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MCHIP/Zimbabwe End-of-Project Report



Maternal and Child Health Integrated Program (MCHIP)

Committed to Saving the Lives of Mothers, Their Babies, and Children

October 2010 – April 2014

Table of Contents

About MCHIP/Zimbabwe	4
Impact of MCHIP-supported Activities on MNCH Morbidity and Mortality	6
A Catalyst for Improved Policies in Support of MNCH	8
Improving Quality of MNCH Care through Implementation of the SBM-R Model	10
Shifting the Focus toward Competency-based MNCH Clinical Training	12
Supporting Scale-up of Under-utilized and New MNCH Interventions	14
Supporting Revitalization of Routine Immunization and the Introduction of New and Under-utilized Vaccines	16
Strengthening Integrated Community-based MNCH	18
Cross-cutting Themes	20
Recommendations and Way Forward	22



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Letter from the Director

Dear Colleagues and Friends,

It is my singular pleasure and honor to have this opportunity to present the end-of-project report on behalf of the USAID/MCHIP Zimbabwe team. The three-year project period has certainly moved very quickly and this is a mark of a very busy project. When the MCHIP/Zimbabwe project started in October 2010, the maternal, newborn, and child health (MNCH) indicators for Zimbabwe as later evidenced by the Zimbabwe Demographic and Health Survey of 2010/11 were difficult to discuss in a public forum. However, through USAID/MCHIP's systematic approach to working with stakeholders and partners, we have seen what a difference three years can make. USAID/MCHIP's catalytic approach of influencing national MNCH policy and strategy, supporting development or review of relevant national guidelines, and training national trainers, followed by supporting MNCH implementation and learning in two districts in Manicaland, has been very fulfilling and has borne important fruits. Most satisfying has been seeing maternal, newborn, and child mortality and morbidity trends in Manicaland moving in the right direction (and in fact, the Zimbabwe National Statistics Agency just released key findings from the 2014 Multiple Indicator Cluster Survey showing important decreases in national maternal and infant mortality rates), and experiencing the general improvement in MNCH indicators across Zimbabwe.

MCHIP worked at national level to influence MNCH policy and practice as well as in Manicaland province to scale up new and under-utilized, high-impact, evidence-based MNCH interventions like competency-based training. Two new vaccines that will protect children from pneumonia and diarrhea were introduced during MCHIP. A key role that USAID/MCHIP played was to raise awareness and emphasize quality service provision. The remarkable improvements in MNCH services would not have been achieved without the cooperation, collaboration, and support from multiple dedicated partners. This report provides a bird's-eye view of some of USAID/MCHIP's key achievements. Take time to read the report for more details.

Zimbabwe's gains can be enhanced through continued focus on improving quality of health care, community engagement and involvement in MNCH service provision and use, and support for the health care work force. New ways of integrating community data into the national health information system will also be critical for community intervention planning.

Let me end by thanking all of the MNCH partners for their support and cooperation; the MOHCC at national, provincial, and district levels for their commitment to high-quality health care services; and finally to USAID and the American people for funding USAID/MCHIP for the past and next three years. On behalf of families—especially mothers, newborns, and children—God bless you.

Sincerely,
Prof. Rose Kambarami
MCHIP/Zimbabwe Country Director



About MCHIP/Zimbabwe

Our Vision

MCHIP/Zimbabwe's vision is to significantly contribute to accelerated and sustainable improvement in maternal, newborn, and child health (MNCH) in Zimbabwe by scaling up evidence-based, high-impact, integrated public health interventions.

Our Goal

MCHIP/Zimbabwe's goal is to support the Ministry of Health and Child Care's (MOHCC) efforts to reduce maternal, newborn, and child morbidity and mortality and contribute to the attainment of Millennium Development Goals 1c, 4, 5, and 6 in Zimbabwe.

Our Objectives

From 2010 to 2014, MCHIP/Zimbabwe's activities were informed by the following objectives (which were refined during the course of the program):

- *Objective 1:* Support for national policies, strategies, and guidelines.
- *Objective 2:* Improve maternal, newborn, and child health (MNCH) at health facilities in learning sites and support national-level scale-up plans.
- *Objective 3:* Improve MNCH/family planning (FP) at community level by village health workers (VHWs) and other agents.
- *Objective 4:* Increase routine immunization coverage in Manicaland and support nationwide introduction of pneumococcal conjugate vaccine (PCV) 13 and rotavirus vaccines.

Our Strategy

MCHIP/Zimbabwe worked with the MOHCC and other partners, supporting activities at the national level as well as at selected provincial and district levels. MCHIP/Zimbabwe's strategic approach was guided by the following principles:

- Scale up proven, evidenced-based interventions.
- Maximize resources through strategic integrated programming.
- Build on existing efforts of programs and partners.
- Focus on program learning.

Partnerships

Critical to the success of many of MCHIP's activities was the forging of key strategic partnerships within the Zimbabwean public health community. From 2010-2014, the MCHIP team built strong relationships and collaborated with numerous departments/units within the MOHCC, as well as other USAID-supported projects and partners, NGOs, CBOs, technical partners, and key professional societies and associations.

Where We Worked

Prioritizing populations with the greatest need for intensive support, MCHIP focused its work in Manicaland, a seven-district province with the highest under-five mortality rate reported in the country and among the poorest health indicators. Over the life of the project, MCHIP extensively supported 22 health facilities in two Manicaland districts (Mutare and Chimanimani) to deliver high-quality MNCH services. Collectively, these 22 facilities represent roughly 80% of all deliveries performed in Manicaland facilities. MCHIP also supported scale-up of routine immunization interventions across all seven Manicaland districts.

MCHIP also supported various community-based interventions throughout Manicaland. MCHIP focused on strengthening the quality of community-based health services delivered in Mutare and Chimanimani Districts.

Finally, MCHIP also supported many national-level efforts led by the MOHCC.

Our Key Technical Areas

In keeping with our project objectives, MCHIP/Zimbabwe's key technical areas included:

- **Maternal health/postpartum family planning (PPFP)/prevention of mother-to-child transmission (PMTCT) of HIV:** to reduce morbidity and mortality associated with pregnancy, labor and delivery, and the postpartum period.
- **Newborn health:** to reduce illness and death associated with newborn asphyxia, prematurity and low birth weight, and infection.
- **Child health:** to reduce morbidity and mortality associated with the most common causes of childhood illness.
- **Immunization:** to reduce illness and death in children associated with vaccine-preventable diseases through support for activities to improve routine immunization coverage as well as national introduction of new vaccines.
- **Malaria:** to reduce illness and death in pregnant women and children caused by malaria.
- **Nutrition:** to help reduce stunting and prevent underweight children.
- **Cross-cutting/health systems strengthening:** including quality of care improvement; capacity-building and training; monitoring and evaluation (M&E), health management information systems (HMIS), and research; and health promotion, communication, and advocacy initiatives.

MCHIP's interventions were guided by the MNCH priorities of the Government of Zimbabwe's National Health Strategy. MCHIP's activities were designed for the policy, health facility, and community levels and prioritized the continuum of care from the antenatal care period to a child's fifth year of age.



What's Next for MCHIP/Zimbabwe?

Zimbabwe, while showing encouraging gains, has far to go to reduce unacceptably high mortality levels among women and children. In early 2014, MCHIP/Zimbabwe transitioned to a new three-year, USAID-funded Associate Award, and, as during the previous period, supports the Zimbabwe MOHCC's MNCH efforts. In this next phase, MCHIP/Zimbabwe is incorporating lessons from the past few years into its programmatic design. Doing so will increase the odds of success in the future, with the ultimate goal remaining improved health for Zimbabwe's women, children, and families.

Impact of MCHIP-supported Activities on Maternal, Newborn, and Child Morbidity and Mortality

While direct attribution of health outcomes seen in Manicaland from 2010 to 2014 to MCHIP/Zimbabwe's interventions is not possible, positive trends in maternal, newborn, and child health outcomes were observed and include:

- Decreased facility-based early neonatal and intrapartum deaths from more than 60 deaths/1000 births to fewer than 40 deaths/1000 births, by month for the period October 2010 to March 2014, at the 17 SBM-R-supported facilities.
- Decreased number of facility-based deaths from pneumonia and malaria among children under 5 years of age. Pneumonia-case fatality rates decreased from 7.4% in 2012 to 5% in 2013 and to 3% during the period Jan-Mar 2014. Case fatality rates from malaria decreased from 6.9% in 2012 to 1.6% in 2013, a 77% reduction. These gains coincided with the interventions supported by the project to scale up IMNCI trainings, expand QI activities for child health, introduce PCV 13, and improve community case management for malaria by village health workers (VHWs).
- There was a 25% reduction in the total number of severe pneumonia cases in Mutare and Chimanimani between 2011 and 2013, potentially related to PCV 13 introduction in 2012 and other MCHIP-supported interventions at facility and community levels.
- The proportion of diarrhea cases in children under 5 with severe dehydration decreased from 11.8% in 2011 to 7.6% in 2012 and then to 6.5% in 2013. The increase in number of cases with no dehydration may be due to early treatment in the community as well as expanded access to oral rehydration salts (ORS) and zinc at MCHIP-supported facilities.



With support from government and development partners over the past few years, Zimbabwe's health infrastructure and human and material resources have improved greatly. Still, major challenges persist.

Summary of MCHIP Performance (Oct. 2010-Mar. 2014) , by Key Project Indicator:

Indicator	Baseline (Jan.-Dec. 2009)	Life-of-project (LOP) Performance	Notes
Facility-based maternal mortality ratio (MMR)	296/100,000 live births (data from 79 HFs in 2 learning districts) (source: MOHCC, 2009)	246/100,000 live births	LOP figure is from the two districts, Mutare and Chimanimani, and represents the average over the period Oct 2010- March 2014. There were challenges in completeness of data at baseline.
Facility-based early neonatal mortality rate (ENMR)	63/1,000 total births (data from 79 HFs in 2 learning districts) (source: MOHCC, 2009)	37/1,000 total births	LOP figure is from the two districts, Mutare and Chimanimani, and represents the average over the period Oct 2010- March 2014. There were challenges in completeness of data at baseline.
% of MCHIP SBM-R-supported facilities achieving set target for MNH clinical standards	0% of HFs reached at least 80% of MNH standards	76% of HFs (13/17) reached at least 80% of MNH standards	LOP data is from the two districts, Mutare and Chimanimani covering the period Oct 2010- Mar 2014 and represents performance measured in Aug 2013 assessment.
% of MCHIP SBM-R-supported facilities achieving set target for CH clinical standards	0% of HFs reached at least 60% of CH standards	71% of HFs (15/21) reached at least 60% of CH standards	LOP data is from the two districts, Mutare and Chimanimani covering the period Oct 2010- Mar 2014 and represents performance measured in Aug 2013 assessment.
Number of pregnant women receiving first ANC visit	17,215 (data from 79 HFs in 2 learning districts) (source: MOHCC,2009)	68,021	LOP data is from the two districts, Mutare and Chimanimani, and is the cumulative total over the period Oct 2010- Mar 2014. There were challenges in completeness of data at baseline.
Number of pregnant women receiving at least four ANC visits	9,139 (calculated given 71% utilisation rate for ANC 4+ reported in ZDHS 2005/06, multiplied by ZIMSTAT 2011 expected pregnancies for Mutare and Chimanimani)	65,518	LOP data is from the two districts, Mutare and Chimanimani, and is the cumulative total over the period Oct 2010- Mar 2014. There were challenges in completeness of data at baseline.
% of pregnant women receiving malaria IPT2 during ANC	14% (source: national estimate, MIMS 2009)	52%	LOP figure is from the two districts, Mutare and Chimanimani, and represents the average over the period Oct 2010- March 2014.
Number of deliveries with a skilled birth attendant (SBA)	10,460 (data from 79 HFs in the 2 learning districts) (source: MOHCC, 2009)	47,484	LOP data is from the two districts, Mutare and Chimanimani, and is the cumulative total over the period Oct 2010- Mar 2014. There were challenges in completeness of data at baseline.
% of low birth weight (LBW) newborns admitted in KMC	0%	24%	LOP figure is from the two districts, Mutare and Chimanimani, and represents the average over the period Oct 2010- March 2014.
% of children less than 12 months of age who received Penta 3	52.1% (source: Manicaland provincial estimate, ZDHS 2010/11)	94%	LOP figure is from the two districts, Mutare and Chimanimani, and represents the average over the period Oct 2010- March 2014.
% of children less than 12 months of age who received measles vaccination	64.5% (source: Manicaland provincial estimate, ZDHS 2010/11)	92%	LOP figure is from the two districts, Mutare and Chimanimani, and represents the average over the period Oct 2010- March 2014.

The following pages describe some of the approaches the MCHIP/ Zimbabwe team used to achieve these important results.

MCHIP/Zimbabwe: A Catalyst for Improved Policies in Support of MNCH

Given the massive magnitude of need in Zimbabwe, MCHIP's strategic approach at the national level was forging and strengthening key partnerships and collaborations and providing high-quality technical assistance to influence the national public health dialogue. Zimbabwe's economic and social crises over the previous decade had negatively affected not just service delivery at the health facility level, but also weakened planning, coordination, and monitoring mechanisms at the national (and sub-national) level. Within the MOHCC, some posts within key departments/units were unfilled, available staff had few resources at their disposal, and additional technical expertise was needed to move certain initiatives forward. In terms of the external landscape, many donors and implementing partners were present, but coordination, guidance, and oversight were sometimes lacking. MCHIP sought to take on a "catalytic role" by providing much-needed technical and financial support to the MOHCC and its partners to plan; coordinate; build capacity; advocate; assess, monitor, and evaluate; and mobilize resources.

Strategies, guidelines, training curricula, reports, job aids, and health promotion materials—just some of the materials produced with MCHIP/Zimbabwe support.



“Another aspect found innovative was the approach of **working concurrently at policy and operational level. MCHIP sought to demonstrate clearly the operational effectiveness of their intervention, while at the same time working at policy and strategy levels to facilitate an environment that enabled the adoption of their proposals locally and **enhanced the likelihood of their consideration as a national approach**.”**

— USAID End-of-Project Evaluation Report, 2014



“Thanks to MCHIP, the Ministry is now looking at quality.”

— End-of-project evaluation key informant

Specific MCHIP contributions at national level included provision of critically needed technical and financial support for:

- Convening of national-level MNCH technical working groups and coordination committees responsible for advancing the national MNCH agenda.
- Development, finalization, and/or adoption of key MNCH policies/guidelines like the country's first Quality Assurance/Quality Improvement (QA/QI) policy and strategy.
- Development/finalization of national MNCH training curricula and guidelines and support for national-level training-of-trainers.
- Planning, coordination, training, roll-out, and reporting on new vaccine introductions.
- Conducting national-level program reviews, assessments, and evaluations, and supporting a strengthened national HMIS system.
- Human resources support for the MOHCC Child Health Unit and EPI Unit through filling of much needed technical officer positions.
- National-level advocacy, awareness-raising, health promotion, and health communications campaigns.

“MCHIP skillfully cultivated and utilized strategic partnerships and as a result global best practices such as kangaroo mother care, helping babies breathe, emergency obstetric and newborn care, and integrated management of newborn and childhood illnesses are now accepted and promoted by the MOHCC and MNCH donor partners.”

— USAID End-of-Project Evaluation Report, 2014

MCHIP/Zimbabwe: Improving Quality of MNCH Care through Implementation of the Standards-based Management and Recognition Model

When MCHIP began work in Zimbabwe, substantial government and partner efforts were being committed to *increasing availability and utilization* of MNCH services nationwide. In order to build on these efforts (as well as avoid unnecessary duplication), MCHIP focused on not just increasing access to services where needed and boosting client utilization, but also on *improving the quality* of MNCH services being delivered at all levels. For some stakeholders, this focus represented a paradigm shift in terms of maternal, newborn, and child mortality reduction strategies, as it added consideration for increasing *quality* to the traditional focus on increasing *quantity* of services and coverage. Over the life of the project and through substantial advocacy, sensitization, and technical assistance, MCHIP facilitated an important shift toward “**thinking beyond the numbers**” among stakeholders at national and sub-national levels.

Coverage of antenatal care (ANC), skilled attendance at delivery, and postnatal care (PNC) are reasonably high throughout the country. Despite this, maternal and neonatal mortality rates have worsened considerably over the past decade. This implies that while access to and utilization of these services may be high, the quality of care provided may be low. In response to this situation, MCHIP supported the MOHCC in introducing the Standards-based Management and Recognition (SBM-R) approach to improve quality of care in 17 health facilities in Mutare and Chimanimani. Quality improvement (QI) interventions were targeted at

improving the quality of care provided during ANC, labor and delivery, and the immediate postpartum period.

After three years of MCHIP support, 12 of the 17 (71%) SBM-R-supported health facilities met or exceeded the 80% mark for meeting MNH QI standards, compared to zero facilities meeting 80% of standards at baseline.

In 2011, MCHIP/Zimbabwe expanded the SBM-R approach to include quality improvement for child health (CH) services, which was the first time globally that SBM-R had been applied to child health. MCHIP supported SBM-R in 21 Mutare and Chimanimani facilities.

Over a period of two years, nine of the 21 (43%) health facilities receiving MCHIP support met the 80% score for improving quality of care for IMNCI, again compared to zero facilities meeting the standards at baseline. Improved quality of care at lower-level facilities led to reductions in case referrals to higher-level facilities. This means that more patients are being managed appropriately closer to home, which in turn reduces stress, burden, and costs for patients, health workers, and the health system itself.

“**We have to plan now and we go back to our notes and do self-assessment and it makes us comfortable and happy!**”

— End-of-project evaluation key informant

“MCHIP is perceived as overwhelmingly effective in its approach to improving the quality of maternal, child, and neonatal care.”

— USAID End-of-Project Evaluation Report, 2014



Clockwise from upper left: Health facilities in Mutare and Chimanimani Districts were recognised for achieving the minimum set criteria for MNCH quality of care; health workers receive certificates at a SBM-R recognition ceremony; performance recognition awards included gold, silver, and bronze SBM-R medals; and certificates for high-performing facilities and individuals.



“MCHIP’s MNCH interventions have improved quality of care beyond the implementation sites. As a District Nursing Officer, I use SBM-R assessment tools during supportive supervision in all facilities in Chimanimani district. The result is that all health providers feel more confident in managing MNCH services, as well as emergencies, and we have reported a significant reduction in referrals.”

— S. Sifovo, Chimanimani District Nursing Officer

MCHIP/Zimbabwe: Shifting the Focus toward Competency-based MNCH Clinical Training

A key component of MCHIP's quality improvement approach was building capacity of health workers at all levels of the health system. Rather than traditional-style trainings (which tend to emphasize knowledge acquisition), MCHIP shifted to competency-based training (CBT), which emphasizes clinical skills-building.

Throughout the program, MCHIP employed a comprehensive CBT approach that included:

- Development, updating, and/or finalization of training materials.
- Supply of clinical training equipment including anatomical models for hands-on demonstrations, simulation, and practice.
- Incorporation of ancillary topics such as interpersonal counseling, waste management, and recording and use of HMIS data in MNCH trainings.
- Training-of-trainers in key MNCH topic areas as well as practice in applying CBT methodologies.
- Orientation of MNCH supervisors in planning and conducting post-training follow-up.
- Training MNCH supervisors in planning and conducting routine supportive supervision and providing on-the-job training and mentorship to lower-line health workers.



From 2010 to 2014, MCHIP trained more than 800 trainers and 2,500 health workers in key MNCH topics. Trainings took place at national, provincial, and district levels and focused on building clinical capacity of Manicaland health workers. Trainings were designed to increase knowledge, skills, motivation, and confidence, and reinforced other performance quality improvement interventions being supported by the MOHCC and MCHIP.

“Now we don’t panic; we just manage as we were taught using the guidelines.”

— End-of-project evaluation key informant



MCHIP has trained us, supervised us, and supported us!

They demonstrate procedures and skills. They also provide essential small items.

MCHIP didn't just train, they followed up the training; this is very important.



— End-of-project evaluation key informants



Recognizing that health workers are prone to losing knowledge and clinical skills over time (especially in lower-level facilities where providers are unlikely to encounter and manage obstetric or neonatal emergencies), MCHIP researched the extent to which health workers might retain competencies if given support for learner-driven self-study after training completion. In Chipinge District for example, MCHIP provided a small sample of health workers with their own neonatal resuscitation manikins post-training, and encouraged them to review training handouts and practice on the manikins in their spare time to keep their skills fresh. Study results indicated that health workers' knowledge and skills did not deteriorate, rather they **increased** over time.

MCHIP/Zimbabwe: Supporting Scale-up of Under-utilized and New MNCH Interventions

When MCHIP/Zimbabwe first began in 2010, the team identified several high-impact MNCH interventions that had previously been adopted as national policy (and in some cases partially implemented) but that had become “neglected” over time for various reasons. This meant that though these interventions were known to be effective, they were not being rolled out/scaled up to the extent needed to improve health outcomes nationally. Examples of these evidence-based, high-impact interventions included:

- Kangaroo mother care (KMC) for managing low birth weight (LBW) babies.
- The helping babies breathe (HBB) approach for building health worker skills in newborn resuscitation.
- Integrated management of newborn and childhood illnesses (IMNCI) for managing sick infants and children.
- Revitalization of oral rehydration therapy (ORT) corners and scale-up of zinc for preventing and treating diarrhea.
- The reaching every district (RED) approach for strengthening routine immunization services and reaching the “hard to reach.”



MCHIP has trained 478 health care workers in HBB modular training using updated and standardized clinical training packages. Following HBB training at 22 sites in Mutare and Chimanimani Districts, 968 newborns were successfully resuscitated.

“We saved a 700-gram baby with KMC and now it is 6 months old and thriving.”

— End-of-project evaluation key informant

HBB

KMC

MOHCC with intense support and by 2013, eight functioning KMC units had been established and/or refurbished in Mutare (including Mutare Provincial Referral Hospital) and Chimanimani Districts. This was a marked increase in availability of KMC services, relative to the baseline presence of zero functioning KMC units in 2011.

Data from Manicaland indicate that KMC units improved mother/baby health outcomes. Based on case records from Mutare Provincial Hospital for the period October 2011 to March 2012, the average length of stay for mothers/babies who stayed in the normal post-delivery ward (non-KMC unit) was 12.4 days. In contrast, based on case records from the Sakubva District Hospital KMC unit for the period April-September 2012, the average length of stay for mothers/babies in the KMC unit was just 5.3 days. This is seen as a very important outcome, as shorter hospital stays meant that: 1) the health of babies

MCHIP's efforts to "rejuvenate" kangaroo mother care (KMC) were met with great success. In Manicaland, MCHIP provided the

receiving specific KMC care improved faster than that of babies receiving generalized emergency care in non-KMC wards; 2) KMC services were reducing the amount of time LBW babies spent in the LBW "danger zone;" 3) shorter stays in the health facility meant reduced exposure for mothers/babies to nosocomial (hospital-acquired) infections; 4) admission of babies into dedicated KMC units resulted in reduced case loads at referral hospital level, thereby freeing higher-level resources for patients requiring more specialized care; and 5) reduced costs associated with hospitalization for families, facilities, and the public health system.



Over the life of the project, the proportion of LBW babies in Manicaland admitted to KMC units increased from 4% to over 45%, with KMC register data indicating consistently full bed (ward) utilization. MCHIP plans to expand its support for KMC revitalization in other areas of Manicaland to increase access to this life saving practice.

"KMC had been well forgotten but MCHIP reintroduced it."

— Sister in Charge, Community, Mutare Province



MCHIP revitalized oral rehydration therapy (ORT) corners in all 73 Mutare and Chimanimani facilities after 2011 baseline data showed that only 35% of all facilities in the two districts had an established and functional ORT corner. MCHIP provided ORT corner materials and supplies and supported the MOHCC in scaling up the "7-point plan" for diarrhea management. A major MCHIP priority in this area was improving health worker knowledge of zinc and scale-up of zinc prescription and low-osmolality oral rehydration salts for all children with diarrhea. This included training health workers in diarrhea treatment protocol, monitoring prescription patterns during supportive supervision visits, and distributing job aids and BCC materials to facilities.

MCHIP/Zimbabwe: Supporting Revitalization of Routine Immunization and the Introduction of New and Under-utilized Vaccines



Prior to 2011, Zimbabwe's Expanded Program on Immunization (EPI) program was facing a number of challenges including limited human and material resources in the MOHCC EPI Unit that led to partial national implementation of activities like the RED approach; limited coverage of immunization-related training for health workers at sub-national levels; outdated immunization schedules; the "verticalization" of EPI activities; limited number of vaccine antigens; and community reluctance to immunize children. In response to these challenges, MCHIP provided technical and financial support to the MOHCC at national and sub-national levels in the areas of planning, coordination, policy, capacity-building, M&E, and community mobilization for routine immunization. MCHIP's goals for immunization were primarily two-fold: to support the Zimbabwe EPI program nationally and to increase routine immunization coverage to at least 80% in every Manicaland district.

Over the course of MCHIP, technical support for routine immunization included:

- Secondment of an EPI technical officer to the national EPI Unit.
- Technical support for updating the EPI comprehensive multi-year plan.
- Facilitation of the revision of the national immunization policy and various implementation guidelines.
- Facilitation of the revision of the national immunization schedule and updating of the child health card.
- Support for updating/finalizing national training materials and field guides (e.g., in Reaching Every District, Immunization in Practice, and Training for Mid-Level Managers).
- Training of national trainers and support for cascade training of more than 350 health workers in all seven districts of Manicaland and elsewhere.
- Support for data quality self-assessments in all seven districts of Manicaland Province to improve immunization data quality and usage.



Vaccine carriers enable health workers to keep vaccines cold while they are transported to community outreach events (shown in the photos above and right). Vaccines are temperature-sensitive, so keeping them cold is critical for maintaining their potency.

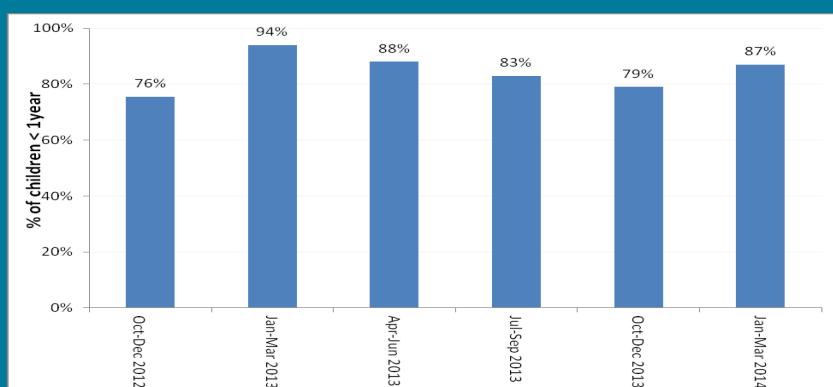
MCHIP also provided strategic support to the MOHCC in the introduction of two new vaccines: pneumococcal conjugate vaccine (PCV) 13 for protection of children against certain types of pneumonia, and rotavirus vaccine to protect children from certain types of diarrheal disease. MCHIP technical support for new vaccine introduction included:

- Development of GAVI proposals for introduction of new vaccines.
- Participation in technical working groups tasked with planning, coordination, and monitoring new vaccine introduction activities.
- Development of training materials and field

guides for PCV 13 and rotavirus vaccine introduction.

- Health system strengthening (e.g., cold chain strengthening, updating the HMIS).
- New vaccine launch activities and national roll-out of health worker training.
- PCV 13 post-introduction evaluation.

PCV 13 was introduced by the MOHCC in July 2012. The figure below shows PCV 13 coverage (third dose) in Manicaland province, from the point of introduction to March 2014. During the first quarter after introduction, coverage was below the national target (80%), likely due to initial data recording problems. During most quarters thereafter however, PCV 13 third-dose coverage in the province was above the 80% target.



Percent of children under 1 year who received PCV13 third-dose in Manicaland Province (source: MOHCC Health Management Information System)



MCHIP/Zimbabwe: Strengthening Integrated Community-based MNCH



MCHIP strengthened the capacity of village health workers (VHWs) to provide high-quality MNCH services (including for malaria and nutrition) in their catchment areas. MCHIP piloted a performance quality improvement (PQI) approach that drew heavily from the facility-based SBM-R model. This approach included interventions like innovative peer-to-peer-driven supportive supervision and the use of a standard set of tools to improve community health data collection. For the first time in the history of community-level MNCH care in Zimbabwe, a structured approach was used to measure the quality of care provided by VHWs during antenatal care home visits, postnatal care home visits, and community case management of sick children and adults. Results from Chimanimani District, where MCHIP worked with VHWs using the PQI approach, showed a statistically significant improvement in the quality of MNCH care provided compared to VHWs who did not use the PQI approach. As of the end of the project, the PQI model had gained the interest of stakeholders nationally and has the potential to be adopted and implemented at scale beyond the two MCHIP-supported districts in the future.

MCHIP placed a particularly strong emphasis on building local capacity in the area of malaria community case management. Manicaland experiences high annual malaria incidence and in 2013 suffered a severe malaria outbreak in multiple districts. During this outbreak, MCHIP and the National Malaria Control Program supported community-level malaria sensitization and training for over 500 community leaders. Throughout 2012-2014, MCHIP also trained health workers in malaria case management at facility level and VHWs in malaria community case management using national guidelines. Subsequent review of MOHCC data indicates that VHWs have increased coverage of early screening, diagnosis, and treatment of uncomplicated malaria at community level and that this has likely averted excess morbidity and mortality due to malaria.



“

VHWs and the village health committee now discuss health with people getting the services. The community now works together.

Our communities really appreciate MCHIP services and how the VHWs extended the services!

The community itself appreciates the services and the community quality committee does exit interviews with clients.

”

— End-of-project evaluation key informants



Cross-cutting Themes



In addition to working across multiple technical areas, MCHIP works across several cross-cutting themes, described at right.

Talking about improved integration of services:

“

We are a one-stop shop now.

We are now doing ‘head to toe’ examinations.

With MCHIP we are using a holistic approach and assessing mother and baby together at each visit is reducing the workload.

We care for the needs of the parent as well as the needs of the child at each visit.

IMNCI has improved things; babies are now managed holistically.

”

— End-of-project evaluation key informants



Program Learning:

Testing innovations; generating evidence; sharing lessons.

Integration:

Working across the MNCH continuum of care and prioritizing delivery of comprehensive services.

Equity:

Focusing on hard-to-reach populations; promoting equitable distribution and use of MNCH services.

Measurement:

Helping others monitor and measure their own performance.

Training:

Building skills and knowledge of health workers; developing tools and job aids to improve services.

Scale-up:

Disseminating evidence of promising results and innovations; advocating the adoption of MCHIP interventions.

Quality:

Encouraging stakeholders to “think beyond the numbers;” raising the quality of MNCH care.

Community:

Building capacity of VHVs to deliver high-quality MNCH services; increasing community access to services.



Recommendations and Way Forward

Zimbabwe, while showing some encouraging gains, has far to go to reverse the unacceptably high mortality levels among women and children under five. In early 2014, MCHIP/Zimbabwe transitioned to a new three-year, USAID-funded Associate Award, and, as during the October 2010-April 2014 period, continues to support the Zimbabwe MOHCC's MNCH efforts. During this next phase of the project, MCHIP/Zimbabwe is incorporating the following recommendations into its programmatic design. The MCHIP team is confident that this will increase the odds of meeting the ultimate program goal of improving the health of the country's women, children, and families.

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

- Continue to advocate/support provision of high-level coordination for MNCH activities within the MOHCC to strengthen national-level strategic planning, coordination, and program implementation.
- Continue to support the MOHCC's efforts to develop evidence-based national policies, standards, guidelines, and training packages.
- Continue to advocate for a "beyond the numbers" approach to providing high-quality health care nationwide and assist the MOHCC

to identify a single national approach to QI.

- Advocate for inclusion and standardization of high-impact MNCH packages and competency-based training (CBT) approaches into pre-service education curricula.
- Improve MNCH service integration by working with partners and providing technical support to MOHCC counterparts to ensure that current national ANC and PNC platforms are used to strengthen malaria in pregnancy (MIP), maternal nutrition and anemia, IYCF, PMTCT, and PPFP/PPIUD interventions.
- Continue to support the MOHCC in the areas of health information systems and M&E.
- Continue technical assistance and support for national MNCH advocacy, communication, and social mobilization activities.

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

- Expand coverage of SBM-R activities to new districts so that health workers can deliver evidence-based integrated services that are respectful and client-centered.
- Increase focus on provincial hospital and high-volume referral sites (i.e., non-learning site district hospitals in Manicaland). Prioritize all Manicaland district hospitals and Mutare Provincial Hospital for additional interventions.
- Simplify SBM-R tools by reducing the number of SBM-R performance standards and verification criteria without compromising the





resulting quality of care. Adapt SBM-R tools so that they have a greater focus on the main causes of MNH mortality and morbidity (e.g., greater focus on critical pathways).

- Revise the SBM-R scoring system to make it less punitive and more encouraging.
- Change the SBM-R approach so that participating health workers are recognized earlier in the process to increase motivation and retention.
- Continue to revise/improve the SBM-R approach as piloted in Zimbabwe for child health, e.g., make tools more responsive to changes in the quality of care delivered to children. Pilot new QI tools to improve quality of services provided to sick children at provincial/district hospital level. In addition, work with Mutare Provincial Hospital to improve in patient care for sick children.
- Involve more partners and engage more policymakers in the quality improvement process to facilitate national-level adoption, scale-up, and roll-out.
- Test new ways to link quality of care improvements to MNC mortality/outcome data.
- Prioritize support for districts with high MNCH mortality and morbidity, and within these, prioritize support for high-impact MNCH interventions and activities such as ENC, KMC, HBB, EmONC, malaria case management, and RED.
- Continue to utilize a competency-based training approach to capacity-building at sub-national level, with a sustained emphasis on post-training follow up, on-the-job training, and supportive supervision.

- Continue to support strategic planning, coordination, data review/M&E, and evidence-based decision-making at provincial/district/facility levels. Continue to provide technical assistance to the MOHCC and seek opportunities to leverage partner resources to amplify MCHIP's technical reach in the province/districts.

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

- Scale up community-based child survival interventions (e.g., early care seeking for pneumonia, reducing indoor air pollution, cIYCF, malaria community case management, use of long-lasting insecticide-treated bed nets), in conjunction with strengthening health facility service provision. Continue, refine, and expand the community PQI approach to one or more additional Manicaland districts and assess results in 6-12 months.
- Prioritize civil society capacity-building by partnering with local civil society organizations (CSOs) and strengthening their capacity to mobilize communities for improved knowledge, access to, and utilization of MNCH services. Working with CSOs will foster further community engagement and facilitate sustainability and local ownership of community interventions.



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Who We Are

From 2008 to 2014, the Maternal and Child Health Integrated Program (MCHIP) was the U.S. Agency for International Development Bureau for Global Health's flagship maternal, newborn, and child health program. MCHIP focused on reducing maternal, neonatal, and child mortality in more than 30 countries, including Zimbabwe.

As of early 2014, MCHIP/Zimbabwe transitioned to a new three-year, USAID-funded Associate Award. As during the 2010-2014 period, under the Associate Award the MCHIP/Zimbabwe team will continue to support the Zimbabwe MOHCC in achieving its maternal, neonatal, and child health goals.

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