> <li>• Complete stage 2 interventions to improve health center and health post links to the community, and communication skills and practices of health workers in 4 initial districts.</li> <li>• Begin stage 3 expansion in 5 more districts.</li> </ul> <p>Begin follow-up in initial districts.</p>

<sup>4</sup> Interventions include appropriate rapid diagnosis and treatment of ARI, malaria, and diarrhea in children under 5 and promotion of exclusive breastfeeding and other essential nutrition actions.

End-of-project Objectives	FY07 Interim Objectives
<b>Improve the delivery of appropriate preventive and curative interventions for priority childhood infectious diseases, nutrition and newborns at all service levels of the MOH, with particular emphasis at the sub-district and community levels. (cont.)</b>	
Ensure that 100% of peripheral health facilities conduct periodic outreach, including vitamin A supplementation for children 6-59 months [in conjunction with immunization].	<ul style="list-style-type: none"> <li>• Organize outreach “mini-campaigns” in stage 1 and 2 districts.</li> </ul>
Increase by 50% the awareness of perinatal and neonatal danger signs in the community ; successfully promote immediate and exclusive breastfeeding of infants 0-6 months; and use of interventions for low birth weight babies at the peripheral facility level, in collaboration with MoH, HAI and other partners in Timor-Leste.	<ul style="list-style-type: none"> <li>• Adapt the post-partum and newborn care curriculum for Family Health Promoters in the community – and initiate FHPs in at least 2 districts</li> </ul>
Increase DTP3 coverage of children under one year of age in peripheral health facilities by at least a 40%.	<ul style="list-style-type: none"> <li>• Design and introduce an immunization self- and peer-performance improvement process through a well-linked training, supervision and monitoring approach.</li> </ul>

End-of-project Objectives	FY07 Interim Objectives
<b>Improve community health practices and increase demand for services</b>	
<p>At the community level throughout Timor-Leste, facilitate a 50% increase in the percentage of caregivers who promptly seek treatment for children under 5 at a health facility</p> <p>Similar to CCQI, Community Mobilization and Participation for child health (CMP or CMPCH) is an information-based strategy that begins with a process for engaging with communities to clarify their needs and expectations for health services. Ongoing consultation and dialogue are key for the CMP strategy, so that initiatives are locally defined, do-able and garner the participation of multiple local institutions and groups, along with community members. To be successful over time, the strategy requires local commitment and leadership as well as the availability of reliable, accessible, quality health care</p> <p>Establishing partnerships and mechanisms to broaden reach and improve effectiveness is to advocate and promote the broad application of official MOH health policies, guidelines and procedures, including the use of common monitoring tools to facilitate better understanding of local disease and service coverage patterns. There should be strong links between this component of CMP and CCQI. The steps followed in CMP are :</p> <p>Phase I: Build Networks of Support;</p> <p>Phase II: Get Organized;</p> <p>Phase III: Plan for Actions;</p> <p>Phase IV: Implement and Monitor as planned</p> <p>For example, in addition to individual health beliefs and practices, a strategic plan to promote child health would also consider and address, as appropriate, the policy environment, community norms and traditions, household dynamics, and the quality and availability of services and products. Messages, approaches and interventions are then tailored to meet the specific needs of different audiences, depending on the program context and goals.</p>	<ul style="list-style-type: none"> <li>• Complete Stage 2 CMPCH; begin stage in the last 5 districts.</li> <li>• Conduct follow-up CMPCH activities in 4 initial districts.</li> </ul>

End-of-project Objectives	FY07 Interim Objectives
<b>Improve community health practices and increase demand for services. (cont.)</b>	
<p>At the community level throughout Timor-Leste, increase the percentage of caregivers' use of appropriate, evidenced-based interventions in the home and community to reduce newborn and childhood morbidity and mortality by 50% or more.</p>	<ul style="list-style-type: none"> <li>• Stage 2 CMPCH activities completed; Stage 3 begun in last 5 districts;</li> <li>• Follow-up CMPCH activities ongoing in 4 initial districts</li> </ul>
<p>In one district, improve the percentage of infants/children (&lt; 2 years) appropriately fed by 50% or more, and improve community-based growth promotion (&lt; 2 years) and health service utilization by at least 25%.</p>	<ul style="list-style-type: none"> <li>• Continue with community-based growth promotion in pilot district (Venilale).</li> </ul>

## Results and Achievements

Civil unrest, political crisis and violence during the past 15 months has had more profound effects on the project than originally understood. Security issues continue to plague the sequential rollout of CCQI and the community mobilization efforts. The political crisis has not only prolonged development of the CCQI and Community Mobilization and Participation (CMP) approaches, but it has also taken more time to build CCQI capacity and technical knowledge within the TAIS team and to engage central level support than initially anticipated. Coordination with the District level has also slowed the process because they have too many activities to coordinate and implement with too few staff. Considering these adjustments to the CCQI process, the number of districts TAIS worked in this year is 3 rather than the projected 9 districts.

Additionally, the capacity level in the districts has led TAIS to break the phase 3 and 4 process into smaller and more locally focused steps. While it was intended that the District CCQI teams would carry through with activities in their own health facilities, it has been found that TAIS will need to support the process at the sub-district level. This additional layer of activities has again slowed the possibility to rollout to more districts as projected for this year. The advantage of this adaptation is that the sub-district activities will provide more opportunity to integrate the community mobilization and participation approach in the solutions proposed for improving coverage and quality of services.

A qualitative midterm review was conducted at the end of this second year of operations of the project. A more quantitative assessment had originally been planned. However, given the events of the past year and other realities, the decision was made to conduct a more qualitative review and reposition the project given many contextual changes in the environment and in the Ministry.

### *Improved delivery of preventive and curative interventions*

- Continued the LLIN distribution and IEC strategy to reach all families with children under the age of 5 in high malaria prevalence districts. Since December 2005, a total of 55,034 nets have been distributed to target families, benefiting 81,032 children. An additional 22,376 nets have been distributed to residents of IDP camps in Dili. Rapid surveys amongst target families in two districts show 80 and 94% appropriate use respectively. During the first quarter of FY08, the LLIN campaign will reach completion through the distribution of about 20,000 nets to target families in Dili and 5,000 to IDP camp residents in Viqueque.
- Held consultations with the MOH malaria program to investigate their desire to pursue a prevalence study, Quality Assurance systems for microscopy, and RDTs. None of these supportive interventions were deemed necessary by the MOH and were then withdrawn from the work plan. No alternative activities have been identified with the MOH.

- Applied the 4-phase continuous coverage and quality improvement (CCQI) model for facility-level health problem analysis and solution generation to cover the three primary health intervention areas—EPI, nutrition, and IMCI—in three separate districts. District focus areas were chosen in response to needs suggested by current health statistics and to optimize lessons learned for follow-on CCQI activities (by addressing a different focus area in the 3 initial districts). In Baucau, where full immunization coverage is below 20%, CCQI reached the fourth phase (implementation of standards and continuous monitoring) and has shown an increase in overall coverage to 61%. The process reached the third stage (information analysis and decision-making) in Manatuto, where nutrition was targeted; specifically to address deficiencies in regular growth monitoring, vitamin A supplementation, and de-worming. In Ermera, where IMCI protocols are estimated to be followed in 66% percent of cases, only phase 2 (data and information collection) was attained.
- Although implementation activities are the primary focus of TAIS, advocacy for updating and clarifying policies has also become essential to enabling project implementation to move forward. In particular, TAIS' efforts to advocate for the expansion of Timor-Leste's IMCI strategy (emphasizing priority interventions for child health) resulted in the inclusion of IMCI for child health in the MOH's newly-defined Basic Services Package. The child survival components of Timor-Leste's new Basic Services Package for Primary Health Care and Hospitals (May 2007) comprise all high-impact interventions defined in the Lancet Series, as well as complementary strategies. Other successful advocacy activities accomplished over the last 12 months have resulted in:
  - a revision, update, and simplification of the national EPI strategy;
  - introduction of zinc for diarrhea treatment as part of the IMCI review and update; and
  - re-orientation of the nutrition strategy to focus on infants and young child feeding ( i.e. exclusive breastfeeding and complementary feeding).

TAIS has also made a proposal for the quality improvement of care for children in hospitals that will complement national level work on the basic package of hospital services. The standards that will be promoted through this process have already received some attention for severely malnourished children. Other protocols will be implemented over the coming year. This process has involved the Timorese doctors in the Child Health Working Group. TAIS is also extending the essential newborn care training for community health center midwives which was initiated by HAI and WHO.

#### *Improved community health practices and increased demand for services*

- As an invaluable companion to CCQI, the community mobilization and participation (CMP) model was developed and introduced to facilitate a similar process of problem identification and solving at the community level. In conjunction with CCQI application in Baucau (see above), CMP was implemented and reached the fourth stage in that district. However this has not been without difficulties. In addition to the above mentioned challenges due to unrest and violence in the country, meeting the community and developing an understanding for moving forward has been impeded by expectation for compensation by community leaders and members for activities which were intended to be done on a voluntary basis.

- The major activity this year has been a formative research investigation into key preventive and care-seeking health practices related to child health. TAIS's assessment is that health promotion in Timor-Leste primarily takes a didactic approach. TAIS believes that an approach to health promotion based on behavior-change principles, rather than only giving people information will be more effective. The community consultation consisted of eight focus group discussions on the context of behavior change (mothers' tasks, schedules, independence, family and community structures and communication opportunities) in five districts, followed by in-depth interviews and trials of improved practices (TIPs) in 13 communities in Ermera and Bobonaro districts. In the TIPs, mothers were asked to try out new, improved practices for a trial period, after which the interviewers returned to get feedback on what people did, their perceived benefits and difficulties, intention to continue the new practices. Out of the 13 behaviors tested selected results are presented here for nutrition. The main poor practices in breastfeeding: rare immediate initiation, insufficiently long feeds, premature supplementation at about four months, bottle use, feeding prelacteals, and sudden cessation due to pregnancy. Although young child feeding practices are far from optimal, most families do appear to have access to some healthy foods that they could feed to young children. While no one aspect of feeding practices stands out as critical, every aspect needs attention – calorie density, portion size, nutrients, snacks, feeding during illness and recuperation. There is good reception for new information from credible sources such as health workers. It was concluded that there is a thirst for information. The negotiation technique used in this community consultation is important to add to health workers repertoire of behavior change skills. The information gathered can be used to improve messages in other communication mediums. Publication of the final report is pending, and will be accessible on the Timor-Leste page of [www.basics.org](http://www.basics.org)

#### **Year 4 planned activities**

- A Mid-term review (MTR) was performed in August 2007. The objective of this mid-term review was to assess the project's progress and achievements to date, and to determine the appropriateness of the project strategy and proposed outcomes in the current and changing context of Timor-Leste. As a result of this MTR, expected outcomes and activities were revised and modified accordingly. Over the remaining two years of the project, TAIS will re-focus its energies at the district level and also in extending program interventions to more districts but using a complementary approach to CCQI / BSP of supportive supervision through the District program officers / coordinators (DPHOs).
- TAIS will also continue to contribute to quality and coverage through the harmonization of its CCQI process with the district-based problem-solving approach of the BSP. The TAIS staff will support the MOH BSP facilitator team that will assist the District teams and sub-district teams to ensure the BSP at an adequate level of quality (as described by clinical and service standards) and optimal level of coverage. The approach for this BSP is evolving.
- Having completed a thorough investigation into health practices via an extensive community consultation process, TAIS will use the findings to guide its input into promoting positive health behaviors via national campaigns and communication messages. Future TAIS community mobilization efforts will aim to integrate the newly functioning Family Health Promoters into district outreach efforts and to continue support to such civil society groups as the suco councils. TAIS pioneered the empowerment of these groups during its bed net distribution and should continue to draw on their strengths for other health interventions, such as using zinc to fight diarrheal disease.

## Policy

- By the end of FY09, TAIS will have successfully advocated for the inclusion of a minimum set of proven, evidence-based newborn and child health interventions within the BSP adopted by the MOH. The project will use the experience gained from its CCQI approach to assist the MOH in rolling out the BSP child health interventions, and supporting a method that addresses both quality and coverage to ensure maximal impact on infant and child mortality (maximizing the number of children's lives saved.) In addition, TAIS will contribute to the policy framework for newborn and child health essential for reaching Timor-Leste's MDG 4. In particular, it will advocate for and contribute to the development or updating of critical newborn and child health policies, and related technical standards, essential for the expanded implementation of the child health interventions within the BSP.
- Policy targets for FY08 include a behavior change strategy for child health; updating IMCI with the addition of zinc and birth spacing; the development of essential newborn care standards; and of hospital standards for severely ill children;

## Improved delivery of newborn and child health services

- By the end of the project, TAIS will have successfully developed the capability of the DHPOs for EPI/CDC and for MCH throughout all districts to provide supportive supervision at the sub-district and facility level, using quality improvement (CCQI), onsite technical skills updates, and mentoring strategies to strengthen the capacity and motivate health workers in CHCs and health posts to improve their delivery of child health services (specifically IMCI and immunizations). Thus, by the end of FY09, 10% of child health encounters in CHCs across the country will be provided according to evidence-based standards of care for IMCI (75% in TAIS focus districts). There will be minimal missed opportunities for immunization (<10%) and coverage for DPT 3 in children under the age of one will be 70% nationally, across all 13 districts. DHPOs for MCH and EPI/CDC will receive refresher training in IMCI or EPI respectively, as well as supportive supervision mentoring. The 2 referral hospitals receiving TAIS technical support will implement case management standards for the severely ill newborn or child under 5 and 70% of child admissions will receive care according to these standards.

## Targets for FY09 include:

- Increased demand and use of child health services, and improved community and family practices
- TAIS will also employ strategies such as behavior change, community mobilization and participation, capacity building in *suco* councils and PSFs, and using local data to empower communities to achieve appreciable coverage of a trio of high impact, proven child health practices. Thus, by the end of the project in FY09, in the 6 TAIS focus districts, 30% of the *suco* councils will be mobilizing and coordinating child health promotion actions in their communities; 60% of children under 5 will be sleeping under bed nets in malaria zones; 80% of children under one year of age will be immunized for measles and DPT3; 70% of diarrheal episodes in children under 5 years of age will be treated with ORT at the all level health facilities; and 70% of newborns will receive breast milk (colostrum) within the first half day of life and be dried/wrapped to prevent hypothermia at all health facility levels.

- In the 6 TAIS focus districts, the project will educate families about danger signs in newborns and children under five, and inform them of the most accessible local facility for immediate care. In some communities, TAIS will work with *suco* councils and community members to develop emergency preparedness plans for severely ill children, to ensure they are taken to an appropriate referral facility for urgent care. In these districts, the combination of improved child health care in facilities, linked synergistically with community mobilization should increase the use of child health services by 10%.

### *Scope of TAIS*

- By the end of the project, TAIS aims to achieve national reach through its supportive supervision, on-site refresher training and mentoring strategies targeting DHPOs in all 13 districts, along with documented improvements in the quality of IMCI and the coverage of immunization services provided in all 65 CHCs in the country.
- In its 6 focus districts, TAIS child health support teams will augment the supportive supervision provided by the “enhanced” DHPOs and provide on-site, facility support and capacity development in child healthcare competencies within the BSP, along with coaching in problem-solving and performance/quality improvement. In these districts, TAIS will also employ strategies that mobilized community participation, built capacity in local leaders and promoted behavior change to increase use (coverage) of a tetrad of proven health practices (ORT, breastfeeding, prevention of hypothermia in newborns and ITN use). In these districts, the efforts to improve child health services in facilities, expand preventive practices in communities and mobilize demand will have been synergistic and resulted in increased use of health services as well as expanded coverage of life-saving preventive practices. In 1 or 2 of these districts, TAIS will have facilitated improved quality of child health care delivery across the continuum from hospital to community.

### *Capacity and System Building for Development*

- Another less tangible and measurable set of expected outcomes for TAIS include human resource development and system building for longer term, sustainable development. To this end, TAIS will undertake specific enrichment and capacity building activities with its own staff, to enable them to develop skills which will be of use in other employment after TAIS. They will be encouraged to take longer term positions within the MOH or other national institutions which will benefit from their increased capacity and knowledge.
- With the same objective, TAIS will strive to strengthen capacity and skill within MOH counterparts through directed strategies to build child health knowledge and skills, but also through mentoring. External consultant advisors will not only be used to strengthen provider performance in facilities, districts and subdistricts, but also to build capacity in national level MOH counterparts whenever appropriate and feasible. TAIS will also provide direct support to national child health programs in the Ministry (MCH, EPI, Health Promotion) by seconding administrative coordinator level staff, and selective technical level officers.

- TAIS will also support longer term sustainable development at community level through its capacity development of sucos councils. Project community level mobilization and participation activities, coupled with sucos council skill-building in useful methods of coordination, problem solving, prioritizing, using local data, setting targets and monitoring for results, although all applied in the context of child health, will clearly be beneficial in non-health areas, including improved empowerment and participation in local governance. TAIS will link with other donor-funded projects in the area of Democracy and Governance, or sucos capacity development to introduce and use child health as a nidus for expanding other related skills in local governance.

#### *Illustrative activities for FY08*

- Refresher training for IMCI facilitators with updated IMCI protocol and then district level refreshers with supportive supervision for all child health care providers.
- Orientation of doctors to the IMCI approach and referral level hospital care standards for children.
- Continued supportive supervision of health care workers to reinforce EPI training.
- Expansion of supportive supervision lessons learned through the DPHO quarterly review processes at the national level for EPI, HMIS and CDC to extend quality improvement activities to some of the management systems that support child health activities (e.g. cold chain management, equipment and space management for more effective service delivery, scheduling and monitoring of outreach /mobile clinic services).
- Development of a BCC strategy for child health – built on information understood from local community investigations into health behaviors.
- Development of linkages with capacity building efforts for suco councils so that they take on health activities and participate in PSF monitoring and support.
- Continued integration of the CCQI lessons learned and tools into the BSP rollout process.
- Continued development of the community mobilization and participation approach, building on the lessons learned in the ITN distribution.
- Continued promotion of immediate and exclusive breastfeeding and complementary feeding for young children with vitamin A supplementation, particularly under the age of 2, using regular growth promotion sessions and community outreach.
- Expansion of newborn care training for community health center level and addition of community level messages for newborn care to PSF skills development.

# LATIN AMERICA AND THE CARIBBEAN REGIONAL INITIATIVE

Since 2004, USAID/BASICS has been a member of the Inter-agency LAC Alliance for Newborn health, which includes PAHO, UNICEF, CORE Group, Access, Save the Children, URC, USAID and others. The alliance is supporting implementation of an initiative to improve newborn health in the LAC region, primarily by working to foster consensus among countries in the region on essential actions for newborn health through the establishment and implementation of a regional strategy.

Additionally, with country partners in El Salvador, Dominican Republic, and Honduras, USAID/BASICS is operationalizing prevention and treatment of neonatal sepsis, an important element of the LAC regional strategy. This initiative is being supported through technical support from USAID/BASICS consultants and local coordinators, as well as distance learning methodologies and elements of collaborative models for quality improvement.

The initiative aims to identify gaps in prevention and treatment of newborn infections at the facility or community level, try short cycles of change, and evaluate their impact. If successful, the changes are then brought up to scale. The distance learning sessions (using either videoconferencing or Elluminate software) permit the sharing of experiences among facilities or NGOs and between countries.

El Salvador and the Dominican Republic are working at the facility level with the involvement of hospitals that offer first level (healthy newborn) and second level (nursery) care. Honduras is participating in the intervention at the community level through different programs that various NGOs are implementing on the ground. In-country partners include:

- 1- Dominican Republic—USAID, Ministry of Health (SESPAS), UNICEF, PAHO, and the 2 bilaterals (Abt Associates and FHI).
- 2- El Salvador—USAID, Ministry of Health (MSPAS), and the bilateral with URC
- 3- Honduras—USAID, local authorities from MOH, Christian Children’s Fund, Catholic Relief Services, Save the Children Honduras, and a local NGO (*Programa para el Desarrollo de la Infancia y la Mujer*—PRODIM)

## Objectives

End-of-project Objectives	FY07 Interim Objectives
Develop regional action plans.	Develop regional action plans.
Introduce selected elements of the regional strategy (i.e., the prevention and management of newborn sepsis) in 2-3 countries.	Introduce the prevention and treatment of newborn sepsis at the facility and/or community levels in 2-3 countries.

## Year 3 Results and Achievements

### *Regional Action Plans*

- As a member of the Inter-agency LAC Alliance for Newborn health, USAID/BASICS contributed to finalization of a regional strategy for newborn health, launched in June 2007. The purpose of the strategy is to highlight and promote evidence based interventions for newborn care in communities and through health services, with a focus on the most vulnerable populations<sup>5</sup>. USAID/BASICS coordinated the Regional Meeting in Antigua in 2006 to obtain inputs from country MOHs.
- The alliance organized a meeting in Paraguay in August 2007 for MOH representatives from 16 countries to develop a regional action plan for newborn health. Countries gave inputs on the different levels of intervention in the Strategy: 1) create a favorable environment to develop and promote effective public policies at all levels using the maternal, newborn and child health (MNCH) 'continuum of care' model while stressing newborns and with special emphasis on community; 2) build linkages across programs; 3) improve the response capacity and quality of health services by strengthening primary health care and levels of referral; 4) provide effective, integrated and culturally appropriate health care; 5) update and strengthen the competencies of the health workforce; 6) promote interventions to empower individuals, families and communities; and 7) develop a surveillance, monitoring and evaluation system to assess progress.

### *Newborn Sepsis*

- Using a PAHO-developed assessment tool (pre-tested in Ecuador during the first quarter of FY07), USAID/BASICS facilitated a process of identifying gaps in the prevention and treatment of neonatal sepsis at the facility level in 5 facilities in El Salvador and 4 facilities in the Dominican Republic, covering 60,000 combined annual deliveries. The following gaps were identified:
  - El Salvador: hand washing, use of individual gowns in the nursery, outdated newborn sepsis treatment guidelines.
  - Dominican Republic: sterile delivery practices, hand washing, outdated guidelines for the prevention and management of newborn sepsis.

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<sup>5</sup> Reducing Neonatal Mortality and Morbidity in Latin America and the Caribbean – An Interagency Strategic Consensus, 2007.

- In Honduras, where roughly 45% of deliveries occur in the home, the intervention is being implemented only at the community level, in 300 communities (spanning 17 municipalities). A baseline study was undertaken through interviews with 100 mothers of infants, as well as observation of 48 AIN-C *monitores* and 36 traditional birth attendants. Results included:
  - Mothers: 63% breastfed in the first hour after delivery, 16% applied harmful substances to the umbilical cord (e.g., cooking oil and chicken fat), 48% attended post-partum care visits (11% in the first week following delivery), and 22% had no knowledge of newborn danger signs.
  - AIN-C *monitores*: Between 67 and 89% performed correct actions, with weaknesses noted in counseling for exclusive breastfeeding, cord care, temperature maintenance, and recognition of danger signs.
  - Traditional birth attendants: Fifty percent practiced all recommended essential newborn care elements following delivery, and most wait beyond the third day after delivery to make a follow-up visit.
- Between January and April 2007, delivered targeted training to 386 community health volunteers, guidance mothers, NGO staff, AIN-C *monitores*, and TBAs in Honduras; to 400 physicians, nurses, interns, and nursing school students in El Salvador, and; to 300 hospital staff in the Dominican Republic. Evaluation after 6 months of program implementation showed significant improvement in targeted actions (e.g., hand-washing before examination of a newborn improved by 42% at intervention sites in El Salvador and 44% in the Dominican Republic), ultimately resulting in a 30-56% reduction of suspected newborn sepsis in three hospitals in El Salvador and 20% in two regional hospitals in the Dominican Republic. Honduras is initiating documentation of changes.
- USAID/BASICS also facilitated 10 distance learning sessions (Videocon and Elluminate).

#### **Year 4 planned activities**

- Expand LAC Initiative within existing three countries to encompass 2 additional hospitals in the Dominican Republic and El Salvador, one additional NGO joining the initiative in Honduras; and inclusion of activities related to the care of the premature baby and the treatment of newborn asphyxia. Conduct additional QI training for partners in-country.
- Facilitate study tours to enhance regional knowledge transfer about QI.
- Incorporate additional elements to improve newborn health into LAC Initiative, such as breastfeeding.