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AFRICAN STRATEGIES FOR HEALTH (ASH) PROJECT ANNUAL REPORT YEAR ONE: 2011-2012

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ACRONYMS

ACD	Advocacy, communication and dissemination
AFENET	African Field Epidemiology Network
AGOA	African Growth and Opportunity Act
ANECCA	African Network for Care of Children Affected by HIV / AIDS
APHA	African Public Health Alliance
APHRC	African Population and Health Research Center
ASH	African Strategies for Health
AU	African Union
AusAID	Australian Agency for International Development
CDC	Centers for Disease Control
CHW	Community health worker
COR	Contracting Officer's Representatives
DHS	Demographic and Health Survey
EAC	East African Community
ECSAHC	East, Central and Southern African Health Community
EPT	Emerging Pandemic Threats
HHA	Harmonization of Health for Africa
HIV/AIDS	Human immunodeficiency virus infection/acquired immunodeficiency syndrome
HSR	Health Systems Research
IDSR	Integrated Disease Surveillance and Response
IPTp	Intermittent Preventive Therapy for Malaria for pregnancy women
ISED	Institut de Santé et Développement
MDG	Millennium Development Goals
MNCH	Maternal Newborn and Child Health
NEPAD	New Partnership for Africa's Development
NIH	National Institutes of Health
OGAC	Office of the U.S. Global AIDS Coordinator
OHA	Office of HIV/AIDS
PMI	President's Malaria Initiative
RH	Reproductive health
RCQHC	Regional Center for Quality of Healthcare
SADC	Southern African Development Community
SMT	Senior Management Team
ST	Strategic Team
TB	Tuberculosis
USAID	US Agency for International Development
USAID/AFR	USAID Africa Bureau
WAHO	West African Health Organization
WHO	World Health Organization
WHO/AFRO	World Health Organization Regional Office for Africa

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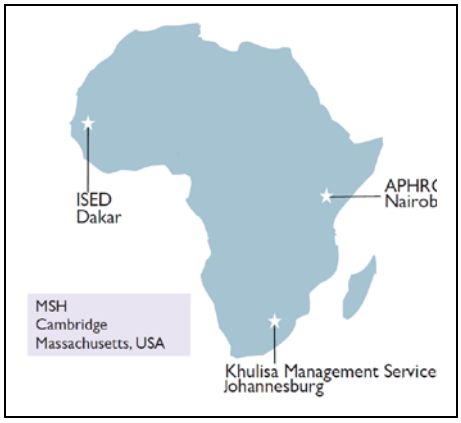
I. INTRODUCTION

The African Strategies for Health (ASH) Project is a five-year contract funded by the United States Government (USG) through the Office of Sustainable Development within the United States Agency for International Development's Africa Bureau (USAID/AFR).

ASH is being implemented by Management Sciences for Health (MSH) in partnership with three core Africa-based partners: African Population and Health Research Center (APHRC), Khulisa Management Services, and Institut de Santé et Développement (ISED) of Dakar University, Senegal. ASH also has collaborative partnerships with selected African regional institutions.



With USAID/AFR funding, ASH works in close collaboration with African health institutions to address and identify constraints impeding the realization of the Millennium Development Goals (MDGs) and the goals of the USG. ASH's key technical areas of expertise include: maternal, newborn, and child health; infectious diseases; health systems strengthening; monitoring and evaluation; as well as communications and advocacy.

ASH works to improve the health status of populations across Africa through a three-pronged approach.

Monitoring and analyzing health issues: ASH gathers knowledge on current trends in health, identifies constraints which prevent progress in improving health in Africa, and identifies solutions for addressing these constraints.

Communicating and advocating for the adoption of promising and best practices: ASH shares information with regional partners about the effectiveness of health interventions, and advocates for the adoption of these practices.

Enhancing technical capacity of African health institutions: ASH engages African regional institutions to address health issues in a sustainable manner and to build capacity in leadership and management. ASH promotes African strategic and technical leadership with the objective of empowering Africans to enhance country ownership.

II. PROJECT START UP

The ASH project was up and running immediately after the award was completed. All technical staff were on board by the end of September 2011. The Director of Finance and Administration, as well

as the Administrative Coordinator were hired by November 2011. Office space and equipment were immediately made available to all staff.

The early months of the project focused on developing the management and financial procedures necessary to run an effective and efficient program. Project guidance was developed for travel, hiring of consultants, processing USAID Contracting Officer's Representatives (COR) letters, making purchases, and reporting. In addition, supervision systems were put in place and all staff received orientation to MSH. ASH also developed clear scopes of work and subcontracts for all three ASH partners (Khulisa, IDRC, and APHRC).

ASH worked closely with USAID/AFR to ensure the project vision, objectives and work plan reflected USAID requirements and needs. A project start-up meeting attended by all USAID/AFR staff involved with ASH was held in late October 2011. A follow up meeting was held in January 2012 to discuss the ASH year one work plan. At the same time, ASH and USAID/AFR held regular management meetings to discuss project progress. Strategic Team (ST) meetings to allow technical staff from both ASH and USAID/AFR to discuss activities began in earnest in early 2012.

During ASH's first year it was absolutely critical to dedicate a significant amount of time to consulting with USAID and other partner organizations, conducting literature reviews, mapping current implementing institutions and their work, analyzing data, listening, and learning. It was especially important for ASH to assess the situation because the project cannot duplicate efforts of USAID/AFR or the Global Bureau or intervene in areas already saturated by activities of other implementing organizations and institutions. Once the background information was collected and synthesized, ASH project staff worked closely with USAID counterparts and international partner organizations to identify the appropriate role for ASH in each of the project's technical domains.

III. TECHNICAL UPDATES

ASH technical activities in year one included reviewing the current trends in health status, examining issues which are impeding delivery of health services, and identifying potential solutions. There are a large number of donors and implementing partners working across the African continent and ASH must stay abreast of the activities and initiatives these development partners are undertaking. The sections that follow detail ASH's accomplishments in each of the ASH technical areas.

MATERNAL, NEWBORN AND CHILD HEALTH

The ASH maternal, newborn and child health (MNCH) team devoted a significant proportion of first year to identifying the most appropriate role for the project. This involved extensive consultations with key global and regional development partners to discuss MNCH priorities and ongoing initiatives. ASH supplemented these consultations with a comprehensive review of the literature focused on global and regional policy, as well as programmatic priorities for MNCH. The literature review included scientific research, policy-oriented documents, and MNCH data analysis. Findings from these sources were synthesized by ASH and discussed with USAID/AFR to reach consensus on the focus of ASH activities.

This initial investigatory phase of ASH's MNCH work led to identification of key partners and establishment of strong, collaborative working relationships with groups such as MCHIP/Jhpiego, the President's Malaria Initiative (PMI), the Saving Newborn Lives Project, Save the Children, the African Union, Australian Agency for International Development (AusAID), and USAID's Global Bureau. A series of meetings held with WHO/AFRO towards the end of year one yielded consensus and plans for collaborate on several maternal, newborn, and adolescent health activities. These relationships create a strong foundation for collaborative work that will continue to be strengthened throughout the project.

Malaria in Pregnancy: IPTp

WHO recommends intermittent preventive treatment for pregnant women (IPTp) with at least two doses of an anti-malarial drug after the first trimester as a key strategy for prevention in areas with high incidence of malaria. Uptake of IPTp varies widely among African countries, but in all countries declines after the first dose.

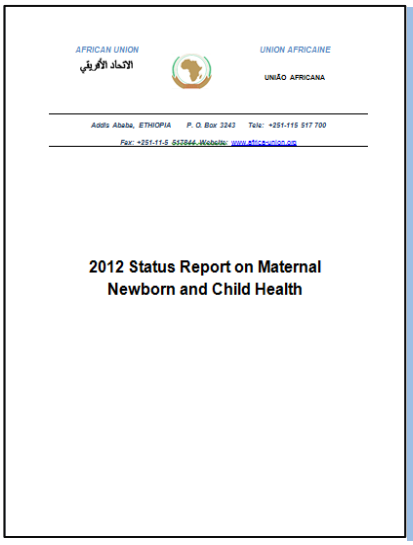
Expansion of IPTp coverage during antenatal care was prioritized in the December 2011 external evaluation of PMI. In collaboration with MCHIP and WHO/AFRO, ASH will undertake facility level reviews of IPTp service delivery during antenatal care in three countries. These assessments will improve the understanding of facility-level factors impeding uptake and implementation of IPTp services from both the supply and demand perspectives. Data from these three facility-level assessments will complement information which has already been obtained from the four more general assessments undertaken by MCHIP.

Utilizing both the MCHIP and the ASH assessment data, ASH will then develop tools/aides for facility managers and providers which will assist them in identifying and overcoming service delivery bottlenecks.

ASH provided technical support to USAID/AFR in preparation for discussions with the USAID Office of HIV/AIDS on the relationships between HIV/AIDS and maternal mortality and between TB and maternal mortality. This involved conducting an extensive literature review and producing a background briefer for use by USAID/AFR staff. The briefer identified programmatic and policy priorities. It also highlighted areas warranting additional investigation, and established ASH as a key resource in this area.

Another area of ASH activity during this first project year was malaria in pregnancy. PMI became interested in ASH and the contribution ASH can make in advancing the agenda for addressing malaria in pregnancy. This led to a request for ASH involvement. In response, ASH began analysis of facility- level data from Malawi that identifies missed opportunities for providing Intermittent Preventive Therapy for Malaria for pregnancy women (IPTp) during prenatal care. This review identified areas needing further investigation and intervention. To address this need, ASH began developing plans to conduct facility level case studies. Through this work, ASH has gained visibility with PMI and established its niche as strengthening facility-level implementation of IPTp. This work will serve as the basis for activities in project years two through five.

ASH provided critical support to the African Union (AU) in revising and finalizing its 2012 Report on Maternal Newborn and Child Health Status which is mandated by the AU's Congress of Ministers of Health. This report is expected to assist the AU and African Ministers of Health in establishing regional and national priorities for MNCH. ASH assistance with this report also helped to strengthen its working relationships with the AU and AusAID.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2012 Status Report on Maternal Newborn and Child Health

ASH made important contributions to the African Union's report "2012 Status Report on Maternal Newborn and Child Health." This report is mandated by the African Union's Congress of Ministers of Health to establish regional and national priorities in MNCH.

ASH made several important contributions to global and regional technical leadership in MNCH. ASH actively participated in the development of the Helping Babies Breathe Global Development Alliance. ASH also participated in high visibility meetings and conferences such as the Programme for Global Paediatric Research's symposium and workshop on childhood diarrheal disease; the Child Survival Call to Action; Advancing Dialogue to Improve Maternal Health; and the Decade of Vaccines Collaboration Consultation.

INFECTIOUS DISEASES

Integrated Disease Surveillance and Response

The major focus of project year one for the Integrated Disease Surveillance and Response (IDSR) team was to develop a strong and collaborative partnership with the key stakeholders who have supported IDSR over the last decade: USAID/AFR, the Centers for Disease Control (CDC), and WHO/AFRO. As part of an orientation process, ASH staff attended a number of meetings with USAID/AFR and CDC to develop a clear understanding of how ASH activities fit into this partnership. Further meetings were held with members of USAID's program on Emerging Pandemic Threats (EPT) to better understand the linkage between IDSR and EPT programs.

In addition, ASH participated in two key conferences: the African Field Epidemiology Network (AFENET) Conference in Dar Es Salaam, Tanzania in December 2011 and a cholera conference in Atlanta in March 2012. The AFENET conference provided ASH with the opportunity to network with colleagues who work on IDSR activities, as well as with representatives from African Ministries of Health. The cholera conference allowed ASH to meet with a range of stakeholders including CDC, WHO, UNICEF, National Institutes of Health (NIH), and the Red Cross.

Communicable diseases are the leading causes of morbidity and mortality in Africa. The continent is also subject to the threats caused by epidemic prone disease. Increasingly, countries are addressing this by integrating efforts to improve human health, animal health, and the environment under the "One Health" concept.

To help countries better manage outbreaks and to reduce the burden of communicable and epidemic-prone diseases under the One Health concept, a strategy for integrated disease surveillance and response (IDSR) has been developed by WHO whereby countries can follow a systematic framework for strengthening their public health surveillance, confirmation, and response systems.

Contributing to the IDSR is the Epidemic and Pandemic Alert and Response Programme (EPT) which brings resources to countries for implementing system components such as laboratory. Since June 2005, International Health Regulations (IHRs) have been in place to contribute to global public health security by providing a new framework for the coordination of the management of events that may constitute a public health emergency of international concern.

Once ASH developed a clear understanding of the project's role in supporting IDSR, ASH representatives travelled to Atlanta in August 2012 and, together with CDC, drafted a joint work plan. The joint work plan was then discussed and finalized during a visit by ASH, USAID/AFR, and CDC to WHO/AFRO in September 2012. Four key activity areas for ASH were outlined in the work plan:

- Undertake an evaluation of IDSR in two to three African countries;
- Develop a communication strategy for IDSR;
- Document progress in the implementation of the Kenyan integrated cholera plan; and
- Provide technical inputs for an e-learning component for IDSR.

While it had been anticipated that ASH and the other IDSR partners would complete the IDSR evaluation framework and protocol in year one, this work was delayed because WHO/AFRO was not available to meet with ASH until the end of year one. ASH contributed to development of a vision and purpose for the evaluation, and in year two, ASH will work with the IDSR partners to complete the evaluation protocol. The goal will be to develop and pilot a tool that African countries can use to evaluate their own progress in order to strengthen IDSR.

The major accomplishment in IDSR technical leadership was in knowledge exchange. ASH identified gaps in knowledge and information about IDSR among partner organizations such as host country governments, the US Department of Defense, and the Gates Institute. The next steps are to create a community of practice with a listserv, conduct exchange visits, and use other mechanisms so that countries, global and regional institutions, and projects can share knowledge and experiences with each other.

Senior ASH staff met with CDC in Atlanta to discuss ways to partner with them and develop a joint work plan for IDSR. During this trip, ASH staff met with a range of stakeholders from CDC to discuss advocacy and e-learning. The joint work plan was finalized in Brazzaville over two days of technical meetings between CDC, USAID/AFR, WHO/AFRO and ASH.

Tuberculosis

ASH began its first year by reviewing the outstanding issues regarding tuberculosis (TB) in Africa. To this end, ASH held a series of consultations with USAID/AFR and with the various TB implementing partners, such as TB CARE I. ASH also completed a comprehensive review of pediatric TB literature and a mapping of institutions implementing pediatric TB activities. The project worked to develop a strong relationship with USAID's Global Bureau and with WHO/AFRO to ensure there was no duplication of efforts. This led to the development of a joint

work plan with WHO/AFRO. Implementation of this plan will be the focus of ASH's year two activities.

Important Components of a Regional-Focused TB Strategy

- Maintain USAID's current technical support footprint
- Develop a regionally-based approach for TB support in West Africa
- Develop strategies to manage important epidemiological drivers such as migration and urbanization
- Use regionally-based activities to strengthen lagging areas of TB control
- Coordinate and harmonize interventions implemented by USAID's regional structures

Per the joint work plan, ASH activities will focus on pediatric TB and will support initiatives aimed at improving service provision. The ASH work plan for year one originally included the development of a study protocol for a standalone pediatric TB assessment in selected countries. After discussion with USAID and CDC, however, it was agreed that ASH will instead work with WHO/AFRO to incorporate a pediatric assessment component into national TB reviews. This will ensure that there is a standardized approach to assessing the implementation of pediatric TB in countries through periodic national TB reviews.

Towards the latter part of year one ASH participated in a series of teleconferences with USAID and CDC that focused on efforts targeted at strengthening pediatric TB in Africa. Significant attention was given to the role that regional institutions such as African Network for Care of Children Affected by HIV / AIDS (ANECCA) could play in strengthening pediatric TB service provision.
Another major accomplishment of ASH in year one was the provision of support to USAID/AFR to develop a draft regional TB strategy. The focus of the strategy was to identify high impact regional approaches that will help strengthen TB programming in Africa. This strategy document assisted USAID/AFR in defending budget allocations for TB in Africa and once the budget was finalized, helped USAID/AFR redefine priorities for TB programming in Africa.

HIV/AIDS

Under PEPFAR, there are a myriad of HIV/AIDS activities already being implemented. One of the guiding principles of ASH is to not duplicate the efforts of other USAID offices and implementing partners. As a result, it quickly became clear that with so many stakeholders already engaged in HIV/AIDS related work in Africa, it would be a challenge to identify a niche area for ASH. In light of this, USAID/AFR recommended that ASH proceed slowly during year one.

Despite the obvious limitation related to work in the area of HIV/AIDS, ASH was able to move forward with two important activities. First, as mentioned in the MNCH section of this report, the ASH HIV team contributed significantly to development of a background briefer on the relationship between HIV and maternal mortality. Second, ASH began developed a working document that describes the way regional economic communities (e.g., the African Union, the Southern African Development Community, the East African Community, the New Partnership for Africa's Development, the West African Health Organization, etc.) can support global HIV initiatives such as voluntary medical male circumcision and "Zero new HIV infections" at the regional and sub-regional levels. The working document was developed through selected interviews with USAID

Missions in East and Southern Africa and a review of source documents and policies of African intergovernmental institutions.

Strengthening the capacity of regional economic communities to lead, advocate for, and coordinate HIV activities in Africa can contribute to achievement of an AIDS-free generation. In order to identify ways in which ASH and USAID can support these organizations, ASH is in the process of documenting:

- The factors related to the development and evolution of these institutions
- The principles by which these institutions are structured, governed and staffed
- The strengths and weaknesses of these institutions
- Why countries maintain membership in multiple regional institutions and how this is effectively managed by member states
- The important regional health initiatives and how regional institutions may best support scale up of these initiatives

HEALTH SYSTEMS STRENGTHENING

ASH's HSS team completed a busy first year that included: participation in strategic meetings; support to USAID's HSS network; compilation of best practices related to management training and eHealth; creation of a mHealth compendium; and development of a health information system (HIS) protocol.

One of the first activities undertaken by ASH was a mapping of activities in USAID-funded countries which provide management training for health care workers. A literature review and informant interviews were conducted that identified several best practices. The draft report will be completed in year two as agreed upon in the year one work plan. The HSS team also worked closely to align this activity with the work of WHO/AFRO. In year two, ASH and WHO/AFRO will develop joint products, including a compendium of training programs and the development of a generic comprehensive management training curriculum.

Preliminary Findings of the Mapping of Management Training for Health Care Workers

- Many management trainings are being held in Africa
- A wide variety of training approaches are being utilized
- There is little standardization in these trainings
- More attention should be given to who is trained and the competencies gained
- Best practices and lessons learned should be better documented
- Curricula should be categorized
- The capacity of local entities that provide these trainings should be built
- Greater attention should be given to quality and evaluation of impact

Also during this first year ASH worked closely with USAID/AFR and USAID/East Africa to develop a template for an mHealth compendium. The team then reviewed a large number of mHealth projects to identify those which should be included in the first edition. A first version of the compendium will be completed early in year two and disseminated at a USAID meeting in Tanzania. The HSS team also assisted with development of background documents for an mHealth session at the African Growth and Opportunity Act (AGOA) meeting (more details on this can be found in the ACD strategic team review). Lastly, in order to stay abreast of current developments in

this fast paced field, the team routinely participated in mHealth-related meetings including the following:

- mHealth Summit (Washington, December 2011)
- E-Health Africa Conference (April 2012)
- Mobile Healthcare: Innovations in Telemedicine (George Washington University, August 2012)
- Follow the mMoney, How Mobile Money can Improve Public Health (USAID Mini University, September 2012)
- Information Technology and Global Health: Past, Present, Future (USAID Mini University, September 2012)
- Monthly mHealth working group meetings

In addition to mHealth, ASH also works in eHealth. In year one ASH began to document best practices and lessons learned regarding development and implementation of eHealth strategies. The team began collecting background literature and reports, as well as copies of actual eHealth strategies. In addition the team developed working relationships with key informants in the ministries of health in Rwanda, Tanzania, Uganda and Tanzania. The team also worked to coordinate with WHO/AFRO on this activity; joint products are expected during year two.

Another year one objective was to support the USAID HSS network which was created in April 2012. As part of this support, ASH began developing a database of potential African-based consultants, as well as potential African-based consulting organizations. The HSS team also worked to identify one specific organization in Ethiopia which can provide direct support to USAID/Ethiopia and the HSS network for study tours and other HSS-related technical assistance. The capacities of three organizations were assessed and at the end of year one the project was in the final stages of making a final selection. It is hoped that in subsequent years the Ethiopian organization selected can access, and perhaps even maintain, the database of potential consultants.

The HSS team also took on a number of tasks that were not part of the year one work plan. For instance, the HSS team assisted USAID/AFR in developing an abstract for and organizing a satellite session to be held at the Health Systems Research (HSR) meeting in Beijing. In preparation for the conference the HSS team helped USAID/AFR develop background materials and develop the PowerPoint presentations. Additionally, due to a variety of staffing issues, the HSS team took the lead on overseeing the development of the HIS study protocol. While this activity was part of the ASH year one work plan, it was not expected to be spearheaded by the HSS team.

CROSS CUTTING

Mapping of Advocacy Training for Elected Leaders

Parliamentarians and other elected leaders have a critical role to play in determining the health priorities of a country, yet they often do not have the skills and information to make effective decisions about their own countries' health policies and systems. Enhancing the capacity of elected leaders to advocate and budget for key health interventions could greatly contribute to health outcomes across the board. The goal of this ASH activity in year one was to document the breadth of activities and tools being employed by stakeholders who are working to train elected officials in the area of health advocacy and informed decision-making. In year two, ASH will focus on

disseminating the findings of the mapping, as well as the recommendations gleaned from discussions with the multitude of programs providing training to elected officials in the area of advocacy.

ASH identified sixty projects that train parliamentarians and elected officials. Based on in-depth interviews with a subset of these organizations and a review of more than 65 relevant publications ASH identified a number of lessons learned, including the following:

- Ensure sustainability
- Utilize multiple funding sources and wide networks of local and international partners
- Document and disseminate successful approaches
- Increase political will through appealing to basic needs of MPs
- Develop a conceptual framework or theory of change for capacity building in advocacy and the policy change process, as well as indicators for evaluation and impact measures on health outcomes
- Develop capacity to use evidence and updated information
- Frame the health issues by crafting and sharing consistent messages
- Foster trusting relationships with the MPs

Harmonization for Health in Africa (HHA)

ASH participated in the landmark conference of Ministers of Finance and Ministers of Health hosted by the African Development Bank in Tunis in July, 2012. Given the current global economic environment in which financial resources have declined and are likely to continue dwindling, health care financing has become a major issue that threatens the achievement of health sector MDGs. The Tunis meeting addressed the urgent need to maximize and leverage available resources in order to accelerate progress towards the health MDGs. The conference aimed to create a common understanding of the causes of ineffective and inequitable health financing. It also discussed solutions to these underlying financing problems, in particular by raising awareness of successful experiences from Africa and the South. Participants agreed on ten important steps to promote value for money, accountability and sustainability in the health sector. One of the ten steps is "Strengthen accountability mechanisms that align all relevant partners, build on the growing citizens' voice and ensure the highest possible level of results for the money spent.

ASH played several important roles before, during and after the conference. For months prior to the conference ASH served as a member of the conference organizing committee. During the conference, ASH met and networked with key stakeholders in health sector financing. For example, ASH attended a presentation about a score card developed the African Public Health Alliance (APHA) that "tracks" trends in health finance allocations by African countries. ASH is currently discussing ways to collaborate with APHA to develop, disseminate and use the score card. During the conference ASH also had the opportunity to better understand the underlying issues and potential solutions to important health challenges facing Africa today.

Harmonization for Health in Africa (HHA) is a mechanism to support country-led efforts at health system strengthening leading to the accelerated attainment of health outcomes particularly the MDGs.

After the conference, the ASH Project Director, on behalf of USAID, attended the HHA Steering Committee Meeting held in Harare in September, 2012. The main purpose of the meeting was to finalize development of a HHA Action Plan for the implementation of the Tunis Declaration. The meeting also focused on developing the agenda, working documents, and logistics of the HHA technical meeting and the seventh Regional Director's meeting. USAID was one of two bilateral development partners that attended the Steering Committee meeting. The ASH project director continues to actively participate in monthly HHA Steering Committee conference calls. The Steering Committee supports the HHA Secretariat in its role of coordinating HHA activities.

Community Strategies to Achieve Health MDGs

In many African countries, responsibility for health has historically been left to health ministries, resulting in most health actions and responses and strategies taking a largely clinical approach without due attention to equally important non-clinical aspects of health. However, over the past two decades there has been increasing realization that in order to achieve long lasting impact in health development, communities need to take a central role in the planning and implementation of health interventions. Lately the quest to reach the health MDG, have resulted in redoubling of efforts by sub-Sahara countries to explore ways to enhance to engage communities and households in the planning and implementation of health services.

During year one, ASH has been working to: i) increase involvement of community level stakeholders in planning and governing health activities; and ii) establish effective tools for achieving better accountability and good governance on health. As a first step, ASH conducted a literature review of community health workers, their activities, and the role of community-level structures and stakeholders in order to develop guidelines for community health interventions that can be shared with African governments, village health committees, and implementing partners and can be adapted for use in different countries and settings. In this review, ASH defined community stakeholders in the most inclusive way possible to include traditional leaders, religious leaders, traditional healers, traditional birth attendants, community health workers, private sector or business leaders, elected leaders from parliamentarians to local councilors, and other elected representatives. The review included socio-political and local governance and development entities such as development committees, health committees, civil society entities, burial societies, and special interest groups for women, youths, and people affected by specific diseases or condition. ASH analyzed peer-reviewed articles, documents from the community health worker (CHW) evidence summit, and published and unpublished reports and papers from different implementing partners working in Africa. ASH also conducted key informants interviews with USAID staff, USAID contractors, academic institutions, and community based organizations. Program information from project websites was also reviewed.

The vision is to have communities that have a solid understanding of the health problems that affect them, a good understanding of the underlying causes of the health problems, an appreciation of their rights and more importantly their roles, responsibilities and actions that they themselves can take to ensure the availability of good quality health services in collaboration with government and development partners.

Key Factors for Improving Community Involvement in Health Services

- Commitment by countries and stakeholders to facilitate community involvement in health.
- Clear national policy, legislation or guidelines on community involvement, which should be followed by all actors and stakeholders in the country.
- Well-defined roles and responsibilities for key players (community stakeholders, health facility staff, district level managers, provincial and national level).
- Adequate and appropriate training and mentoring for all actors to equip key players with the knowledge and skills to perform their functions.
- Tools and supplies to enable community based stakeholders to play their role (communication equipment, stationery).
- Costing tools or methodologies to assist countries, planners, and communities to estimate or calculate the cost of community involvement.
- Allocation of adequate national resources to fund community level involvement.

Once the literature review is complete, a costing tool will be developed. This tool is important because there is a paucity of information on the cost to implement essential community activities that promote and maintain community participation and, as a result, community involvement is often dismissed as being too expensive without a clear understanding of what it actually costs. A tool is needed that countries can use to quickly and accurately cost their chosen community-level approach. ASH has discussed this problem with the Health Care Financing Unit of MSH and agreed that once a tool is developed, it will be piloted in one or two countries. ASH will likely collaborate with other organizations such as World Bank and WHO.

IV. FINANCE AND ADMINISTRATION

FINANCE

ASH was awarded as a hybrid type contract with a fixed price option for salaries and a cost reimbursement option for other project expenses. The obligated funding for year one was much less than the projected budget ($2,657,479 compared to $3,965,228) and could not cover staff costs. The ASH Senior Management Team (SMT) took steps to quickly rectify this problem by meeting with MSH senior management and agreeing that MSH would cover 15-20 percent of the senior technical staff time for year one by engaging them in other, non-ASH, MSH work. In addition, the SMT met with ASH partners Khulisa and APHRC; both offered to reduce their budgets by 20percent for year one. After discussion with USAID/AFR ASH then revised the year one budget to correspond with the obligated funding. The overall ASH budget was then adjusted for years two through five accordingly to keep the project ceiling intact.

Another challenge was that the hybrid mechanism did not provide flexibility for adjusting budget line items between labor and other project costs to keep the costs within the obligated funding for year one. Moreover, the hybrid contract came with a cap on the travel line item, which meant the project could only undertake a limited number of trips each year. This would have severely

hampered implementation of project activities because ASH is heavily focused on collaboration with African partners which s requires international travel. To resolve this problem the SMT discussed the constraints of the hybrid type contract with COR. The COR and her team immediately realized the problem and agreed to convert the contract to a cost reimbursement type contract which would provide complete flexibility for realigning budget line items. In February, 2012 the project submitted a formal request to USAID to change the ASH contract from a hybrid to a cost reimbursement contract with a budget modification and removal of line item restrictions. ASH received USAID Contracting Officer's approval through modification #1 to the ASH Contract on March 20, 2012.

PROJECT COMMUNICATION

During this first year of the project, ASH worked closely with USAID/AFR to understand the USAID guidelines for contracts on branding and graphic design. Several communications activities were delayed as ASH and USAID/AFR developed a better understanding of the allowable limits of the contract and its implications on advocacy, communication and dissemination (ACD). By the end of year one ASH had clearer guidance on communications within the project and moved forward quickly.

A draft ASH Advocacy, Communication and Dissemination Strategy was submitted to USAID/AFR in early April. Working closely with USAID/AFR the ACD Strategy was then revised and formally approved by the end of the first year. ASH also completed a project brochure and a general presentation about the project which can be used for technical audiences. Based on the USAID Graphics Standard Manual, ASH also created standardized technical report template for external reports.

Because ASH is a contract, the project is prohibited from utilizing a logo without specifical approval. To this end the USAID/AFR COR offered to request an exception through their internal system. With assistance from ASH, USAID/AFR prepared a request for an exception to allow ASH to have a project logo. This request is still being reviewed by USAID. . However, in preparation for this, draft logo concepts were designed and circulated to ASH staff for feedback. Based on internal feedback, ASH finalized the project logo with the graphic designer.

In January 2012, ASH researched the website needs of the project and developed a short brief outlining the desired features and requirements. ASH also worked with USAID/AFR to select URL addresses for the website and for the email addresses of project staff. ASH then purchased the URL addresses for the website and ASH email addresses for the project. Because the cost of hiring an external website developer, given the year one budget shortfall, proved prohibitive, ASH worked with the internal MSH communication staff to explore lower-cost alternatives. It was agreed that the project would buy programming software and develop the website internally. To this end, a draft webpage with menus and drop-down sub-menus was developed. Unfortunately in September, USAID/AFR informed ASH that the agency had issued a moratorium on all new partner websites. However, ASH worked with the USAID/AFR COR to request an exception and this was subsequently granted. Work to finalize the ASH webtie will be a priority for year two.

In addition to the creation of ASH ACD materials, ASH also provided ACD support to USAID/AFR on three of their important activities this year.

- ASH participated in the USAID planning for World TB Day. The project helped develop an "Op Ed" piece for USAID to submit to various media outlets on pediatric TB and prepared two fact sheets on TB in Africa for diseemination. ASH also drafted "Tweets" for USAID to use during the week preceding World TB Day.
- In order to have comprehensive data on family planning by country, USAID/AFR had begun to develeop a set of Family Planning Country Briefs. ASH assisted in writing, editing, and formatting these for dissemination.
- As mentioned above, ASH provided support to USAID/AFR for a mHealth session at the 2012 AGOA Forum, held at the US Department of State in Washington, DC in June. ASH prepared a flier for USAID/AFR to advertise the session, as well as designed and printed materials for dissemination at the meeting. The project also assisted in reviewing the session presentations and helped to rehearse the presenters. Lastly, ASH staff attended the meetings and ensured that attendees received the materials.

PARTNERSHIP AND COLLABORATION

Achieving impact with ASH can only be accomplished through effective partnerships with organizations and institutions throughout the African continent. These partnerships, based on collaboration, coordination, and mutual commitment, will maximize and sustain the impact of health innovations across the region. ASH's approach to partnerships is based on evidence showing that successful partnerships are characterized by strong engagement on the part of the partner organization. An important aspect of this engagement is that both partners consider themselves equal, allowing them to play active roles in the entire project cycle, expanding their space to manage, influence and provide meaningful inputs at every stage: from identifying needs, determining priorities and timelines, mobilizing and aligning stakeholders, to developing and finalizing the final products.

African Partners with whom ASH Collaborated in Year One

- African Public Health Alliance (APHA)
- African Center for Global Health and Social Transformation (ACHEST)
- Building Local Capacity Project
- African Health System Governance Network (ASHGOV)
- Human Service Research Council (HSRC)
- Desmond Tutu TB Centre
- EQUINET

The fundamental purpose of partnering is to develop, through partnerships, a network of African regional institutions which have the capacity to identify issues, trends and proven practices, to advocate for the adoption and scale-up of proven or promising practices and innovations, and to strengthen health systems so they are more effective and efficient in leading and managing their health sectors resulting in a positive impact on the health of their populations.

To this end, ASH engages with local African partners in three ways:

- Dialogue to identify the key health issues facing Africa and potential solutions to these issues;

- Partnering to advocate and disseminate best practices and other potential interventions which can positively impact the health of Africans; and
- Provision of technical assistance to build the institutional capacity of partners.

During year one of the project, ASH focused primarily on collaboration with African partners to identify the most pressing health issues facing African today. ASH met with a wide range of partners in the region attending over 17 individual meetings with these partners. In addition, ASH attended 24 key international meetings, which provided an additional opportunity to dialogue with African partners.

Essential Elements for Building Strong Local Organizations

- High demand from clients, political leaders
- Visible leadership from top management level
- Integrated approach to change management
- Involvement of a critical mass of staff
- Quick wins that deepen commitment are visible early in the process
- Top management manage change process strategically and proactively

Towards the end of year one, ASH also began to develop more formal partnerships in order to collaborate on activities and disseminate the result of this work. Specially, ASH developed a joint work plan with WHO/AFRO whereby a set of key activities will be jointly implemented and results disseminated. ASH also identified an Ethiopia organization with which the project will collaborate to address health systems strengthening issues and to disseminate best practices. ASH also began a dialogue with the African Union (AU) to jointly implement activities related to their CARMMA campaign.

ASH staff met with WHO/ AFRO in Brazzaville, Republic of Congo to develop a joint work plan.

Although in year one ASH did not implement any institutional capacity building (ICB) activities with African partners, the project did begin to identify partners with whom the project will work in future years. In order ensure there is no duplication of efforts in providing ICB support to local African institutions ASH coordinated closely with USAID/East African and started to reach out to USAID/West Africa who also have a mandate to provide this type of support. ASH also coordinated closely with the Leadership, Management and Governance Project (LMG) to again limit duplication of efforts. It is important to note, that the focus of the ASH ICB work is to provide support to organizations with which ASH can implement technical activities and not just to provide capacity build alone. For example, in year two, ASH may be working with ANECCA and Regional Center for Quality of Healthcare (RCQHC) to implement TB activities and during the course of this work the project will also provide ICB support.

V. LOOKING AHEAD

ASH will continue to provide technical leadership in MNCH, infectious disease, health systems, ACD, as well as, monitoring and evaluation. ASH will work with local African partners to explore ways to strengthen and expand health programs across the African continent. While the focus in year one was one partnership building and planning, during the project's second year, ASH will move into implementation mode. Emphasis will be on carrying out the studies and activities for which protocols have been developed. ASH will also focus on documenting the impact of country studies, sharing lessons and results with global health colleagues, and promoting the adoption of innovations and good practices. In addition, ASH will begin to undertake ICB activities in order to ensure the sustainability of activities.