Healthy mothers, healthy babies and children

Concept paper: AusAID Initiative to Improve Maternal, Newborn and Child Health in Myanmar

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March 2011

Australian Government
AusAID

Contents

Acronyms

3 MDG Fund	Three Millennium Development Goal Fund
3DF	Three Diseases Fund
AIDS	Acquired Immune Deficiency Syndrome
EU-CP	European Union - Common Position
GAVI	Global Alliance for Vaccines and Immunisation
GFATM	Global Fund to fight HIV/AIDS, TB and Malaria
HIV	Human immuno-deficiency virus
HMIS	Health management information system
HSS	Health systems strengthening
INGO	International non- governmental organisation
M and E	Monitoring and evaluation
MDG	Millennium Development Goal
MNCH	Maternal, newborn and child health
MoH	Ministry of Health
NGO	Non- governmental organisation
OECD	Organisation for Economic Cooperation and Development
PONREPP	Post Nargis Recovery and Emergency Preparedness Plan
TB	Tuberculosis
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USD	United States Dollars
WFP	World Food Programme
WHO	World Health Organisation

Summary of parameters and focus for AusAID's new Maternal, Newborn and Child Health (MNCH) initiative in Myanmar

Improving the health of mothers, babies and children by increasing access to high quality health service provision for all, including marginalised and hard to reach populations, through:

- Antenatal, delivery, postnatal and newborn care provided by skilled health personnel
- Basic and comprehensive emergency obstetric and newborn care
- Birth spacing[1]
- Prompt and effective treatment of diarrhoeal disease, pneumonia and malaria
- Effective preventive and health promotion interventions at the community level

The initiative will address the constraints in the Myanmar health system, including:

- **service delivery** (limited access to MNCH services due to management, infrastructure, supply, logistics, demand-side, financial, geographic and cultural barriers);
- **human resources** (limited training provision, overall shortages and inequity in the distribution of staff, lack of clarity over roles and responsibilities);
- **programme coordination** (limited guidelines and strategic framework for coordination of ministry of health and donor partners' inputs).

The approach will maximise Australia's profile: capitalising on Australia's new development assistance program which, whilst continuing to address humanitarian needs, will focus on rebuilding capacity of the health sector in Myanmar. The approach is guided by the principles of effective and responsible donorship, consistent with the Paris and Accra declarations.

Five key health outcomes are the focus of Australia's Myanmar MNCH initiatives:

- Ensuring evidence-based policies are in place, and improved sector coordination
- An increase in the number of children receiving appropriate case management
- An increase in skilled delivery and of access to basic and emergency obstetric and newborn care
- An increase in the prevalence of birth spacing
- Improved nutrition outcomes for pregnant and lactating women, and of infants and children

Australia has been a significant donor to the health sector in Myanmar but assistance has largely focused on MDG 6 – communicable diseases such as HIV/AIDS, TB and malaria (through the five-year multi-donor Three Diseases Fund, 3DF). It has been the sector where donors, UN agencies and NGOs have made the most in-roads and had the most success. Building on the collective experience of development partners in

1 These activities will comply with Australia's Family Planning and the Aid Program Guidelines (August 2009) (http://www.ausaid.gov.au/publications/pdf/fam-plan-principles.pdf.

Myanmar and Australia's expertise in MNCH, Australia is planning to increase its support to the health sector, with a particular focus on improving the health of mothers, babies and children.

1. Introduction

Progress towards achieving the Millennium Development Goals (MDGs) is central to Australia's aid program. At the MDG summit in September 2010, Foreign Minister Kevin Rudd reaffirmed Australia's commitment to the MDGs, with particular mention of MDGs 4 and 5: decreasing child and maternal mortality. He announced that over the next five years (2010-2015), Australia will contribute $1.6 billion for major advances in the health of women and children.

Underpinning this is Australia's drive to maximise aid effectiveness with a strong emphasis on real development outcomes against the MDG targets. This requires an innovative aid program that is built on and driven by evidence-based policy, and is delivered through appropriate mechanisms and partnerships that drive the aid dollar further.

Myanmar is unlikely to meet any of the MDGs. There is widespread poverty; 32% of the population live below the national poverty line[2]. Myanmar allocates less that USD1 per head per year to the health budget[3]. Improving the health of mothers and children remains a challenge: pregnancy complications are the leading cause of death for women of reproductive age and one in twelve children will die before their fifth birthday. The UN estimates that in Myanmar at least 70 000 children and 2400 pregnant women die annually of largely preventable causes.[4]

Australia has for many years sought to help the people of Myanmar through a program of humanitarian assistance targeting the most vulnerable and disadvantaged. None are more vulnerable and disadvantaged than the women and children of Myanmar whose health status remains poor and who are unable to access basic services. Australia has committed to do more.

In February 2010[5], the Government announced an increase in Australia's aid program to Myanmar to AUD50 million annually to support accelerated progress towards the MDGs. Australia's new development assistance program will continue to address the critical humanitarian needs of the people of Myanmar but it will also focus on rebuilding the capacity of people and institutions in Myanmar to provide for the population's basic needs. This gives Australia more ability to engage in capacity building than other donors bound by the EU Common Position, EU-CP.[6] Health will be a priority sector for Australian assistance.

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2 *UNDP/GoM Integrated household living conditions assessment*, 2007. UNICEF, 2007

3 *World Health Report 2010*. 2010, WHO Geneva.

4 *Child and maternal mortality estimates – IM interagency working groups 2010*.

5 Ministerial Statement, then-Minister for Foreign Affairs Stephen Smith MP. 8 February 2010.

6 The EU Common Position on Myanmar (EU-CP) (April 2006) restricts EU member states aid programs to humanitarian programs only. Article 3 of EU-CP states that non humanitarian aid or development programmes shall be suspended. Exceptions (b) health. The programmes and projects should be implemented through UN agencies, non governmental organisations, and through decentralised cooperation with local civilian administrations. (http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2006:116:0077:0097:EN:PDF).

This concept paper explores a range of opportunities for Australia to support MNCH activities in Myanmar in 2011 and to better position the broader multi-donor MNCH initiative (3MDG Fund) in 2012. The paper also considers additional MNCH activities that could be undertaken under Australia's broader mandate.

John James, international consultant, Joanne Greenfield, AusAID health adviser, and Julia Wheeler, AusAID Senior Program Officer, visited Myanmar 17-30 October 2010. Through an assessment of current MNCH provision in Myanmar (a combination of desk review of relevant documents, meetings with key stakeholders and field visits, they derived an MNCH gap analysis. This formed the basis for the options and recommendations outlined in this paper.

1.1. Principles of proposed engagement

AusAID support to MNCH in Myanmar will be based on the following principles adapted from the Organisation for Economic Cooperation and Development, Development Assistance Committee in combination with global aid effectiveness best practices:

- Aim for equitable access to basic health services to improve the health of women and children - avoid pockets of exclusion – ensure hard to reach and marginalised and the poorest populations are prioritised; give focus to investing in proven interventions, reducing demand side barriers, including geographic, cultural and financial
- Context will be the starting point - a 'one size fits all' approach will be avoided: instead a sound and robust political analysis of the context and sector will underpin Australia's modes of engagement
- Moving from reaction to prevention – supporting capacity building of the people of Myanmar and institutions to withstand the current health threats in the country; whilst maintaining some focus on immediate needs and flexibility to act fast at short notice
- Focus on state building - mobilisation of civil society groups active in the health sector
- Align with local priorities – supporting priorities as identified in the national health plan, child and reproductive health strategies, township health plans and as identified by local and international non-governmental organisations (NGOs) and civil society
- Recognise the political-security-development nexus – through highlighting health sector financing and planning and management issues
- Promote coherence between donor agencies – Australia will strive to undertake joint analysis, assessments, share strategies and coordination of political engagement in relation to the health sector, support appropriate joint funding mechanisms. Where possible Australia will work jointly with other donors, national reformers and civil society to develop shared analysis
- Support practical coordination mechanisms between international actors and health sector officials – promote Australian leadership in sector coordination and support the United Nations, specifically the World Health Organisation to take up its role as lead technical international health agency
- Do no harm – Avoid undermining national institutions including the health system
- Staying the distance – longer term engagement to contribute to capacity building
- Gender equality – principles to ensure gender equality is addressed will be prioritised.

2. What works? Global best practice to improve the health status of women and children

"Piecemeal approaches lead to piecemeal results"
Ban Ki-moon. UN Secretary General. India, November 2010

We know what technical interventions work (Lancet 2003 series)[7], and increasingly the mix of demand and supply side policies and programming required. To maximise impact these need to be delivered from pre-pregnancy, birth and childhood periods and as an integrated essential health package. These interventions include birth spacing, skilled birth attendance, emergency obstetric care, treatment of common childhood conditions and quality post natal and newborn care.

The response requires a combination of the following:

- **Quality Health Services:** Maternal, neonatal and child deaths can occur at any time. This means that good quality services need to be easily and permanently accessible, including trained staff to provide delivery, emergency obstetric and neonatal care and treatment of common childhood illnesses. In addition, medicines, commodities and facilities are required. It is estimated that if women go to clinics with trained staff for midwives and proper equipment, 50% of mothers and newborns could be saved.[8] Improving basic services for managing neonatal problems can reduce deaths from low birth weight and neonatal sepsis by two-thirds[9,] and basic equipment and training for giving oxygen can reduce deaths from pneumonia by 35%[10] Strategies that will improve health service quality for mothers, newborns and children are available and need to be scaled up.
- **Improving geographic access**: providing services in the community such as treatment of common childhood illnesses through 'lay-health workers' can improve breastfeeding rates by 94%, reduce neonatal mortality by up to 60%[11], reduce maternal morbidity but not mortality and reduce child mortality.
- **Reducing financial barriers**: adequate financing of the health sector, removal of user fees for health care and demand side financing such as maternal health voucher schemes have dramatically increased the numbers of skilled deliveries in countries such as Nepal, India and Bangladesh and have increased access for sick children.
- **Birth spacing**: to help families adequately space the birth of their children. UNFPA estimates that preventing unintended pregnancies through access to family planning would avert 32%[12] of all maternal deaths, saving the lives of up to 100 000 women annually.

In addition a wider set of interventions are required including:

- **Addressing the wider social determinants:** Female education, linked to economic status is a critical determinant of maternal and child health. In addition

7 *Knowledge into action for child survival*. Bellagio study group on child survival. Lancet 2003: 262; 323–327.

8 *Countdown to 2015 decade report (2000-10): taking stock of maternal, newborn and child survival*. Lancet, 375: 2032–2044.

9 Duke T, Willie L, Mgone J. *The effect of introduction of minimal standards of neonatal care on in-hospital neonatal mortality*. PNG Med J 2000; 43:127-136.

10 Duke T, Wandi F, Jonathan M, Matai S, Kaupa M, Sa'avu M et al. *Improved oxygen systems for childhood pneumonia: a multihospital effectiveness study in Papua New Guinea*. Lancet 2008; 372:1328-1333.

11 Cochrane Review: Community-based intervention packages for reducing maternal and neonatal morbidity and mortality and improving neonatal outcomes.

12 *Maternal mortality: who, when, where and why*. Ronsmans C, Graham WJ. Lancet 2006, 368;1189 – 1200.

access to clean drinking water and improved sanitation facilities can dramatically improve child health.

- **Addressing countries' health financing gap** through increased more effective and efficient resourcing of the health sector. In most developing countries there is a fundamental lack of health resources often with USD 5-10 per person compared to USD 2000–3000 per capita in developed countries. The World Health Organisation (WHO) estimates that MDG 5 could be met by 2015 if countries invested 15% of their national budgets in health and if official development assistance increased to 0.7% of GNI in OECD countries.

Improving the health of mothers and children requires a holistic approach. Individuals, families, communities, health centres, hospitals and government leadership are required. Countries that have reduced maternal, neonatal and child deaths have demonstrated long-term government commitment and funding over decades to address the social determinants of poor maternal health (e.g. girls' education), whilst increasing access to high quality health services.

3. The status of women's and children's health in Myanmar: situation analysis

Myanmar has a population estimated at 58 million, with a population growth rate of 1.75%[13]. Around 60% of the population are mothers and children; estimated fertility rate is 1.75. Maternal and under-five mortality rates continue to be high; recent UN estimates are 240 per 100,000 live births[14] and 71 per 1000 live births[15] respectively, with significant variation between urban and rural rates.

Myanmar is not on track to achieve the health MDGs.

Table 1: Key maternal and child health indicators in Myanmar

Indicator	Value
Maternal mortality ratio	240/ 100,000 live births
Under-five mortality rate	71/1,000 live births
Neonatal mortality rate	49/1,000 live births
Contraceptive prevalence	37%
Delivery by skilled birth attendant	57%

Source: Health of the World's Children 2010, UNICEF; UN reports; Health in Myanmar 2009, MoH, Myanmar

The leading causes of maternal mortality are haemorrhage, hypertensive disease of pregnancy and abortion-related sepsis[16]. The immediate causes for death in under-fives are neonatal causes (within the first 28 days of life), followed by pneumonia, diarrhoea and malaria[17] Under-nutrition continues as a significant contributing factor to both maternal and child mortality.

3.1. Health Sector Funding for MNCH

Under-funding of the health sector is constraining improvements in maternal and child health. Although public expenditure on health increased between 2002 and 2007[18], the government spends just 0.2% of GDP on health (USD 0.67 per capita). Expenditure on private health care provision is increasing continuously; out of pocket expenditure now accounts for over 88% of total expenditure on health. Combined government and private health care expenditure is estimated at USD 6.20 per capita.[19]

Hospitals account for 41% of the government health budget; ambulatory care 14%; public health programs 19%; and pharmaceutical supplies 5%. There is increasing reliance on the private sector[20] where few can afford the costs of critical care. The 2010 World Health Report states the most crucial element of increasing access is reducing reliance on direct payments. There is some experience in Myanmar that suggests enabling the public sector to deliver free services reduces reliance on the private sector and the out of pocket payments.

13 *Health in Myanmar 2009*, Ministry of Health, Myanmar.

14 *Trends in Maternal Mortality: 1990–2008 Estimates developed by WHO, UNICEF, UNFPA and the World Bank*. WHO,2010.

15 *Levels and trends in Child mortality: Estimates developed by the UN inter-agency group for child mortality estimates*. UNICEF 2010

16 *Nationwide cause specific maternal mortality survey*, DOH, Myanmar 2005.

17 *Nationwide overall and cause-specific under-five mortality survey*, DoH/UNICEF, Myanmar 2003.

18 *National Health Accounts 2002–2005*. MoH, Myanmar, 2008.

19 *National Health Accounts 2006-2007* (unpublished). MoH, Myanmar, 2009.

20 Three Diseases Fund Scoping Mission on options for future funding to health May 2010.

3.2. External support for MNCH services

External aid flows to the health sector in Myanmar are amongst the lowest in the world[21], less than USD 6 per capita as compared with USD 62 for Laos and USD 52 for Cambodia.[22]

WHO, UNICEF and UNFPA are actively engaged in supporting MNCH programmes. Their activities include: policy support to MoH; immunisation programmes; Women and Child health programmes in more than 180 townships; and nutrition programmes. The World Food Programme provides nutrition support in 5 states. Many NGOs and INGOs providing MNCH services are supported by bilateral donors. The Post Nargis Recovery and Preparedness Plan (PONREPP) provides MNCH services to four townships badly affected by the cyclone.

3.3. Needs and challenges

The team conducted a gap analysis of MNCH services through a desk review of key documents, in-country stakeholder meetings (MoH, UN agencies, bilateral donors, and INGOs and NGOs), and field visits to three townships

The analysis was directed towards achieving universal access to comprehensive MNCH services – with an emphasis on hard to reach areas – by addressing the principal causes of maternal and under-five mortality through ensuring:

- Antenatal care: safe delivery by a skilled birth attendant; postnatal care
- Access to Basic/Comprehensive Emergency Obstetric and Newborn Care (B/CEmONC)
- Increased access to birth spacing services
- Effective community based and facility case management of pneumonia and diarrhoea and diagnosis and treatment of malaria

Analysis of the health system showed the following gaps

- Inadequate health sector funding
- Policy framework gaps: While the Ministry of Health has clear and targeted strategies for reproductive health and for child health, gaps remain in the policy framework. These include: increasing access to services through community level management and treatment of common childhood illnesses; removal of financial barriers to access and alternative financing methods for the health sector.
- Limited health management information systems, HMIS: there is considerable variation in the quality of data collection and analysis across the country. Furthermore, the national HMIS does not include data from community activities. As a consequence donors have developed individual monitoring and evaluation systems for specific programmes – for example, the 3DF, PONREPP, and the proposed GFATM programmes.
- Limited and fragmented coverage of MNCH services by NGOs and INGOs
- Limited management capacity at regional and township levels (and recognition of the onerous workload on township medical officers, responsible for coordination of MoH and donor activities, training and supervision of health staff, service delivery, and monitoring and evaluation of services)
- Human resources

21 International Aid flow data from OECD Development Cooperation Directorate.

22 OECD International Development Statistics database, 2009.

  - Inadequate staff numbers - especially midwives, responsible for ANC, intrapartum and postpartum care, EPI, and outreach services
  - Limited roles and responsibilities of health staff (midwives, nurses and auxiliary midwifes)
  - Skills/training: pre-service training not aligned with roles and responsibilities; no structured in-service training, supervision/workplace training

- Service delivery
  - Limited community outreach services
  - Limited community case management of diarrhoea, pneumonia and malaria
  - Lack of drugs, equipment, commodities
  - Limited referral to health facilities (knowledge, geographic, and financial barriers)
  - Poor infrastructure – inadequate facilities for safe delivery, B/EmONC

3.4. Future health funding mechanisms

New health funding mechanisms are coming on-stream in the near future. These will increase significantly external funding of the health sector in Myanmar.

- GAVI Health Systems Strengthening

Myanmar's application for GAVI HSS funding (2008) was successful; it is anticipated that funds (USD 125 million over 5 years) will be released in the near future. 180 Townships will be beneficiaries by year five.

- GFATM round 9

Myanmar's recent GFATM Round 9 proposal has also been successful; the five-year, USD 320 million programme will commence early 2011. Currently, HIV/AIDS, TB and malaria activities have been supported currently through the five-year 3 Diseases Fund, 3DF, established by donor partners in response to withdrawal of GFATM support to Myanmar in 2005. The 3DF ends in December 2011.

- 3 MDG Fund

With GFATM support to HIV/AIDS, TB and malaria confirmed, donor partners' future support will focus on maternal, newborn and child health[23], through the **3 MDF Fund** (USD 250 million[24] 2012 – 2015). The programme design is near completion; final approval by the donor consortium is expected in May 2011.

4. Recommendations for AusAID support

It is proposed that AusAID's MNCH initiative in Myanmar provides support to three key areas:

- equitably **deliver an essential package** of prevention measures and health interventions that tackle the main causes of maternal and childhood deaths;
- support **national level capacity building and policy dialogue** to ensure the right plans and policies are in place to improve the health outcomes of women and children;

23 *Three Diseases Fund: Scoping mission on options for future funding to health*: Reveillon M et al. May 2010, AusAID 2010

24 Current donor partner commitment to the 3 MDG Fund (February 2011).

- support **analytical work** to build the evidence base for this investment and to promote aid effectiveness and value for money principles.

There are two elements to consider:

- implementing MNCH support in 2011 (before the 3MDG Fund commences)
- determining areas for AusAID support both within, and outside, the multi-donor 3MDG Fund from 2012 onwards.

4.1. Recommendations for AusAID support in the short-term (2011 13):

In the **short-term (2 years)** it is proposed to support the following mechanisms to lay the foundation for the broader MNCH initiative.

Recommendation 1: Joint UN MNCH program

This represents an innovative approach to improve UN cohesion, delivering as one UN, supporting our international commitments to multilateral working and strengthening UN reform. A joint UN (WHO, UNICEF, UNFPA) MNCH program offers the opportunity to go to scale and build health system capacity in over 130 townships. In addition it builds upon the UN health agencies existing support to policy dialogue with the central Ministry of Health and further support could maximise the UN's current engagement with NGOs and the private sector.

During their visit to Myanmar, the team invited WHO, UNICEF and UNFPA to submit individual, indicative proposals for potential AusAID funding for 2011. The proposals shared commonality in identifying key areas for support: drugs and commodity procurement and distribution; pre- and in-service training for health workers (government and the voluntary sector); equipping and refurbishment of health facilities in order to provide emergency obstetric care; addressing the barriers to referral; and increasing access to treatment of common childhood illnesses and emergency obstetric care.

A joint UN program that includes strong UN and NGO collaboration is recommended to maximise effectiveness, efficacy and impact in the short-term. UN agencies are already working in over 130 townships, are engaged in policy dialogue and capacity building and able to absorb significant funds at short notice and go to scale quickly. In order to learn from the experience in funding this short-term initiative, a strong evaluation/lessons learned process that examines efficiency and beneficiary accountability should be built into the design of the program

The costed proposal should focus on a limited number of evidence-based interventions (to include community case management, safe delivery, and newborn care). The proposal should provide a clear assessment of individual UN agencies' capacity, identifying roles, and identifying specific staffing, logistical requirements. The proposal should identify clear outputs and indicators, as well as an M and E framework. The necessary upstream policy changes required should also be identified. AusAID will provide international technical support to the preparation of the report.

Recommendation 2: Appointment of an international MNCH expert to coordinate and inform upstream MNCH policy

Appointment of an international expert within WHO to ensure coordination of MNCH and sectoral activities, as well as work with MoH in supporting policy and planning. WHO, UNICEF and UNFPA were all supportive of this recommendation (a similar appointment of a TB expert in WHO has already proved successful). Funded through

AusAID, early appointment to this position would facilitate smooth implementation of the 3MDG fund. Ongoing support for the post may be covered by the 3MDG Fund if deemed appropriate by the 3MDG Fund design team and donors.

Recommendation 3: Analytical work

Commission **analytical work** on key issues to inform the policy agenda: this support is aimed at providing a sound evidence base for government and partners' policy. Potential areas include:

- Healthcare-seeking in the public and private sectors
- Political economy in the health sector
- Aid effectiveness
- Supply-side and demand-side funding mechanisms
- Action research: review of PONREPP projects for lessons learned to inform implementation of the 3MDG Fund

4.2. Options for AusAID support in the medium-term (2012-17)

In the medium-term (2012 onwards) following satisfactory and timely implementation of 3MDG fund it is envisaged **most AusAID funds will be channelled through this pooled mechanism**. (The 3MDG Fund in-country design mission took place 26 November-10 December 2010). AusAID's position, in contrast to that of the EU -CP, provides the opportunity for support to health system strengthening - key to the sustainability of the 3MDG Fund interventions. The donor consortium have indicated that sustainability and system strengthening could be a separate component within the 3MDG fund, thereby incorporating system strengthening support from AusAID within the fund. A decision is expected with the finalisation of the 3MDG fund design (May 2011).

4.3. Summary of short- and medium-term options for AusAID support

The short- and medium-term options are presented in the table below. They are listed against four key outputs, together with indicators. Activities that lie outside the EU-CP, but fall within the health system strengthening component of the 3 MDG Fund are bolded; AusAID could support these directly. Activities marked with an asterisk (and in blue typeface) do fall within the EU-CP but would, introduced in 2011, provide an important platform for the 3MDG Fund.

Table 2: Options for AusAID support to MNCH activities in Myanmar

Outcomes	**Decrease maternal and under five year mortality**	
Outputs	**Indicators**	**Activities ***

Evidence based policies in place & improved sector coordination	Number of analytical pieces of work
	
	Sector coordination framework in place
		• Analytical work*
		  • Healthcare-seeking in the public and private sector
		  • Political economy in the health sector
		  • Aid effectiveness review
		  • Supply-side and demand-side funding
		  • Action research: review of PONREPP projects for lessons learned to inform implementation of the 3MDG fund
		
		Sector coordination, health policy review (eg, community case management)
		
		• WHO MNCH/Sector Coordination Staff position.*
		
		Development of an integrated health management information system, HMIS
		
		• **Technical support to MoH**

Increase % of children receiving appropriate case management	% children adequately treated for pneumonia, diarrhoea and malaria	Vaccines, supplies, essential medicines, micronutrients (sprinkles & Vit A) Improved malaria treatment and prevention (including to combat anti-malarial drug resistance) Health worker training, including CHVs Outreach services Supportive supervision Behaviour change communication
Increase % skilled delivery and provision of newborn care *safe delivery including CEMONC & BEMONC* *appropriate newborn care in the first week of life*	% skilled delivery	**Voucher scheme – demand side financing** **Curriculum development for midwives; training of trainers** In service and **pre service** training of health staff Supportive supervision Newborn care training for AMW and CHW **Refurbishment & construction of health facilities** Establishing maternity waiting homes Drugs, equipment & clean delivery kits

Outcomes	Decrease maternal and under five year mortality	
Increase access to services providing support for birth spacing services	% receiving birth spacing support	Commodities Health worker training

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