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Inspired Leadership. Sound Management. Transparent Governance.

When Midwives Lead and Manage

Illustrative successes in maternal, newborn, and child health

Photo Credit: Brooke Huskey

Maeve Conlin, Monitoring & Evaluation Specialist , The LMG Project

Sarah McKee, Project Associate, The LMG Project

Katie Martin, Project Associate, The LMG Project

amref health africa | IPPF | Johns Hopkins Bloomberg School of Public Health | Medic Mobile | Yale Global Health Leadership Institute | msh Management Sciences for Health

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List of Abbreviations and Acronyms

ANC	Antenatal Care
DMR	Desirable Measured Result
LMG	Leadership, Management & Governance (Project)
L+M+G	Leadership, Management, and Governance (Skills)
M&E	Monitoring and Evaluation
MSH	Management Sciences for Health
RMNCH	Reproductive, Maternal, Newborn, and Child Health
SBA	Skilled Birth Attendant
TOT	Training of Trainers
USAID	United States Agency for International Development

About the LMG Project

Funded by the USAID, the Leadership, Management and Governance (LMG) Project (2011-2016) is collaborating with health leaders, managers and policy-makers at all levels to show that investments in leadership, management and governance lead to stronger health systems and improved health. The LMG Project embraces the principles of country ownership, gender equity, and evidence-driven approaches. Emphasis is also placed on good governance in the health sector – the ultimate commitment to improving service delivery, and fostering sustainability through accountability, engagement, transparency, and stewardship. Led by Management Sciences for Health (MSH), the LMG consortium includes Amref Health Africa; International Planned Parenthood Federation (IPPF); Johns Hopkins University Bloomberg School of Public Health (JHSPH); Medic Mobile; and Yale University Global Health Leadership Institute (GHLI).

1. Introduction

The United Nations Population Fund asserts that midwives could deliver up to 87% of the world's necessary reproductive, maternal, neonatal and child health (RMNCH) services if properly trained and deployed[1]. However, strengthening midwives service delivery skills must go beyond clinical education and incorporate leadership, management, and governance, identified by the World Health Organization as critical components of a functioning health system[2].

To strengthen the competencies of RMNCH service providers in these areas, Management Sciences for Health (MSH) and Amref Health Africa, under the USAID-funded Leadership, Management & Governance (LMG) Project, developed an in-service leadership, management, and governance (L+M+G) certificate course for midwives in Sub-Saharan Africa. First, staff from MSH and Amref Health Africa conducted a skills gap assessment with midwifery managers to identify topics deemed critical for professional preparation, but missing in clinical education, this includes: teamwork and communication, advocacy, coaching and mentoring, data use for decision-making, change management, and strategic problem solving. MSH and Amref Health Africa staff then used existing training materials on these topics to forge a new experiential-learning style program, the LMG for Midwifery Managers Certificate Course.

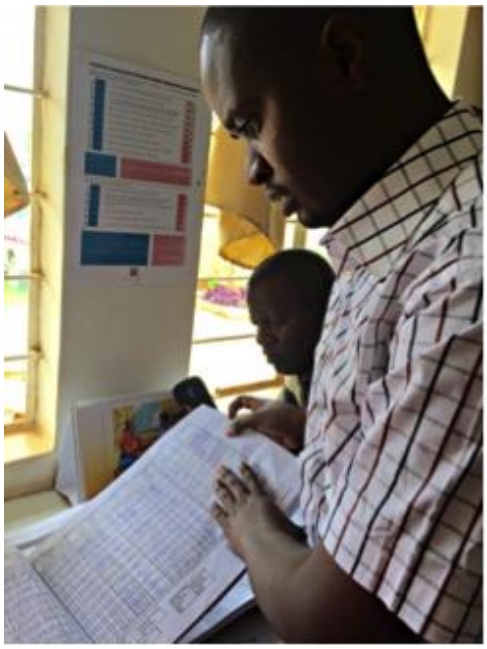


Figure 1: Victor Omido, Kenya, shares an ANC register that collects new data in accordance with his LMG action plan to improve use of delivery services at Kilungu sub-County Hospital. Credit: MSH

The LMG for Midwifery Managers Course consists of a five-day workshop focused on using adult-learning exercises to teach participants the aforementioned six skills. To facilitate this course, two midwifery trainers from each country participate in a Training of Trainers workshop at the Amref Health Africa headquarters. Following this workshop, the trainer pairs then return to their countries and conduct a training to 10 midwife participants.

Following the course, each participant is expected to utilize their new skills to implement a 6-month action plan to address a clinical workplace challenge. This action plan presents priority interventions needed to achieve a predetermined service delivery target, known in the course as a desired measurable result (DMR).

As of December 2015, the course has been delivered in two cohorts involving 99 midwives from ten sub-Saharan African countries with particularly complex MNCH challenges. Each participant was nominated by his or her respective Ministry of Health because of their service in a region with low RMNCH indicators. This selection process has resulted in a diverse mix of male and female participants from both rural and urban areas, and anywhere from 1-30 years of on the job experience.

Using skills learned during the workshop, the 99 participants have developed 88 action plans in two cohorts that aim to improve RMNCH service delivery. Eighty-eight action plans were undertaken

[1] "Midwifery." UNFPA. United Nations Population Fund, n.d. Web. 30 Sept. 2015.
[2] "The WHO Health Systems Framework." WPRO. The World Health Organization, n.d. Web. 30 Sept. 2015.

because while most midwives worked alone, some collaborated on their plans. As of December 2015, **forty-five plans (51%) from both cohorts have met their targets**. Preliminary clinical results from the pilot cohort – examples of which will be shared in this report – demonstrate that this leadership development approach to service delivery improvement is a promising practice for further implementation, evaluation, and scale-up. The data from each participant's action plan from both cohorts can be found in the annex.

2. The Data and Defining Success

In this report, we assess the relative success of participants' plans according to the following criteria:

1. Progress made toward achievement of the target defined in the action plan [note the target is referred to in the course as the Desired Measurable Result (DMR)] and
2. Perceived changes in service delivery due to the utilization of L+M+G skills.

The LMG for Midwifery Managers Course pilot was launched in 2014 in Ethiopia, Kenya, Malawi, Tanzania, and Uganda. The second cohort was delivered in 2015 in Lesotho, Rwanda, South Sudan, Zambia, and Zimbabwe.

Within the **pilot cohort**, 48 midwives were trained and 40 action plans were created. Of the 40 action plans created, 16 teams (40%) met their target goal[3], 12 teams (30%) did not achieve their target, while 12 teams (30%) were lost to follow-up. Improvements reported by midwives at their facilities include increases in: the number of women delivering at facilities with skilled birth attendants (6 teams), the number of women attending ANC during the first trimester (2 teams), reducing the proportion of neonatal deaths (4 teams), availability of cervical cancer screening (1 team), male engagement strategies (1 team), instituting Kangaroo Mother Care (1 team), and reducing postpartum hemorrhages (1 team).

Table 1: LMG for Midwifery Managers Course Action Plans Status

	Cohort 1 (pilot)		Cohort 2	
	# Action Plans	**%**	**# Action Plans**	**%**
Target Achieved *≥80% target*	16	40.0	28	58.3
Target Not Achieved *≤80% target*	12	30.0	8	16.7
Lost to Follow-Up	12	30.0	--	--
Project Ongoing	--	--	12	25.0
Total	**40**	**100**	**48**	**100**

While the second cohort is not highlighted in this report, as their six months projects have not yet concluded, preliminary results on achievements of their projects are available[4]. Within the second cohort, 48 action plans have been developed by participants. Preliminary data from the second cohort shows that some teams have already meet their targets before the end of the 6 months; 28 teams (58%) have already achieved their targeted results and an additional 12 teams (25%) on track to achieve their target.

[3] The LMG for Midwifery Managers Course defines "achievement" of a target as meeting 80% or more or the target at endline data measurement.

[4] After implementation of pilot cohort, curriculum was updated with the strengthening of M&E and follow up with the participants, therefore increasing the number of tracked DMRs and results in the second cohort

3. Data Collection Methods

The cases selected for this report are from the pilot and are illustrative examples of work undertaken by midwives who successfully completed their action plans from the LMG for Midwifery Managers Course.

Quantitative data for progress made towards DMR target achievement was collected from clinic registers. Each team collected monthly data throughout the 6-month action planning period. Baseline was collected by participants before attending the training, or if unavailable, the midwife would use the first month of data after the training as the baseline measurement. The two illustrative examples presented in this report were selected because there was additional data available; allowing for multiple months of pre-implementation as well as 5-8 months post-intervention data collection.

Qualitative data on perceived changes in service delivery due to utilization of L+M+G skills was collected via in-personal key informant interviews. Self-reported changes in eight L+M+G activities were also collected. These activities were deemed to be key factors associated with change from the LMG for Midwives Certificate course but not an exhaustive list of actions undertaken by those completing the course. The activities were as follows:

- Convened stakeholder meetings to discuss action plan
- Convened stakeholder meetings to discuss other workplace challenges
- Developed a funding proposal to obtain necessary equipment/supplies from another organization
- Used service delivery data to make workplace decisions
- Used Root Cause Analysis or the Challenge Model to resolve an additional workplace challenge
- Trained other staff members in L+M+G tools or approaches
- Developed a structured mentoring relationship with another midwife
- Used advocacy skills to promote their project within their clinic or with external stakeholders

The two highlighted cases represent different countries, clinic sizes, and rural or urban communities. It is important to note that the selection of these cases does not imply that they are representative of the larger sample, nor does it seek to assert that other iterations of this course will produce similar results. An evaluation of program results will be conducted once the second cohort has completed the action planning process of both the pilot and the second cohort.

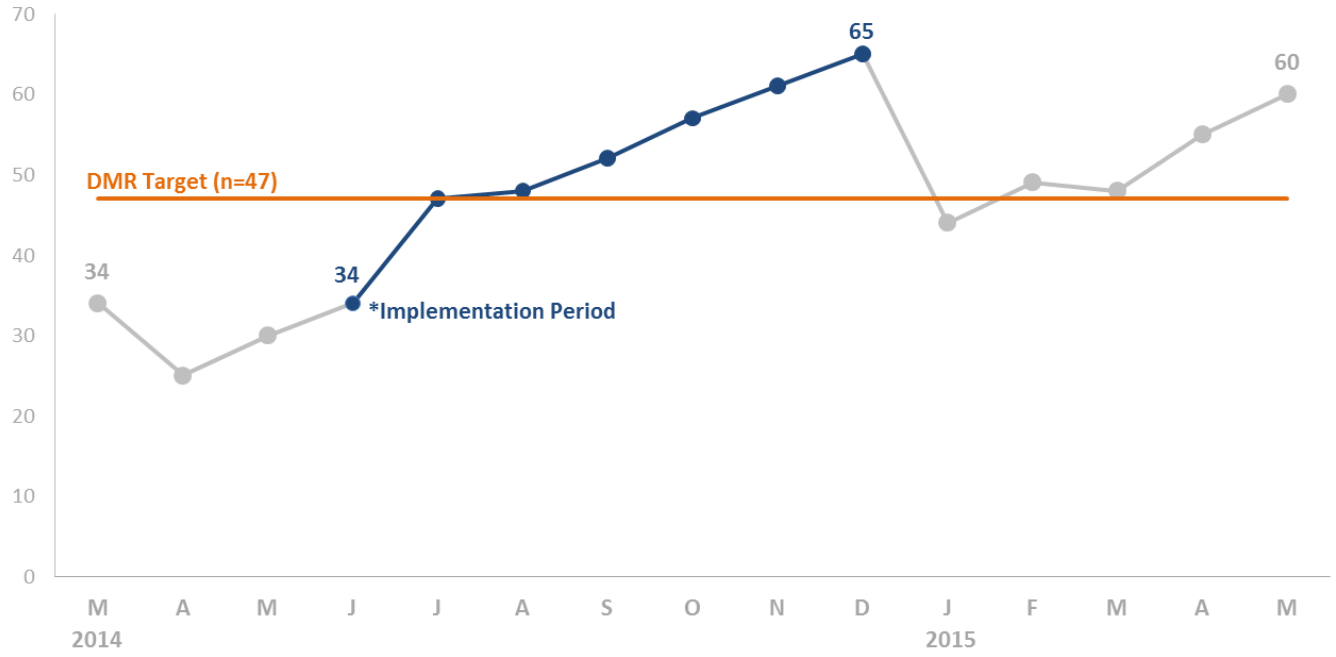
4. Implementation Data from the Selected Cases

Kilungu Sub-County Hospital

Participant: Victor Omido
Country: Kenya
City: Nunguni
Clinic Size: 14 beds (small)
Rural or Urban: Rural
Public or Private: Public

Kilungu Sub-County Hospital is located in rural Makueni County in southeastern Kenya. The participant from this clinic, Victor Omido, utilized his L+M+G training to address **Nunguni's challenge of low utilization of available skilled birth attendant delivery services.** Victor developed the following DMR: "Increase the number of deliveries by Skilled Birth Attendants (SBA) from 34 to 47 per month from July 1, 2014 through December 31, 2014." After completing a root cause analysis[4], Victor determined that the low utilization rate was due in large part to **negative community perceptions of midwifery and ignorance surrounding birthing procedures**. To overcome these challenges, Victor developed an action plan that included instituting outreach days at the local market to invite community members to tour the facility, meet the midwives and learn about their skills, and the available services and procedures. His progress can be seen in the Figure 1.

Figure 1.



[4] A root cause analysis is a method used to identify the root cause of a problem and used for problem solving.

Success Indicators for Kilungu Sub-County Hospital

1. Progress made toward achievement of the action plan target/DMR

Victor made significant progress toward achieving his DMR, far surpassing his initial target of 47 deliveries per month and achieving up to 65 per month at the conclusion of implementation in December 2014; a 91.2% increase from his baseline measurement in June 2014. While this number dropped after the formal conclusion of his 6-month plan, it is worth noting that the lowest post-implementation measurement of 44 deliveries per month still represented a 29.4% increase from baseline pre-implementation. It is possible that this drop can be at least partially attributed to the beginning of the monsoon season, when severe rains often cause mudslides and impede transportation efforts in Kilungu.

Fifteen months of data was provided, giving a clear picture of the clinic's data 3 months prior to implementation, during 6 months of implementation, and 5 months post-implementation[5]. The amount of data provided is particularly useful as it allows us to rule out seasonality as a contributing factor to Victor's success. The last data point (May 2015) shows double the use of skilled birth attendants at delivery compared with the year prior (May 2014).

A key limitation of this example is the lack of comparison with community level birthrate data. Without the community level data on birthrates, we can only follow facility level trends, without comparing the increase in facility level SBA attendance as a proportion of total births within the community.

2. Perceived changes in service delivery due to the utilization of L+M+G skills

After implementing his plan, Victor was promoted to sub-County Reproductive Health Coordinator and reported using 6 (75%) of the surveyed L+M+G skills after his training:

- ✓ Convened stakeholder meetings to discuss action plan
- ✗ Convened stakeholder meetings to discuss other workplace challenges
- ✓ Developed a funding proposal to obtain necessary equipment/supplies from another organization
- ✓ Used service delivery data to make workplace decisions
- ✓ Used root cause analysis or the Challenge Model to work on an additional workplace challenge
- ✓ Trained other staff members in L+M+G tools or approaches
- ✓ Developed a structured mentoring relationship with another midwife
- ✗ Used advocacy skills to promote their project within their clinic or with external stakeholders

The utilization and sustainability of the above L+M+G skills obtained by participants can be seen in the actions taken beyond the 6 month project required for this course. In addition to Victor's project on increasing deliveries involving skilled birth attendants, Victor instituted a number of new programs at his clinic using his L+M+G training: a regional mentorship program, integrated family planning and cervical cancer screenings, and follow-up coaching with mentees (midwives from other low-volume clinics who wished to increase the use of skilled birth attendants). Victor's efforts resulted in a significant expansion of services; as a result, the county government paid to construct three new facilities on Kilungu's premises to absorb the increase in clientele. One of these new facilities will host a ward for caesarian delivery – a procedure previously offered only at the county hospital.

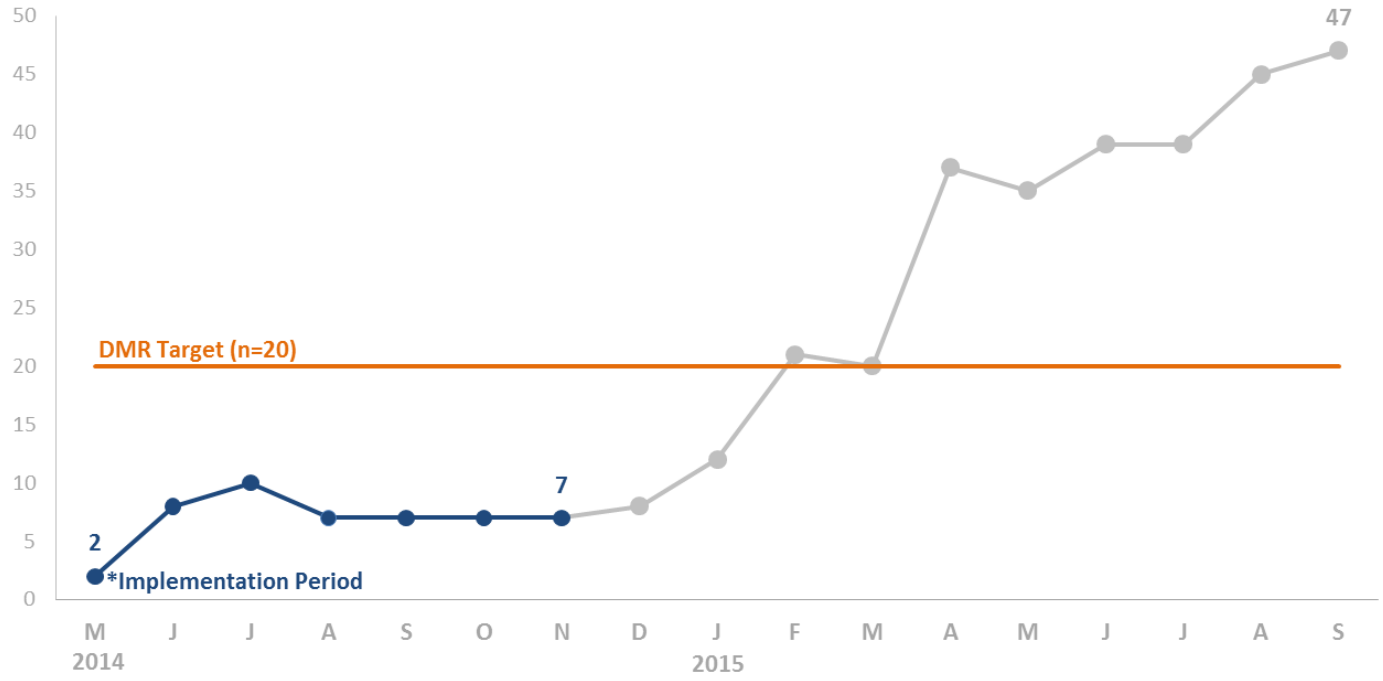
[5] The first month (June) indicates the baseline measurement, while the following 6 months (July- December) are the months of implementation of Victor's action plan,

Mikindani Health Centre

Participant: Jerry Thomas
Country: Tanzania
City: Mikindani
Clinic Size: 16 beds (small)
Rural or Urban: Rural
Public or Private: Public

Mikindani Health Centre in rural southwestern Tanzania achieved significant gains in **male involvement during antenatal care** through the implementation of Jerry Thomas' action plan. Jerry chose to address the community challenge of high maternal mortality rates due to pregnant women delaying coming to the clinic until late stages of labor. He developed his DMR to "Increase the number of first-time male involvements at Mikindani Health Centre from 2 males to 20 males per month from June 1, 2014 through the end of November 2014." After completing a scan of his community and completing the root cause analysis, Jerry determined that poor male involvement in antenatal care (ANC) and a **lack of knowledge about maternal processes prevented women from obtaining timely care**. Jerry implemented a leaflet campaign encouraging male accompaniment to ANC visits and held community workshops on maternal health specifically targeted towards men. His progress can be seen in Figure 2 below.

Figure 2.



Success Indicators for Mikindani Health Centre

1. Progress made toward achievement of the action plan target/DMR

While Jerry did not achieve his target (20 first-time male visits per month) during his 6-month implementation period, he did surpassed this target two months later in February, and his progress continued to steadily increase thereafter. By September 2015, Jerry had achieved a 2,250% increase (47 first-time male ANC visits with partner) from his baseline of 2 visits per month in May 2014 – an impressive accomplishment in just 17 months.

Seventeen months of data was provided, giving a picture of the clinic's data during 7 months of implementation, and for 10 months post-implementation.

Like Victor's data, the amount of data Jerry provided helps rule out seasonality as a contributing factor to his success. The last data point (September2015) shows an almost seven-fold increase in the number of first-time male accompaniment visits, compared with the year prior during the same month (September 2014). Additionally, it provides strong evidence that the progress has been sustained (and expanded) in the 10 months post-intervention.

A major limitation of the information presented above is that only male partner participation was monitored as part of this DMR. Male involvement must be viewed within the context of women attending ANC visits. Without data on the ANC trends for women, interpretation of these data is limited.

2. Perceived changes in service delivery due to the utilization of L+M+G skills

When interviewed in person at a sensitization workshop in Nairobi, Jerry remarked that the LMG training "…has helped me to improve my service, because I have [new] knowledge and power. The training has made me feel more confident." With this newfound confidence, Jerry reported using 3 of the 8 surveyed L+M+G skills while implementing his action plan:

- ✘ Convened stakeholder meetings to discuss action plan
- ✘ Convened stakeholder meetings to discuss other workplace challenges
- ✘ Developed a funding proposal to obtain necessary equipment/supplies from another organization
- ✓ Used service delivery data to make workplace decisions
- ✘ Used root cause analysis or the Challenge Model to work on an additional workplace challenge
- ✓ Trained other staff members in L+M+G tools or approaches
- ✘ Developed a structured mentoring relationship with another midwife
- ✓ Used advocacy skills to promote their project within their clinic or with external stakeholders

Of particular note was Jerry's experience using advocacy skills to engage the local chiefs in encouraging male accompaniment to antenatal care services. This "grass-tops" approach nicely complemented his efforts of grassroots advocacy by engaging with patients directly to impart the importance of both partners actively participating in maternal health services.

5. Data Limitations

DMR Achievement

Specific data limitations for the two DMR examples presented in this report are included in the above sections. For quality assurance purposes, ongoing follow-up and support by the TOT facilitator was meant to ensure quality data was provided by each midwife but verification of each individual facilities' data was not conducted.

Perceived changes in L+M+G skills

Self-report bias, that is the desire for a participant to answer favorably to please the interviewer, is a limitation of the L+M+G skills assessments used in this report. Additionally, these data were only collected at endline. Without a baseline measurement, we are unable to quantify the change in L+M+G skills from before implementation of the LMG for Midwifery Managers course compared to skills reported after completion.

6. Recommendations for Data Quality Improvement

Based on the findings from the pilot cohort of the LMG for Midwifery Managers course, it was recommended that the data monitoring components of the course be strengthened. Modifications of the Midwifery Mangers Course were conducted before the rollout of the second cohort, especially in the monitoring and evaluation section. This included more in-depth work on identification of appropriate indicators, collecting accurate baseline measurements, and wider understanding of key additional data points necessary to make inferences about trends. For example, additional facility or community level data points that relate to a particular DMR would strengthen a claim of correlation between the LMG for Midwifery Mangers course competencies and the improvements in DMRs and service delivery.

The collection of high-quality M&E data can serve as a powerful tool to understand an intervention's impact, serve as quality improvement mechanisms to improve program implementation, and underscore the value of documentation for decision-making. Combining the collection of M&E data with the collection of other success factors can provide a fuller picture of the impact that an L+M+G training can have at the facility and community level.

7. Conclusion

The inclusion of Leadership, Management, and Governance competencies in midwifery training can increase midwives' ability to provide skilled MNCH services to larger populations. The midwives highlighted in this report both described using data to make workplace decisions and training other staff members on L+M+G tools and approaches, while making substantial progress in addressing the service delivery challenges identified at their facility. A final evaluation of both cohorts will be conducted in 2016, to look in aggregate at the links between improved L+M+G skills and changes in service delivery as well as to determine overall integration and sustainability of L+M+G skills for midwifery participants.

8. Annex

Target Not Achieved

Target Achieved

Lost to Follow-Up

Action Plan's Pilot Cohort- Midwives												
Country	*Team Name*	*Gender/Seniority*	*Desired Measurable Result*	*Baseline*	*Mo 1*	*Mo 2*	*Mo 3*	*Mo 4*	*Mo 5*	*Mo 6*	*Target*	*Target Met?*
Kenya Participants												
Kenya	Kaia Dispensary (Veronicah Mwongela)	0M, 1F	To increase the number of deliveries by skilled birth attendants from 2 to 6 per month by December 2014	2 deliveries with SBAs/month	2	1	1	2	1	1	6 deliveries with SBAs/month	
Kenya	Kaiti Sub County (Augustine Mukosi)	1M. 0F	To increase safe delivery by skilled birth attendant in Kaiti sub-county from 27% to 60% by December 2014	27% deliveries with SBAs/month	27%	29%	32%	41%	56%		60% deliveries with SBAs/month	
Kenya	Kilala Health Center (Dorcas Muendo)	0M, 1F	To increase the number of women screened for cervical cancer from 2 to 10 per month by December 2014.	2 women screened/month	0	4	10	11	11	12	10 women screened/month	

Kenya	Kilungu Sub County Hospital (Victor Omido)	1M, 0F	To increase the number of deliveries by skilled birth attendants from 34 to 47 per month from July 1 through December 31, 2014.	34 deliveries with SBAs/month	47	48	52	57	61	65	47 deliveries with SBAs/month	
Kenya	Kyenzeni Dispensary (John Musyoka)	1M, 0F	To increase the number of Antenatal Care mothers attending fourth visit from 1 to 5 per month by December 2014 at the Engavu sublocation	1 ANC visit/month	3	3	3	2	2	0	5 ANC visits/month	
Kenya	Kyuasini Health Centre (Laurenzia Njoki)	0M, 1F	To increase the number of deliveries by skilled birth attendants from 4 to 10 per month by December 2014.	4 deliveries with SBAs/month	6	8	4	1	6		10 deliveries with SBAs/month	
Kenya	Mbuini Dispensary (Elizabeth Kiilu)	0M, 1F	To increase the number of deliveries by skilled birth attendants from 6 to 12 per month by December 31, 2014.	2 deliveries with SBAs/month	6	2	2	5	3	4	12 deliveries with SBAs/month	

Kenya	Mukuyuni Health Centre (Loise Mutuku)	0M, 1F	To increase the number of women screened for cervical cancer at Mukuyuni heath center from 2 to 20 per month by the end of December 2014 .	2 screenings/ month	2	13	4	8	2	14	20 screenings/ month	
Kenya	Musalala Dispensary (Redempta Kiio)	0M, 1F	To increase the number of deliveries by skilled birth attendants from 1 to 10 per month by December 31, 2014.	1 deliveries with SBAs/month	1	2	2	0	1	1	10 deliveries with SBAs/month	
Kenya	Iuani Health Centre (Josephine Kariuki)	0M, 1F	To increase the number of deliveries by skilled birth attendants from 4 to 10 per month by December 2014.	4 deliveries with SBAs/month	8	3	4	3	8	6	10 deliveries with SBAs/month	
Tanzania Participants												
Tanzania	Ligula Hospital Group 1Sophia Mchinjita and Unknown	2F, 2 mid	To reduce perinatal deaths due to birth asphyxia from 48% to 41% per six months by the end of July 2015	48% perinatal deaths due to birth asphyxia per 6 months	5/32: 15%	5/30: 16%	8/35: 22%	5/26: 19.2%	6/15: 40%	4/26: 15.3%	41% perinatal deaths due to birth asphyxia per 6 months	

Tanzania	Ligula Hospital Group 2; Dinah Mhagama and Lucy Mkolea	2F, 2 mid	To reduce sepsis to antenatal and postnatal mothers from 5%-4% by the end of June 2015 at Ligula refferal hospital Mtwara regional.	5% per month	9/46: 19.6%	13/54: 24.1%	9/44: 20.5 %	19/51: 37.5%	16/38: 42.1%	15/44: 34.1%	4% per month	
Tanzania	Likombe Health Center; Sophia Mpunga and Adelina Joseph	2F, 1 junior, 1 mid	To reduce the number of early neonatal death from 5 to 1 every month by end of June 2015.	5 early neonatal deaths/month	2	3	2	0			1 early neonatal death/month	
Tanzania	Newala District Hospital; Debora Vitajohn	1F, 1 mid	To reduce the number of early neonatal death due to asyphyxia from 13 to 10 per quarter by June 2015	13 neonatal deaths/quarter	1	2	2	2	1	2	10 neonatal deaths/quarter	
Tanzania	Mangaka Health Center	2	To reduce the number of neonates admitted monthly due to neonatal sepsis from 4 to 0 by the end of June 2015	4 neonatal sepsis admissions/ month	4	3	3	3	4	3	0 neonatal sepsis admissions/ month	

Tanzania	Mikindani Healthy Center; Jerry Thomas	1M, 1 mid	To increase the number of male involvements at RCH clinics during first visits from 2 males to 8 males per month at Mikindani H/C by the end of July 2015	2 male visits/month	8/36: 22.2%	10/34: 29.4%	7/37: 18.9 %	7/33: 21.2%	7/11: 63.6%	7/7: 100%	8 male visits/month	
Malawi Participants												
Malawi	Daeyang Luke Hospital (Beatrice Chimata)	1F, 1 mid	To increase the number of premature babies initiated on Kangaroo Mother Care by 90%	43% of premature babies inititated on KMC	3/14: 21.4%	8/24: 33.3%	11/24: 45.8 %	5/6: 83.3%	7/15: 46.6%	12/12: 100%	90% of premature babies initiated on KMC	
Malawi	Kamuzu Central Hospital; Pauline Tembo	1F, 1 mid	To reduce the cases of women registered in the admission book with unknown HIV status to 5%	80/458=17.4%	75/578=12.9%	209/607=34.4%	76/442=17.1%	76/422=18	65/378=17.1%	30/390=7.7 %	5%	
Malawi	Kabudula Community Hospital (Isabel Kachipira)	1F, 1 mid	Increase the number of pregnant women utilizing antenatal services during the first trimester from 8% to 15%	8% of women recieve antenatal services	18/180=1%	15/215=6.9 %	24/200=12%	24/205=11.7%	25/191=13 %	27/206=13.1%	15% of women recieve antenatal services	

Malawi	Kasungu District Hospital (Phebby Lodzeni)	1F, 1 mid	Increase the number of pregnant mothers attending ANC in their 1st trimester by 20% by December 2014	6% of mothers in Kasungu District attending ANC in their first trimester	170/3187=5.3%	206/3187=6.5%	293/3187=9%	184/3187=5.8%	198/3187=6.2%	187/3187=5.9%	26% of mothers in Kasungu District attening ANC in their first trimester	
Malawi	Kasungu District Hospital (Bibiana Dzimbiri)	1F, 1 mid	To reduce number of puerperal sepsis cases from 19% to 5%	19% per month	4/712=0.6%	8/711=1.2%	6/784=0.8%	10/883=1.1%	2/741=0.3%	5/824=0.6%	5% per month	?
Malawi	Kawale; Joyce Muhota	1F, 1 mid	Reduce the proportion of PPH (Postpartum hemorrhage) in relation to total obstetric complications by 20% by Jan. 2015.	4/19: 21%	2/15: 13%	5/19: 26%	4/23: 17%	6/27: 22%	0/18: 0%	1/11: 9%	1%	
Malawi	Mitundu Community Hospital; Linvell Nkhoma	1F, 1 junior	Reduce the percentage of neonatal death due to prematurity from 33.3% to <10% by June 2015 and improve KMC documentation	17/37:45.9% of neonatal death	2/12: 16.6%	4/21: 19.04%	4/11: 36.4%	6/21: 28.5%	3/33: 9.09%	7/36: 19.4%	27% lower than baseline of neonatal death	
Malawi	St Gabriels' Hospital	1F, 1 mid	Increase number of pregnant women	3.8	3.8%	5.2%	2.7%	4%	4.5%	5.40%	18.80%	

	(Mary Ngalande)		starting antenatal care during first trimester by 15%										
Malawi	Chileka Health Centre (Thokozani Kumbani)	1 F, 1 mid	Increase the number of deliveries by 10% to an average of 10 clients per month by the end of six months										
Malawi	Kamuzu Central Hospital (Jessie Mwakasungula)	1 F, 1 mid	Health education and number of postnatal check- ups increased by 30% by September 2014										
Uganda Participants													
Uganda	Jinja Referral Hospital; Ateng Florence and Mondo Irene	2F, 2 senior	Increase partograph utilization in monitoring mothers in labour from 30%- 90%	30% utilization	30	50	85	78	85	90	90% utilization		
Uganda	Kawolo Hospital; Participants - Abiria Silvio and Nalumansi	2F	Improving the punctuality of midwives on duty from 30% to 90%	30%	30	30	60	65	80	85	90% of workers report on time		

	Betty											
Uganda	Kiswa H. Center; Aliisa Mariam Frectus	1F	Increase in partograpgh use in monitoring of mothers in labor from 15% to 90%	15	15	15	15	70	90	90	90	
Uganda	Paragon Hospital; Participants - Nakalimo Claire and Nabunya Gorret	2F	Capacity building in nursing documentation from 5% to 90%	15%	15	40	70	70	85	85	90	
Uganda	Domiciliary Home - Kakajo-Namasuba; Participant - Sarah Kikomeko	1F	Capacity building among midwives on partograph utilization in monitoring labor from 50% to 85%	50%	27	24	33	37	42	41	85%	
Uganda	Entebbe Hospital; Mutonyi Walimbwa Roselyn and	2F	Capacity building in nursing documentation from 5% to 90%	3/10: 15%	15	15	33	60	77	95	90%	

	Nasuna Silvia											
Ethiopia Participants												
Ethiopia	Yeka Kifle Woreda 8 Health Center: Delivery Department (Sr.Tsion Damenu)	1F, 1 junior	To increase the average number of deliveries with skilled birth attendants per month from 6 – 12 at the end of Yekatit 2007 EC (2015) in our health center.	6 SBA births/month	5	3	8	13	13	12	12 SBA births/month	
Ethiopia	Guta Meda Health Center (Sr. Hewan Birhanu)	1F, 1 junior	Increase the number of first visit ANC follow up from 4.9% to 9.8%	4.9% (Taking the first month as baseline)	18/366=4.9%	27/366=7.3%	28/366=7.6%	30/366=8.2%	30/366=8.2%	33/366=9.1%	9.80%	
Ethiopia	Addis Ketema Health Center-Millennium Health Center (Sr. Knojit Yifru)	1F, 1 mid	Increase ANC care/skilled birth "package" in health center from 2-3 deliveries/month to 12-19?	2-3 SBA deliveries/month	2	1	2	3	2	5	12 or 19	

Ethiopia	Kolfe Keraniyo Health Center (Yeshialem)	1F, 1 mid	To increase Delivery service by skilled birth attendant from 6.7% to 13.4%.	6.7% (Taking first month as baseline)	20/150=6.7%	9/150=6%	18/150=12%	7/150=4.7%	20/150=13%	26/150=17.3%	13.40%	
Ethiopia	Nifase Silk Lafte	1F, 1 mid (2 people)	To increase Delivery service by skilled birth attendant from 27% to 47% by March 14	27% SBA births/month	10/125=8%	12/125=9.6%	8/125=6.4%	7/125=5.6%	11/125=8.0%	15/125=12%	47% SBA births/month	
Ethiopia	Bole Woreda 10 Summit Health Center	1F, 1 mid	To increase post abortion care services from 0 to 4 at Summit Health Center from Meskerem 13 to Megabit 30.	Zero	A	2	3	3	4	4	4	
Ethiopia	Gulele	2 F, 2 mid	Increase the number of first ANC visit follow-ups from 20% to 40% within six months.									
Ethiopia												