EXTERNAL REVIEW

OF THE

MATERNAL AND NEONATAL HEALTH PROGRAM

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ACRONYMS

BCI	Behavior change interventions
BGH	Bureau for Global Health
BP/CR	Birth preparedness and complication readiness
CA	Cooperative Agreement
CEDPA	Center for Development and Population Activities
CTO	Cognizant Technical Officer
EmOC	Emergency obstetric care
EOC	Essential obstetric care
IMPAC	Integrated management of pregnancy and childbirth
IR	Intermediate result
JHPIEGO	Corporate affiliate of Johns Hopkins University
JHU	Johns Hopkins University
JHU/CCP	Johns Hopkins University/Center for Communication Programs
MAC	Malaria Action Coalition
M&E	Monitoring and evaluation
M&NHN	Maternal and newborn health and nutrition
MCPC	*Managing Complications in Pregnancy and Childbirth* (manual)
MNH	Maternal and Neonatal Health Program
NGO	Nongovernmental organization
PATH	Program for Appropriate Technology in Health
PQI	Performance quality improvement
PVO	Private voluntary organization
RFA	Request for application
RP	Results package
SO	Strategic objective
TRH	Training in Reproductive Health (USAID project)
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization
WRA	White Ribbon Alliance

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EXECUTIVE SUMMARY

The United States Agency for International Development (USAID) designed the Maternal and Neonatal Health Program (MNH) to be its innovative flagship program to improve maternal and neonatal health. The program vision was to move beyond small-scale, pilot, or demonstration activities in maternal and neonatal health to support broad, integrated MNH programs in country programs worldwide. USAID awarded the $59.6-million Cooperative Agreement (contract number HRN-A-00-98-000-43-00) for the MNH Program to JHPIEGO Corporation in 1998. JHPIEGO made subawards (16 percent of the program budget) to three partner organizations: the Center for Development and Population Activities; the Johns Hopkins University Center for Communications Programs; and the Program for Appropriate Technology in Health. In September 2002, USAID extended the cooperative agreement (CA) by one year, to September 30, 2004, and increased the agreement ceiling to $79.6 million.

The MNH Program external review took place from late January through March 2003, during the program's fourth operational year. The purpose of the review was to identify important lessons from the MNH experience that would assist the USAID Strategic Objective 2 (SO2) team in redesign of the follow-on program and would help the MNH team complete the program successfully.

The review team was asked to look the MNH cooperative agreement from two vantage points. First, it was asked to look at the agreement from a retrospective angle and to answer the principal question: What is the evidence that MNH activities have made or will have made improvements to access, utilization, quality, scaling up, and sustainability of maternal and neonatal health programs? The team found that while MNH is tracking its activities and outputs, documentation of significant results is not yet available.

Second, the team was asked to look prospectively at emerging issues and challenges in expanding the availability and quality of the safe motherhood program and future needs to achieve SO2. (These issues and options are included in a separate document to USAID.) The Scope of Work for the External Review of the Maternal and Neonatal Health Program is located in Annex A. A list of persons contacted for interviews is listed in Annex B.

The CA described the results expected, and the original program SO indicator, in the following words: *Increase proportion of births attended by a medically trained provider.* The original program emphasized results for integrated interventions in maternal and neonatal nutrition, birth preparedness in the home and facility, and basic and emergency obstetric care. Specific areas of interest were integration of appropriate maternal and neonatal nutrition interventions into services; improved birth preparedness; improved safe delivery, postpartum, and neonatal care; improved management of complications; improved maternal and neonatal health research, policy, and programming; and support for the Global Bureau for Health contribution to maternal and neonatal health. MNH refocused its program in the Third Annual MNH Work Plan (2000) and in Modification 22 to the CA, September 2002. The program now focuses on increased collaboration among organizations working to promote maternal and neonatal survival; improved

essential maternal and neonatal care; improved policy environment for maternal and neonatal survival at the global, regional, and national levels; and increased demand for quality maternal and neonatal services at all levels.

Focused efforts in the remaining year of the program could enable the MNH Program to describe how it has made measurable progress toward meeting the SO2 Results Package indicators and achieving some of the technical and programmatic objectives and intermediate results described in the CA. An opportunity exists for USAID and MNH Program leaders to jointly make a positive but objective review of past and present achievements and issues and to decide which technical and programmatic areas would benefit from greater support during the last year of operation. (A summary list of priority conclusions and recommendations is located in section VI of this report.)

The review team suggests the following priority technical and programmatic actions for the remaining life of this project:

MNH

- As a learning experience for all the partner organizations, conduct a retrospective review of all major MNH priority interventions. Bring together field program directors and counterparts with headquarters staff to review what has worked and what has not worked, with a view to improving MNH assistance efforts.

- For the remainder of the program, focus resources on a comprehensive MNH monitoring and evaluation (M&E) system. Ensure that there is dedicated, experienced senior staff assigned to consolidate and analyze existing data to demonstrate progress toward the SO indicator and the achievement of results. Specifically:

    - Analyze local data to demonstrate, for example, the measurable impact of behavior change interventions and community mobilization activities on access, availability, and utilization of services. While these data may be available only from the four integrated country surveys (Indonesia, Nepal, Burkina Faso, and Guatemala), the importance of this information cannot be overstated.

    - Assess the extent to which MNH training has had an impact on the quantity and quality of maternal and newborn health and nutrition services at the national, regional, or local levels (e.g., an increase in the number of providers or facilities providing basic and comprehensive obstetric care in a region, district, or country).

    - Document the reasons for the success of the performance quality improvement process in countries where it is well developed and demonstrate how it has led to an increased proportion of births attended by a skilled attendant.

USAID

- Continue to concentrate on global maternal and neonatal health. Focus on what was agreed in the modified CA and on what MNH has actually implemented, in order to ensure that program accomplishments and results are adequately documented and communicated.

USAID AND MNH

USAID and MNH must agree on what is meant by "results" and what evidence will demonstrate achievement of results. Therefore, it is necessary for USAID and MNH to

- Reach a clear understanding of the USAID definition of results and how MNH can best show it has achieved such results by the end of the program. The MNH M&E team should have a separate meeting with USAID M&E specialists to reach agreement on definitions and on the actions MNH should take over the next year to show achievement of results.

- Identify the specific outputs, outcomes, accomplishments, and results that the current M&E framework will address, assess, and report. USAID and JHPIEGO should agree on a plan of action and a time lines for producing the needed information and documentation.

- Review the M&E plan to ensure that it focuses on capturing data that will produce significant information for USAID program managers and that have met reasonable quality and validity standards.

- Ensure that all significant MNH activities implemented during the period 1998–2004 are adequately assessed and documented in the final year of operations, and well before the end of the CA in September 2004. Such a record will help establish an operational baseline for setting targets and progress benchmarks for future interventions and programs.

I. INTRODUCTION

The United States Agency for International Development (USAID) designed the Maternal and Neonatal Health Program (MNH) to be its innovative flagship program to improve maternal and neonatal health. The program vision was to move beyond small-scale, pilot, or demonstration activities in maternal and neonatal health to support broad, integrated MNH Programs in country programs worldwide.

The Maternal and Neonatal Health Program external review took place from late January through March 2003. The purpose of the review was to identify important lessons from the MNH experience that would assist the Strategic Objective 2 (SO2) team in the redesign of the follow-on program.

The review team was asked to approach its task from two perspectives. First, the team was asked look retrospectively at the MNH cooperative agreement (CA) and answer the principal question: What is the evidence that MNH activities have made or will have made improvements to access, utilization, quality, scaling up, and sustainability of maternal and neonatal health programs? Second, the team was also asked to look prospectively at emerging issues and challenges in expanding the availability and quality of the safe motherhood program and future needs to achieve SO2. (These issues and options are included in a separate document to USAID.) The Scope of Work for the External Review of the Maternal and Neonatal Health Program is located in Annex A.

Program Description and Objectives

USAID awarded the $59.6-million cooperative agreement (contract number HRN-A-00-98-000-43-00) for the Maternal and Neonatal Health Program to JHPIEGO Corporation in 1998. JHPIEGO made subawards (16 percent of the program budget) to three partner organizations: the Center for Development and Population Activities (CEDPA); the Johns Hopkins University Center for Center for Communications Programs (JHU/CCP); and the Program for Appropriate Technology in Healthcare (PATH). In September 2002, USAID extended the CA by one year, to September 30, 2004, and increased the agreement ceiling to $79.6 million.

The program description of the CA is the application submitted by the JHPIEGO consortium. It describes the results expected under six intermediate results (IRs). The original SO indicator is as follows: *Increase proportion of births attended by a medically trained provider.*

The six original IRs in the CA emphasized results for integrated interventions in maternal and neonatal nutrition, birth preparedness in the home and facility, and basic and emergency obstetric care (EmOC).[2] These IRs were as follows:

1. Integration of appropriate maternal and neonatal nutrition interventions into services.
2. Improved birth preparedness.
3. Improved safe delivery, postpartum, and neonatal care.
4. Improved management of complications.

5. Improved maternal and neonatal health research, policy, and programming.
6. G/PHN's contribution to maternal and neonatal health supported.

The Third Annual MNH Work Plan (2000) reduced the number of IRs from six to four. This change was incorporated into the official CA documentation at the end of year four (Modification 22 to the CA, September 2002). The current IRs are as follows:

1. Increased collaboration among organizations working to promote maternal and neonatal survival.
2. Improved essential maternal and neonatal care.
3. Improved policy environment for maternal and neonatal survival at the global, regional, and national levels.
4. Increased demand for quality maternal and neonatal services at all levels.

This report reviews the program within the framework of the four IRs adopted by MNH in 2000 and the changes since that time. It includes some coverage of the original IRs in the SO, the RP, and the original CA.

II. PROGRESS IN ACHIEVING PROGRAM OBJECTIVES

The MNH program has made measurable progress toward achieving USAID's Strategic Objective. The program is doing valuable work, and the interventions it is doing, it is doing well. However, these interventions may not be sufficient to produce an increase in the program's SO indicator "the percent of births with a skilled attendant" (Global Monitoring and Evaluation Framework) or to achieve its IRs.

The program supports the Bureau for Global Health's (BGH) SO3: *Increased use of key child health and nutrition interventions*. Through recent collaboration with the World Health Organization (WHO), Basic Support for Institutionalizing Child Survival (BASICS II), and other cooperating agencies working in child health, it addresses neonatal health. The programs' contribution to SO5: *Increased use of effective interventions to reduce the threat of infectious disease of major public health importance* has been primarily through the use of malaria resources to facilitate the integration of intermittent treatment of malaria in pregnancy into maternal health programs where malaria is an important factor in maternal and neonatal survival. MNH has incorporated communications messages and training for treatment of malaria in pregnancy. MNH activities have had a critically important role in raising the profile and advancing the agenda of malaria programs, especially those of the Malaria Action Coalition (MAC); these activities have been less effective, however, for raising the profile of antenatal care. (The USAID Strategic Framework for Population, Health, and Nutrition sectors is presented in Annex C.)

At the end of year 2002, the MNH program reported field activities in 18 countries, including Indonesia, Nepal, Zambia, Bolivia, Guatemala, Honduras, Tanzania, Guinea, Paraguay, Burkina Faso, Peru, Afghanistan, Haiti, Senegal, Rwanda, Ghana, Nigeria, and Kenya, as well as regional activities for east and west Africa. Integrated programs are carried out in specific sites in four program countries: Indonesia, Nepal, Burkina Faso, and Guatemala. Indonesia and Nepal are the two countries with significant MNH Program funding that were included as first priority countries in the RP; and funds from USAID/Indonesia account for more than half the total field support MNH Program funding. A document review of the Nepal program suggests that MNH built on earlier programs and played a minor but significant role in the overall country program by coordinating donor-supported activities and supporting the Ministry of Health's policy development and planning. Two years ago the new USAID bilateral program assumed responsibility for maternal health activities and continued to fund one in-country technical advisor from the MNH program in order to obtain appropriate technical expertise for the Mission.

The main thrust of the MNH Program's technical assistance efforts has been the adaptation or adoption of JHPIEGO's reproductive health clinical training strategies to the area of maternal health, focusing especially on essential maternal and newborn care and management of the complications of pregnancy and childbirth. One of its main service and policy achievements was its collaboration with WHO to produce the clinical manual *Managing Complications in Pregnancy and Childbirth* (MCPC) and related training materials and courses. This manual is

part of the WHO series for the Integrated Management of Pregnancy and Childbirth (IMPAC) strategy, supported by the WHO, the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF), and The World Bank. MNH has used the MCPC manual to develop national standards of obstetric care and international standards for midwifery education, standards, and professional requirements. The MNH review team's interviews and site visits indicate that the MNH training has improved the skills and self-confidence of the doctors, nurses, and midwives completing the program. MNH has also collaborated with WHO on a second IMPAC manual for the management of neonatal complications. This manual will be published by the end of the MNH Program in 2004.

The three partner organizations, CEDPA, JHU/CCP, and PATH, have collaborated on a common set of activities identified as behavioral change interventions (BCI). The partners were able to use their relatively small share of the program budget to initiate important efforts in such areas as social mobilization, advocacy, communications for behavior change, and maternal and neonatal health and nutrition (M&NHN) education for women and their families, and for communities.

III. MAIN ACCOMPLISHMENTS OF THE PROGRAM

The review team was asked to answer the bottom-line question: What is the evidence that MNH activities have made or will have made improvements to access, utilization, quality, scaling up and sustainability of maternal and neonatal health programs?

- **Access.** In the four integrated country programs, counterparts involved in the performance quality improvement (PQI) problem-solving approach are energetically addressing the barriers to access. MNH expects that by the end of the program, selected data on access to services will be available from those programs. However, in other focused country programs, access to services probably will not be increased unless more linkages are made to other maternal and neonatal health interventions in these countries. Except for Indonesia, where USAID and other donors are training thousands of new midwives, the number of new providers in the country programs is probably insufficient to bring services closer to the women who are most likely to die, that is, those with complications of pregnancy and childbirth who reside at too great a distance from obstetric services that can address these problems. Nonetheless, MNH data suggest that program interventions are contributing to improving access to maternal and neonatal health programs.

- **Utilization.** At the time of the review, there was no conclusive evidence of an increase in utilization of services in areas where facility-based skilled providers have been trained. Social mobilization activities are raising awareness of national and regional leaders of the issues of maternal mortality, and communities are beginning to plan for treating birth complications and to develop transportation plans for emergencies. At present, the MNH M&E system does not intend to report changes in utilization rates where program trainees are deployed or facilities have been improved. In some sites, the data on changes in utilization are being collected by the facility teams and are available through service statistics at the local level.

- **Quality.** The MNH clinical training approach is improving the competencies and self-confidence of providers, some of whom (such as doctors, nurses and midwives) would have been considered skilled providers before the JHPIEGO training. In several country programs, the MNH Programs are improving the quality of training of new providers. However, the data available do not assess the extent to which MNH training improvements have had an impact on the quantity or quality of maternal and newborn health and nutrition (M&NHN) services at the national, regional, or local levels (i.e., an increase in the number of providers and facilities providing basic and comprehensive obstetric care in a subregion, district, or country). MNH expects that such information will be collected as part of the four integrated country program evaluations to be completed next year. MNH program activities were limited to improving the quality of the facilities and services available at the MNH training and practicum sites. However, the MNH program sees this as a foundation and starting point on a path of quality improvements that others may eventually support. With the exception of those facilities

participating in the PQI approach, which made improvements in structure, operations, and equipment with other resources (e.g., Guatemalan), MNH efforts to improve the quality of health facilities were mainly devoted to those facilities used for training and for practicum.

- **Scaling Up.** MNH has espoused the definitions of scaling up proposed by the predecessor project, MotherCare, in which *quantitative scaling up* entails an increase in clients served; *functional scaling up* involves an expansion of the number and types of programs conducted by the same organization; *political scaling up* addresses the root causes of a problem through collaboration and social and community mobilization; and *organizational scaling up* increases the amount or quality of human or financial resources. Using these terms, the MNH Program has probably had a positive effect in most of these areas. (In May 2003, after the team completed their review, the MNH Program produced a new comprehensive document addressing scale up.)

  Quantitative scale-up is taking place in program sites that are measuring increases in the number of clients served by tracking numbers of hospital and facility births and a calculated met need at the local level. The data are not immediately available. This information could be collected before the final surveys are conducted in the four integrated country programs.

  Functional scale-up is occurring where MNH has a productive partnership with the Ministry of Health (MOH) and where it has helped governments introduce new maternal interventions in increased numbers of facilities. While the number of service sites may not be increased, the types of programs in the facilities have changed. In addition, JHPIEGO is scaling up by embracing a new type of training program and increasing the activities it carries out worldwide. Replication of program approaches by other organizations working with the MOH might also meet this definition.

  Political scale-up efforts, such as MNH's social and community mobilization and communications activities, are beginning to address root causes, when they are part of a strategic approach. MNH anticipates that evidence of such results will be available from the four integrated country programs; however, the more isolated country experiences may not provide sufficient information or data to demonstrate an impact on policies or on broadening political and legal support for maternal and neonatal health.

  Finally, the program has begun to **organizationally scale up** by increasing the quality of skilled attendants within a system. However, it is unlikely that the program has significantly increased the financial resources for MNH within the health services systems, other than through attraction of additional donor resources. In the longer term, the advocacy focus of the MNH partners, the White Ribbon Alliance (WRA), CEDPA, and the POLICY Project will continue to address resources for maternal and neonatal programming. They may achieve an increase in national resources devoted to maternal and neonatal health and be able to measure that increase.

- **Sustainability.** Where changes in the training program have been institutionalized, and where funding is assured for continued training, there is a strong likelihood of sustainability in improving the human resources in a country. In some cases, MNH Program expert trainers believe that the positive effects of this so-called cascade training have not yet materialized because of a lack of funds and competing country priorities. One of the improvements that is likely to continue is the problem-solving teamwork approach in the PQI integrated programs.

The principal constraint to answering the key review question was the nature of the evidence that demonstrated the desired improvements at the time of this review. It is the early impression of the team that progress has been made and that MNH is working toward verifiable results.

Promising Approaches

One of the MNH Program's promising practices is performance quality improvement in maternal care. PQI links communities, traditional healers, intermediate facilities, and health workers with the health facilities where infrastructure and performance improvements are taking place. The forthcoming country program data may capture improvements in program quality and performance and consequent changes in utilization. The potential for broad impact has been achieved in Guatemala, where maternal care PQI systems are used in hospital and facility improvement and accreditation, and where community and social mobilization activities have linked the community with facility improvement and outreach activities. PQI approach programs have also emphasized objective, quantitative data for measurement of changes in service utilization, quality, expansion, and, to some extent, access.

The MNH Program promotes birth preparedness and complication readiness (BP/CR) as a way to improve skilled attendance at birth. The program has developed a BP/CR matrix that includes behaviors and practices that improve BP/CR at multiple levels—from the individual woman, her family, and her community, to the provider, facility, and relevant policy makers. While the BP/CR framework is an excellent from a conceptual perspective because it can be modified for different purposes, it has been underutilized by the program. The BP/CR matrix has great potential as a strategic planning tool for program managers, nongovernment organizations (NGOs), and others to monitor and measure program progress. It also has potential value as an advocacy tool and for use in informing a monitoring and evaluation plan. In addition, the BP/CR Index, currently under development, has potential use as a monitoring tool for program managers, NGOs, and others.

The White Ribbon Alliance (WRA) is a worldwide, grassroots maternal and neonatal health advocacy movement that was originally motored by a coalition of interested individuals and groups from U.S. private voluntary organizations (PVOs), consulting firms, professional organizations, international donors, and political figures. The WRA has now been taken up by NGOs in an increasing number of countries. Of important note is the recent establishment of a WRA in India, where the alliance is influencing local and national government policy decisions. MNH contributions to the organizational development of the WRAs in several program countries (through training, logistics, and personnel support) have been instrumental to their success.

The major comparative advantage of the MNH approach to improving maternal and neonatal health is through its clinical training methodology. JHPIEGO is widely recognized by other donors and organizations as an important training resource. Many groups have commissioned its services for their own programs. Its influence in clinical training has allowed it access to ministry and professional organizations in different countries, and this has facilitated the use of the *MCPC* manual in improving clinical norms.

IV. CONSTRAINTS, PROBLEMS, AND AREAS FOR FURTHER ATTENTION

This section identifies some of the key leadership, technical, and programmatic constraints or weaknesses that hindered the MNH Program and that would benefit from greater MNH attention. The team was asked to identify factors that contributed to the slow start-up of the program as well as current implementation issues.

- **Leadership:** The biggest constraints to the success of the MNH Program have been weak leadership, at the beginning of the program, and a nonsupportive organizational structure. JHPIEGO did not provide the innovative technical or managerial leadership needed to initiate the program in a timely and effective manner. Consequently, program operations during the first two years were slow and characterized by many shifts in focus and priorities. Much of the energy of the new leadership team appointed in year 3 of the program was therefore devoted to getting the program more focused and productive. The new leadership has made many improvements in technical direction and program management.

- **Technical and Program Management Experience:** At program start-up, MNH senior program managers had relatively little understanding of (1) the programmatic complexities and technical issues of maternal and neonatal care programs, including the broader issues of country-level policy, programming, and service outreach; and (2) the issues affecting the demand for, and accessibility to, high-quality services. The early MNH managers were also slow to develop integrated and close relationships among the partner organizations that were experienced in many of these technical and program areas and that could have made stronger contributions.

- **Organizational Capacity:** When the MNH Program CA was awarded, JHPIEGO was fully engaged with implementation of a major USAID agreement for training in reproductive health, which may have affected the speed with which the MNH Program activities were developed and launched. JHPIEGO managers reported the stress that resulted from undertaking two complex and innovative USAID programs simultaneously.

- **Technical Focus:** The MNH Program has focused the majority of its resources on the actions where JHPIEGO has its strongest capability--clinical training. Perhaps because of this, the other MNH partners feel that their technical depth and resources have not always been fully tapped. The impact of clinical training on service delivery systems appears to be limited. Upgraded clinical facilities and operations are often limited to those facilities chosen as sites for practicum training.

- **Technical Modifications**

Nutrition—The MNH Program has not pursued nutrition interventions to the extent originally envisioned in the technical proposal. While the program does not support a stand alone vertical intervention it does include antenatal iron and folate supplementation, recommendations on diet, breastfeeding and infant feeding options for HIV+ women, and

intrapartum nutrition activities. At this point, initiating new nutrition interventions would be difficult and costly.

Antenatal Care—Quality, access, and utilization of antenatal care are not specifically monitored or measured. Antenatal care has been refocused to emphasize the recognition and treatment of birth complications.

- **Capacity Building:** MNH has engaged in activities to build the capacity of counterpart training institutions and local partners, but has not developed explicit capacity-building plans or monitored its own progress, or that of its partners and the NGO/PVO collaborators, for programming in maternal and neonatal health.

- **Policy:** The principal policy activities of the MNH Program have strengthened national clinical standards and protocols. However, their efforts have not addressed other constraints to maternal programs, such as human resources, procurement, logistics and supplies, and legislative changes that may have a critical impact on policies and actions needed to increase the number and proportion of births attended by skilled personnel.

- **Research:** The studies of cost and effectiveness and the analyses of the cost-effectiveness of programs or methodologies that were proposed in the CA did not materialize and, with the approval of the cognizant technical officer (CTO), were eventually dropped from the program plan. Likewise, the MNH research that was envisioned in the SO strategy has not materialized.

- **Monitoring and Evaluation:** The development of the MNH framework for monitoring and evaluating multi-intervention programs in maternal and neonatal health was delayed for more than two years. Moreover, the position of M&E director within JHPIEGO has been vacant at various times, leading to a lack of leadership in this critical arena.

At the time of the MNH review, there was no evidence of the existence of a performance monitoring system that could provide the data on results and changes in access, utilization, or quality that would be needed to translate the program's advocacy, communications, or service innovations into broader policy, action strategies, and programs for decision-making by host governments or USAID.

With the current effort in M&E, the MNH Program's global M&E framework and the reduced and refocused M&E activities are likely to produce information to evaluate and report program efforts to work toward achieving results and outputs at the country level. The major M&E focus is now on analysis of the Burkina Faso, Guatemala, Indonesia, and Nepal country programs.

The country-level M&E activities and results have been used in only a limited way to inform and refine the global MNH Program implementation plans or to inform activities of other country programs.

- **USAID Management:** USAID staff turnover at the initiation of the MNH Program and less- than-optimal support from Global Bureau for Health also reportedly contributed to the slow start-up of program operations. The USAID management team was originally envisioned to include a CTO and a technical advisor and strong support by the SO2 team. For the majority of the program implementation period, there has been a CTO but no technical advisor. SO2 team involvement has generally been limited to reviewing annual work plans and budgets.

V. PRIORITY RECOMMENDATIONS FROM THIS REVIEW

Focused efforts during the remaining months of the program could enable the MNH Program to describe how it has made measurable progress towards the SO2 results package (RP) indicators and how it will achieve the technical and programmatic objectives and intermediate results described in the CA.

The changes in MNH and JHPIEGO leadership have been constructive. All partners see the current MNH management team as exhibiting a broader and more positive outlook and as competent in managing MNH activities. Closer relationships have been established among the partners. The potential now exists for the USAID and MNH program leaders to jointly make a positive but objective review of past and present achievements and issues, and then decide which technical and programmatic areas would benefit from greater support during the last year of operation. The review team suggests the following priority technical and programmatic areas for focus and concentration for the remaining life of project.

MNH

- Conduct a retrospective review of the MNH Program as a learning experience with all the partner organizations. Make sure that this review covers all major MNH priority interventions. Consider bringing together field program directors and their counterparts with headquarters staff to review what has worked and what has not worked, with a view to improving future MNH assistance efforts.

- Focus resources on a comprehensive MNH M&E system. Ensure that experienced senior staff are assigned to consolidate and analyze existing data to demonstrate progress toward the SO indicator and the achievement of results. Specifically:

    - Analyze local data to demonstrate, for example, the measurable impact of BCI and community mobilization activities on access, availability, and utilization of services. While this information may be available only from the four integrated country surveys (Indonesia, Nepal, Burkina Faso, and Guatemala), its importance cannot be overstated.

    - Assess the extent to which MNH training improvements have had an impact on the quantity and quality of M&NHN services at the country, regional, or local levels (e.g., an increase in the number of providers or facilities providing basic and comprehensive obstetric care in a subregion, district, or country).

    - Document the reasons for the success of the PQI process in countries where it is well developed and how it has led to an increased proportion of births attended by a skilled attendant.

USAID

- Keep focused on global maternal and neonatal health. Direct attention on what was agreed to in the modified MNH CA and what MNH has actually implemented, in order to ensure that program accomplishments and results are adequately documented and communicated.

USAID AND MNH

USAID and MNH currently do not agree on what is meant by "results" and what evidence would demonstrate achievement of results. Therefore, it is necessary for USAID and MNH to

- Reach a clear understanding of how the USAID defines results and how MNH can best show it has achieved such results by the end of the program. The MNH M&E team should have a separate meeting with USAID M&E specialists to reach agreement on definitions and on the actions MNH will take over the next year to show achievement of results.

- Identify the specific outputs, outcomes, accomplishments, and results that the current M&E framework will address, assess, and report. USAID and JHPIEGO should agree on a plan of action and a time line for producing the needed information and documentation.

- Review the M&E plan to ensure that it focuses on capturing only data that will produce significant information for USAID program managers and that have met reasonable quality and validity standards.

- Ensure that all significant MNH activities implemented between 1998 and 2004 are adequately assessed and documented in the final year of operations, and well before the end of the CA in September 2004. Such a record will help establish an operational baseline for setting targets and progress benchmarks for future interventions and programs.

VI. SUMMARY OF PRIORITY CONCLUSIONS AND RECOMMENDATIONS

The MNH review team has reflected on the many lessons learned from its brief review of a complex and challenging program. The most important of these lessons is that there has been a fundamental difference between USAID and MNH with respect to *achieving* results and *working to achieve* results**.** For example, improving the skills of a skilled attendant is *not* the same as increasing the proportion of births attended by a skilled attendant or increasing skilled attendance at birth.

A summary of the review team's priority conclusions and recommendations follows. It is anticipated that USAID and the MNH team will consider these and determine the specific actions they will undertake for the remainder of the program. This section is a condensed version of a more comprehensive list of priority conclusions and recommendations and does not include any explanatory or analytical statements and findings.

MONITORING AND EVALUATION

Conclusions

- The development of an M&E system for multi-intervention programs in maternal and neonatal health was delayed by more than two years. The position of the JHPIEGO M&E director has been vacant for some time, leading to a lack of leadership for the MNH Program in this critical arena. MNH further reduced the M&E function in the fourth year of the program. The MNH Program global M&E framework and the reduced and refocused M&E activities currently identify process-oriented outcomes and outputs and are measuring "working toward results," rather than the results themselves. The framework is not a system; does not identify data sources, methodologies, analysis, responsibilities, or the use of data; and, at the time of the review, was unlikely to produce the information required to evaluate and report program results at the global or country levels.

- Major M&E activities focus on the end-of-program surveys for the integrated country programs in Burkina Faso, Guatemala, Indonesia, and Nepal.

- The BPCRI Index now under development has great potential for use by program managers, NGOs, and others to monitor and measure progress in achieving BP/CR at each of the levels associated with increasing skilled attendance at birth.

Recommendations

- For the remainder of the program, focus resources on a comprehensive MNH M&E system and hire a dedicated MNH M&E director.

- Identify the specific results, accomplishments, outcomes, and outputs that the current M&E framework will address, assess, and report. USAID and JHPIEGO should agree on a plan of action and time line for producing the needed information and documentation.

- Jointly identify any activities in the M&E plans that should be removed, either because they will produce no significant information for USAID program managers or because the quality of the results is unlikely to meet minimum standards. These include items lacking baseline data required to meaningfully assess "before" and "after" states or operational results that have no standard measures.

- Work with the community of experts in monitoring and evaluation of maternal care programs to ensure that such activities contribute to global thinking about indicator development—what has been shown to be appropriate and why.

- Consolidate the elements of the M&E plan to collect and review data across all the program countries, as originally proposed, and attempt to measure the impact or results of program activities on coverage, availability, access, and use of quality services.

- To improve data collection, identify and apply a more appropriate set of process indicators than those proposed in the current framework. Include indicators on coverage and access to and utilization of essential obstetric care (EOC) facilities, such as percentage of women with obstetric complications treated in the updated EOC facilities, the percentage of all deliveries by caesarean section, and met need.

- Complete the BP/CR Index so that is can become a useful tool for determining program achievements. Complete and populate the index during the remainder of the program to demonstrate the positive and negative results of program interventions.

NUTRITION

Conclusion

- Maternal and neonatal nutrition is an important element of an improved maternal and neonatal care approach. Failure to use a defined and monitored set of nutrition field activities has been a major shortcoming of the MNH Program. At this point in program implementation, initiating a new and separate nutrition intervention will be difficult and costly.

Recommendations

- Enhance the BP/CR matrix by defining appropriate nutrition actions for each level.

- When reviewing national policies on maternal care, examine nutrition policies to ensure that they include maternal nutrition.

BEHAVIOR CHANGE INTERVENTIONS

Conclusions

- The BP/CR framework is an excellent conceptual structure for maternal and neonatal care that may be enhanced for other purposes. In the MNH Program, however, this tool has been underutilized.

- Data to demonstrate measurable impact of behavior change interventions in the country programs are generally available at the country level but may not be adequately reported to MNH headquarters.

- Community mobilization may have the biggest payoff in the integrated country programs because it links the community with facility improvement and outreach activities. Documentation of the results of community mobilization activities will be available from the end-of-program surveys.

- By the end of the program, CEDPA will be able to measure the policy impact of the advocacy work of CEDPA and the WRA.

- MNH has not developed explicit capacity-building plans or monitored progress of the capacity development of its local partners, NGO/PVO collaborators, or itself (this includes non-BCI collaborators such as sections of ministries of health capacity to plan and execute program improvements, facility staff planning capability) because the BCI partner, CEDPA, is measuring the capacity of advocacy groups.

Recommendations

- Analyze country–level data to demonstrate the impact of BCI and community mobilization activities on access, availability and utilization of services. While these data may be available only from the four integrated country surveys, the importance of this information cannot be overstated.

- Add guidance to the BP/CR matrix describing how to select appropriate interventions at each level in order to better plan integrated intervention programs at the local, national, or international levels.

- Use the BP/CR tool to enhance program activities in the final program year, to coordinate activities across countries, and to establish a starting point for a more comprehensive M&E system.

- Use the BP/CR matrix to help all MNH partners increase their understanding and awareness of the complexity of maternal care programming.

- Document the factors and interventions that have most contributed to strengthening the capacity of local partners. Describe what capacities have been built and the main challenges in building the capacities of MNH partners in each country.

TRAINING

Conclusions

- MNH uses clinical training as its primary technical approach. The training has improved the skills and self-confidence of the doctors, nurses, and midwives completing the training program.

- Clinical skills assessments that are used as baselines in the training programs have been applied inconsistently across the country programs. As a result, MNH might not be able to document, report, or communicate changes in skill levels.

- The MNH training intervention is not consistently targeting the appropriate health personnel who attend most of the births.

- The program has not consistently addressed with its government partners the logistical requirements for supporting maternal and newborn health. Newly trained providers are frequently assigned to facilities that do not have the equipment and supplies that were available to them during the training.

Recommendations

- Document the change in utilization of services after training personnel in a facility. For example, describe how the training of X personnel to a Y skill level increased the level of care available at Z percent of facilities from B care level (e.g., basic obstetric care) to A care level (e.g., comprehensive obstetric care), and consequently, the use of services increased from ## to ##.

- In order to maximize the impact of the clinical training approach, examine issues such as (1) recommended standards for entry into midwifery education, (2) ways for increasing the number of midwives trained, and (3) options for increasing access to midwifery training in rural areas, where the greatest shortages of midwives exist. In addition, inform the USAID mission and counterparts of the findings.

- Assist authorities and nursing, midwifery, and medical schools with examination of the repercussions of the curriculum revisions in different school settings, including who is trained and how long it takes, and work with the schools to make these changes.

- Collect data on the deployment of trainees, particularly graduates of preservice programs that increase the number of skilled providers, to determine whether the graduates are providing services to women who previously did not have access to skilled birth attendants.

- As part of the closeout of each country program, conduct a gap analysis of the barriers to access in each country setting in order to identify actions that might affect the program results. Make recommendations to the mission and host country as to how they might address these in future programming.

POLICY

Conclusions

- JHPIEGO's collaboration with WHO to produce the clinical manual, *Managing Complications in Pregnancy and Childbirth: A Guide for Midwives and Doctors,* is the major achievement upon which JHPIEGO's training and policy activities are based. This manual is part of the WHO series for the integrated management of pregnancy and childbirth strategy, supported by the WHO, UNFPA, UNICEF, and The World Bank. MNH has used the *MCPC* manual to develop not only national standards of obstetric care but also international standards for midwifery education and professional requirements.

- The principal policy activities of the MNH Program are limited to training and clinical standards developments; they do not include consideration of other important related policy areas such as links with human resources, procurement, logistics and supplies, and legislative change.

- MNH's efforts to support policies that will lead to an increase in the number and proportion of births attended by skilled personnel have not been systematically and effectively planned and applied within the range of realities in the MNH program countries.

- The MNH Program data are not sufficient to systematically translate the program's advocacy, communications, and service innovations into broader policy, action strategies, and programs for decision-making by USAID or host governments.

Recommendations

- Document that the clinical standards adopted on the national level are indeed being applied nationwide and in nonprogram facilities.

- Use the lessons learned and the aggregate results of the program to inform health policy at the national and global levels.

- Conduct a policy assessment of each country program to determine the extent of policy work still needed and whether MNH Program activities will have an impact. Make recommendations for additional activities that USAID or other donors can and should support in future maternal and neonatal health programs.

- Develop a methodology for determining the cost, the effectiveness, and the cost-effectiveness of program interventions, particularly the clinical training methodology and cascade training approach.

- Use locally generated data to document the overall results of the country programs. Carefully analyze, present, and disseminate the data being generated at the facility and district levels in selected country programs.

BALANCE AND EFFECTIVENESS OF INTERVENTIONS

Conclusions

- The MNH Program has focused its technical approach and the majority of its resources on the actions where JHPIEGO has its strongest capability (i.e., clinical training).

- The country-level activities have been used in only a limited way to inform and refine program implementation plans of the global MNH Program or to inform activities of other country programs.

- Integrating community mobilization efforts with facility improvements has resulted in more effective (although not yet measured) birth planning, preparedness, and complication readiness.

- Community mobilization alone cannot eliminate the barriers to access for services.

- One of the promising practices currently used by MNH is PQI in maternal care. The data collected in these programs could be used to communicate improvements in program quality and performance, as well as increases in access and utilization.

Recommendations

- Call on all MNH country program (with special attention to the integrated country programs) human resources, including the partner expertise, to identify the most important and promising program approaches and the lessons learned from them. Document what has and has not worked in community mobilization for maternal and newborn survival, and why.

- Identify what barriers remain in each intervention country, and make recommendations to USAID and other donors on actions needed to address these barriers. Focus the remaining program implementation period on resolving these issues.

- Consider holding a PQI symposium, inviting a team consisting of one MNH person and one MOH person from each country. At the symposium, discuss the PQI approach and develop an action plan for introducing it in the intervention country.

- Develop policy and program guidelines for introducing and applying the PQI approach, using MNH Program experiences as a basis.

- Document, through case studies or operations research, the reasons for PQI success in countries where it is well developed and has led to an increased proportion of births attended by a skilled attendant.

- Document the role and experience of MNH in implementing single interventions within the context of a larger maternal neonatal health program comprising separate interventions and different implementing organizations, and demonstrate how the MNH piece enhances the whole.

- Identify the important program intervention variables developed for increasing the skill of the birth attendant and those that increase the proportion of births that take place in the presence of a skilled attendant.

RESEARCH

Conclusions

- The research that was envisioned in the SO strategy and the MNH proposal has not materialized beyond the baseline and follow-up surveys, and the study on acceptability and safety of Misoprostol use for prevention of postpartum hemorrhage.

Clinical Research

- The MNH research portfolio currently consisted of one study entitled "A Safety, Acceptability, Feasibility, and Program Effectiveness Study of Community-based Distribution of Misoprostol for Prevention of Postpartum Hemorrhage in Rural Indonesia," the results from which will be published in a peer-reviewed journal article and presented at the International Federation for Gynecology and Obstetrics meeting.

Nonclinical Research

- Much of the BCI research being done under MNH, for example, studies undertaken for setting baselines, evaluating message impact, and changing interventions, are not explicitly acknowledged in the overall program as research.

Recommendations

Clinical Research

- Submit study results to USAID before presenting them at an international forum or publishing them in a journal.

Nonclinical Research

- Encourage all the partners that have been involved in operations research for program implementation to summarize their efforts in their final reports.

JHPIEGO MANAGEMENT OF MNH

Conclusions

- The MNH Program now benefits from a skilled and experienced senior manager with a broad understanding of field-based health programs.

- The matrix structure of JHPIEGO has complicated lines of communication, reporting, and assistance with field operations. Field staff and USAID mission staff believe that this structure delayed decisions on program plans and activities that rely on agile financing.

- MNH did not structure and staff the CA partnership to obtain and utilize the talent and other resources needed for effective performance in key areas such as nutrition and perinatal health. Some of the partners have expertise in technology, community mobilization, monitoring and evaluation, and management that, according to them, has not been sufficiently employed.

- JHPIEGO is doing a satisfactory job in the financial management of this program, given the limits of weak program management and resource allocation decision-making, and the difficulties of the university accounting system.

- The financial reporting being submitted by JHPIEGO is beyond that required under a USAID CA and more than sufficient to document whether the program is financially on track.

Recommendations

- For the remaining program period, streamline communication channels between MNH field staff and headquarters so that MNH field office directors report directly to the MNH program director instead of to the JHIEGO geographical offices. At the end of the program, compare experiences and identify which option provides the more efficient channel for communication between headquarters and the field.

- Seize the opportunity of program closeout to gather technical and programmatic lessons learned and to determine what MNH might have done differently. Bring together the full talent of each of the organizations to analyze the MNH experience and make recommendations to USAID for innovative future programs.

- Conduct a postprogram review on the MNH Program as a learning experience with all the partner organizations, specifically concerning PQI and the training approaches.

- To facilitate understanding of the budget and reports, ensure that the budget and expenditure categories match in all MNH documentation.

USAID MANAGEMENT OF MNH

Conclusions

- USAID program management and support are not what was envisioned in the results package, namely, that a multidisciplinary SO team would be in place that would ensure an appropriate division of labor for comprehensive project management.

- The Bureau for Global Health demanded financial reporting that was more than necessary and sufficient for monitoring a CA and this program.

- USAID did not provide an adequate level of monitoring of overall program implementation or clear written documentation of agreed upon USAID-MNH decisions in response to major program changes. For example, MNH made it clear that its decision to change its IR in 2000 was based on a phone call with the CTO, which they took to be a directive, with no USAID confirming documentation. (The MNH review team had limited access to the CTO's project files. When seeking information regarding specific approvals, the CTO referred the team to the agreement officer, who, in turn, referred the team back to the CTO.) Other instrumental USAID personnel were interviewed.

Recommendations

- Keep focused on the global maternal and neonatal health picture. Pay particular attention to what was agreed in the modified MNH cooperative agreement and to what MNH has actually implemented in order to ensure that program accomplishments and results are adequately documented and communicated.

- Consider creating a program management system and organization in the Bureau of Global Health to provide a division of labor for complex programs such as MNH. This system would include financial analysts, program specialists, and contract and legal specialists who could support the CTO on key program management support tasks.

ANNEX A

SCOPE OF WORK

SCOPE OF WORK

Maternal and Neonatal Health Program (MNH)
Evaluation for Redesign

I. IDENTIFICATION OF TASK

The assignment under this scope of work (SOW) is to assist the USAID Bureau for Global Health, Office of Health, Infectious Diseases and Nutrition, Division of Maternal and Child Health in conducting an evaluation of the Maternal and Neonatal Health Program cooperative agreement. The anticipated start and completion dates for the assignment are o/a January 22 to o/a March 30, 2003.

Activity: The Maternal and Neonatal Health Program No. 936-3092.01 Evaluation (Agreement No. HRN-A-00-98-00043-00)

Contract: Monitoring, Evaluation, Design and Support Project (MEDS) Contract No. HRN-I-00-99-00002-00.

II. BACKGROUND

The Maternal and Neonatal Health (MNH) Program was established in 1998 as USAID's flagship initiative to reduce maternal and newborn deaths in the developing world. The MNH Program is a partnership among four organizations: JHPIEGO Corporation, the Center for Development and Population Activities (CEDPA), Johns Hopkins University Center for Center for Communications Programs (JHU/CCP), and the Program for Appropriate Technology in Healthcare (PATH). The original MNH program cooperative agreement was for five years. MNH was recently extended by one year so that the end date of the program is now September 30, 2004.

The program's mission is to increase access to, demand for and use of appropriate maternal and neonatal healthcare. The program intends to build on progress made by the USAID-funded 1989 Mother Care Project and to support the ongoing efforts of the global Safe Motherhood Initiative launched in 1987.

The MNH Program directly supports the Agency's goal of *reducing deaths, nutrition insecurity and adverse health outcomes to women as a result of pregnancy and childbirth* and the Bureau of Global Health's Strategic Objective 2*: Increased use of key maternal health and nutrition interventions*. The program also supports GH SO3 (*Increased use of key child health and nutrition interventions*) and SO5 (*Increased use of effective interventions to reduce the threat of infectious disease of major public health importance).*

The SO2 Results Package/Activity Authorization Document specifies five Intermediate Results:

1. Integration of appropriate maternal and neonatal nutrition interventions into services;
2. Improved birth preparedness;

3. Improved safe delivery, postpartum and neonatal care;
4. Improved management of complications; and
5. Improved maternal and neonatal health research, policy and programming.

III. PURPOSE OF THE ASSIGNMENT

The purpose of the evaluation is to identify important lessons from the MNH experience that will assist the SO2 team in redesign of the follow-on flagship activity. The Evaluation Team will look retrospectively at the MNH cooperative agreement and expected to answer the principal question: What is the evidence that MNH activities have made or will have made improvements to access, utilization, quality, scaling up and sustainability of maternal and neonatal health programs? The Evaluation Team will also look prospectively at emerging issues and challenges in expanding the availability and quality of the safe motherhood program and future needs to achieve Strategic Objective 2.

IV. SPECIFIC OBJECTIVES

1. Describe the contribution of MNH toward achieving Strategic Objectives 2, 3 and 5.
   a. Evaluate to what extent MNH has met (or is likely to meet in the final year of the program) the technical and programmatic objectives and intermediate results described in the Results Package and the cooperative agreement.
   b. Evaluate to what extent MNH is using a balance of approaches to achieve maximum impact on maternal and neonatal health and survival.
   c. Evaluate the extent to which MNH has contributed to the Global Bureau's program focus on global technical leadership, support to the field Missions and research.
   d. Evaluate the extent to which MNH is collaborating with other USAID-funded cooperating agencies, and other organizations and groups (including the private sector) working in the field of maternal and newborn health, and what has been accomplished.
   e. Evaluate the extent to which MNH has developed and implemented a monitoring and evaluation plan that effectively captures and communicates program results - a monitoring and evaluation plan exists, the system is in place, they effectively communicate lessons learned, what has occurred. What would they do differently?

1. Identify lessons learned from the MNH program experience regarding the demand on the flagship program to provide a range of services, including support to the field, technical leadership and research among others.

1.1. Identify any major programmatic shifts (and the reasons for them) since program inception.
1.2. Determine how funding patterns (source, amounts and earmarks) have aided/hindered MNH in accomplishing results.
1.3. Document the extent to which the diverse USAID customers' (e.g. Missions, Global Bureau, Regional Bureaus) expectations and needs/demands of MNH have been met and how realistic those expectations were.

1.4. Document JHPIEGO's management of the MNH project, including financial and technical/programmatic issues which affected the pace of start up, achievement of results, and communication with USAID/Washington and Missions. Discuss both the resolution of the problems as well as ongoing problems/issues.
1.5. Document USAID/Global/Mission and Regional Bureau oversight and management of the MNH project including issues which affected start up, achievement of results and communication. Discuss the resolution of problems as well as ongoing problems/issues
1.6. Based on information presented in points d) and e), how were the work plans and the approval process used as a management tool for MNH and USAID.

3. Based on information and analyses from objectives #1 and #2 above, identify promising approaches and strategic choices for improving maternal and newborn services (that may include USAID bilateral programs or programs initiated by governments of developing countries, PVOs/NGOs, or programs funded by other donor agencies). Identify issues and options for the redesign of the SO2 program in light of the changing landscape of public health and the changing role of USAID.

4. Chart the sequence (correspondence and gaps) from the RP to the RFA, to the MNH program description (cooperative agreement), to the actual implementation for the main technical lines of work for the MNH Program.

V. AUDIENCE

The audience for MNH includes USAID staff involved in the management of the MNH program (both Washington and the Missions), the various MNH Program partners and other stakeholders.

VI. METHODS AND PROCEDURE (Evaluation Strategy)

The following steps for the evaluation are proposed:

1. Engage in a 3 day team planning meeting to discuss the evaluation scope of work, agree on team member roles and responsibilities, clarify the evaluation expectations of USAID and MNH, draft an evaluation work plan and decide on methodology.
2. The team will take a consultative approach to the evaluation: meet with MNH senior management and USAID CTO during the planning and review process as much as time allows, and will communicate with them on a regular basis throughout the evaluation, providing updates at reasonable intervals.
3. Review all relevant MNH documents and products including the RFA, the proposal, cooperative agreement, annual work plan documents, quarterly reports, management review reports, etc. as determined by USAID.
4. Perform interviews with a representative, sufficient number of key persons involved with the MNH Program, including: key MNH staff, USAID/Washington (both GH and the Regional Bureaus), persons in USAID Missions, and selected partners with whom MNH has worked most closely.
5. Carry out two country site visits (geographically representative), including service sites, where MNH has engaged in longer-term, more comprehensive program implementation.

Countries to be visited are Guatemala and Zambia (selected by the CTO in consultation with MNH and the Missions).

6. Prepare a final report with findings, conclusions, and recommendations, including options, based on a format acceptable to the USAID CTO (MEDS format).

VII. PRODUCTS

1. An evaluation work plan
2. A detailed report outline
3. An oral presentation to MNH partners and USAID
4. A written evaluation report of 25 pages (approximately)
5. An executive summary (of no more than 5 pages), findings, recommendations and conclusions; use of annexes is acceptable

VIII. TIMELINE

1. February/March 2003 for information-gathering and site visits; draft final report to be completed NLT end March 2003.
2. The evaluation should begin o/a January 16, 2003 for a twelve week duration (work will be intermittent but ongoing according to team schedules and work requirements) .
3. Reviewing relevant documents (a list will be provided) will occur prior to beginning the evaluation but will be ongoing as necessary.
4. Developing interview questions and conducting interviews/discussions and other data gathering should occur during the first 4 weeks of the evaluation.
5. A debriefing should be conducted during the fourth week of the evaluation (and others scheduled as appropriate).
6. The final report should be submitted to USAID no later than March 31, 2003.

IX. TEAM COMPOSITION

The assessment team should comprise three individuals who are independent consultants (a Team Leader, a technical maternal health specialist and a USAID program specialist) with the following mixture of expertise and experiences:

1. Maternal and neonatal health technical knowledge;
2. Background in the social sciences and public health; evaluation and design experience;
3. Background of working with public and private health sectors;
4. Experience managing and/or working with USAID-funded projects;
5. Knowledge of USAID;
6. Strategic thinking and planning skills;
7. Familiarity with the international donor environment is desirable; and
8. USAID program management experience.

X. FUNDING AND LOGISTICAL SUPPORT

The Monitoring, Evaluation and Design/Assessment Project (MEDS) will provide the following technical and logistical support to complete the evaluation to inform re-design of the MNH Program.
Specifically, MEDS will:

1. Carry out the necessary preparation activities for the evaluation, including but not limited to the following:
   -Identify appropriate consultants
   -Gather background information for the team, including the project paper, the original RFA, the RFA proposal, the annual work plans, any relevant Mother Care (predecessor projects) evaluations, and any other documents as identified by the CTO.
2. Organize a team-planning meeting with consultants and USAID. The purpose of this meeting is to: introduce the consultants, provide a background briefing, produce a detailed work plan, develop a draft outline of the report, develop preliminary evaluation tools and questions, develop a list of contacts to be interviewed, and determine how USAID will be kept informed of progress.
3. Organize a meeting with the MNH Program staff.
4. Manage and support the team.
5. Submit a final draft (four copies) of the report to USAID for comments and feedback.
6. Incorporate any necessary changes into the draft and submit a final version to the evaluation team leader for approval.
7. Summit final edited report to USAID.

XI. RELATIONSHIPS AND RESPONSIBILITIES

In addition to providing consultants, MEDS will provide all technical, administrative, logistical and secretarial support for completion of the SOW. Technical direction from USAID will be as follows:
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Address: GH/HIDN, RRB , Washington, DC 20523

Draft: revised SH/JMK 09/26/02; Draft revised PS 11/04/02; Draft revised: JMK/SH 12/25/02;
Revised SH:JMK 1/30/03

ANNEX B

PERSONS CONTACTED

PERSONS CONTACTED

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Michelle Kline, Senior Financial Manager

Allisyn Moran, M&E Advisor
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Project Hope

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UNFPA
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Alice Ruano de la Cruz - Area Coordinator
Maria Eugenia de Monroy- Monitoring and Evaluation Coordinator
Ilse Santizo Salazar – Training Advisor
Silvia de Arana – Financial Administrator

Evelyn Rosales – Administrative Assistant
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Ruben Gonzalez –
Vilma Chavez de Pop – Head of Accreditation
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Ministry of Public Health Department of Health Services Development (SIAS)
Sergio Molina
Coordinators of UPSI, UPSII, UPSIII

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Social Worker
Administrator
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Auxiliary Nurses
Representatives of community committees from El Porvenir & San Pablo

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Elisa Barrios
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William De Leon – Basic Nucleus
Zoemia Chew – Basic Nucleus
Mirian Merida – IEC

Solola Hospital and Area Directorate
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Patricia Barahona
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ANNEX C

USAID STRATEGIC FRAMEWORK

USAID STRATEGIC FRAMEWORK

Table 1. Strategic Framework: Population, Health and Nutrition Sector					
Agency Goal	**World population stabilized and human health protected**				
Agency Strategic Objectives	Unintended and mistimed pregnancies reduced.	Death and adverse health outcomes to women as a result of pregnancy and child birth reduced.	Infant and child health and nutrition improved and infant and child mortality reduced.	HIV transmission and the impact of HIV/AIDS pandemic reduced.	The threat of infectious diseases of major public health importance reduced.
PHN Center Strategic Support Objectives	Increased use by women and men of voluntary practices that contribute to reduced fertility.	Increased use of key maternal health and nutrition interventions.	Increased use of key child health and nutrition interventions.	Increased use of improved, effective, and sustainable responses to reduce HIV transmission and to mitigate the impact of the HIV/AIDS pandemic.	Increased use of effective interventions to reduce the threat of infectious diseases of major public health importance.