MIDWIVES SAVE LIVES – BASELINE REPORT

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ACRONYMS	Definitions
ANC	Antenatal Care
ASFB	Association sages-femmes du Benin
BEONC	Basic Emergency Obstetric and Neonatal Care
CAM	Canadian Association of Midwives
CHW	Community Health Worker
CI	Confidence Interval
COGECS	Health Centre Management Committee (Benin)
CSPRO	Census and Survey Processing System
DRC	Democratic Republic of Congo
EMwA	Ethiopian Midwives Association
FP	Family Planning
HF	Health Facility
HMIS	Health Management Information System
ICM	International Confederation of Midwives
IUD	Intra-Uterine Device
MICH	Maternal, Infant and Child Health
MICS	Multiple Indicator Cluster Survey
MNCH	Maternal, Newborn and Child Health
MSL	Midwives Save Lives
NHIS	National Health Information System
PMF	Performance Measurement Framework
RC	Community Relay (Benin)
SCOSAF	Société Congolaise de la Pratique Sage-Femme
SR	Reproductive Health
TAMA	Tanzania Midwives Association
ToR	Terms of Reference
UNAAC	National Union of Congolese Midwives
UNFPA	United Nations Population Fund
WHO	World Health Organisation

ACKNOWLEDGEMENTS

ABSTRACT

The baseline survey of the MSL Project was conducted to validate the Performance Measurement Framework (PMF) indicators and obtain baseline data for the project. This information will be used to assess the results obtained at the end of implementation.

The results of this baseline survey as described in this report are intended to provide a complete and accurate picture of the situation prior to the implementation of the project's activities. This basic survey is not only a requirement under the contract with the donor but is also an essential pillar of results-based management. It is meant to be used as a point of reference to grasp the progress and achievements of the project. As such, the baseline will enable project stakeholders to report on the efforts made and the results achieved.

Data collection took place in the four project countries during the period from October 2016 to March 2017. In Ethiopia, data collection was limited to health facilities and midwifery associations due to restrictions and regulations imposed by its government.

In all other countries, in addition to health facilities, the projects' beneficiaries were also consulted at community level.

This survey provides us with an overview of: the level of knowledge of men, women, and adolescents concerning reproductive health; women's perception of respectful care; what midwife's knowledge and use of the partogram, and referral protocols; as well as the organisational capacity of midwives' associations and their ability to advocate on behalf of their members.

The main findings from this evaluation confirm the relevance of the project design and demonstrate that men and women have limited knowledge about reproductive health and what to do in case of an emergency. In the communities surveyed, the notion of a birth plan is almost non-existent and is limited to providing for the necessary delivery costs. Results from surveyed health care providers demonstrate that the practice of respectful care needs to be explained and promoted, and there is need to strengthen clinical skills required for the proper management of emergency cases requiring a referral to a higher level of care.

Based on these results, recommendations can be made to each series of results as described in the logic model:

- **1100** Improved delivery of environmentally sound and gender responsive quality respectful health services for women of reproductive age, mothers, pregnant women and newborns in target regions Take specific actions to provide respectful maternity care for women and adolescents in particular;
- Improve the quality of services focusing on the attitude of health care providers;
- Strengthen the capacity of health care providers to correctly use and complete the partogram and to correctly follow the referral protocol.

1200 Improved utilization of quality gender responsive and environmentally sound health services by empowered women of reproductive age, mothers, pregnant women and newborns in target regions

- Develop reproductive health messages for populations with low levels of education and use appropriate channels, such as radio in Benin and Tanzania, and television in the DRC;
- Carry out specific awareness activities for men and adolescents about complications during pregnancy and childbirth;
- Conduct awareness campaigns on family planning;
- Promote knowledge and use of a birth plan amongst beneficiaries and health care providers;
- Carry out specific awareness activities for men and adolescents on newborn health complications and when to seek help from a health care provider.

1300 Strengthened capacity and influence of midwives to enhance national standards of care and increased recognition of midwifery by RMNCAH stakeholders as a cost effective, high quality path to improved reproductive, maternal and newborn health (RMNCAH) in target countries.

- Strengthen the organizational capacity of the midwives' associations, particularly advocacy efforts;
- Strengthen the midwives' associations' capacity in the area of communications taking into account the needs of their members.

INTRODUCTION

The MSL Project

On April 1, 2016, Cuso International, in partnership with the Canadian Association of Midwives (CAM), launched the implementation of a four-country reproductive health project entitled" Midwives Save Lives", funded by the Government of Canada through Global Affairs Canada. With a total budget of CAD 12,973,725, this project will help reduce maternal and neonatal mortality and morbidity by strengthening the availability, access, acceptability, and quality of reproductive, maternal, and neonatal health services delivered by midwives in the four target countries, namely: Benin, Ethiopia, the Democratic Republic of Congo, and Tanzania. The project will help improve the skills of pre-and in-service midwives, strengthen health systems to work more effectively with and for midwives, respond to the low demand for RMNCAH (Reproductive, Maternal, Newborn, Child and Adolescent Health) services at the community level, improve use of health services in target communities, and strengthen the capacity of midwives' associations to play the role for which they were established. At the centre of this project is the universal right of all women to be treated with dignity and respect. This initiative will be built on the unique Canadian midwifery model that promotes midwives to work independently and in remote areas, as well as on additional technical resources available through the International Confederation of Midwives (ICM).

The specific objectives of the project include:

- Improving the delivery of quality essential health services for women;
- Improving the use of quality essential health services by women and their communities;
- Strengthening the influence and empowerment of midwives' associations, as well as their ability to meet their members' needs, and increasing the recognition of midwifery as an effective way to improve mother and child health.

Expected outcomes include:

- Increased competence of midwives to provide timely, quality, and respectful RMNCAH care, including basic emergency obstetric and neonatal care (BEmONC);
- Increased midwives / primary health workers' skills to refer women with complications during pregnancy and childbirth to appropriate secondary and tertiary healthcare services in a timely fashion;
- Increased awareness among men, women and community health workers (CHWs) of the health needs of women of childbearing age, mothers, pregnant women, and newborns;
- Increased capacity of men and women to participate in assessing the quality of local facilities offering reproductive, maternal, newborn, child and adolescent health services;
- Increased capacity of midwives' associations to work with key stakeholders to strengthen midwifery curriculum and clinical practice guidelines;

- Improved capacity of midwives' associations to contribute to the strengthening of legislation required to oversee the profession (i.e. training, regulation, and accreditation);
- Increased capacity of midwives' associations to provide leadership in the health sector and advocate for the professional interests of the midwives they represent.

The above expected outcomes will be achieved through the implementation of several activities such as in-service midwife training and training for midwifery instructors and health facility administrators. At the same time, outreach campaigns and workshops delivered by community workers and local NGOs will be carried out for the benefit of the communities living in the project area. The project will also provide technical support to national midwives' associations in education, regulation, licensing, and organizational development. Awareness activities will also be organised to bring together key stakeholders to share knowledge, promote coordination, collaboration, and social dialogue, as well as discuss lessons learned and best practices.

Objectives of the baseline survey

The objective of this survey is not only to meet one of the donor's requirements, but also to validate the project's performance measurement framework, which is one of the essential management tools of the results-based management approach. The survey is used to evaluate the status of the baseline indicators at the onset of the project so as to inform the monitoring and evaluation plan. It will also contribute to all the accountability and learning efforts that will be recorded through the monitoring of activities and the evaluation of project results.

The baseline survey is therefore a key component of the performance measurement framework, which is used to inform the decision-making process during project implementation; confirm the proper use of funds, and makes it possible to document and measure the impact of project activities.

METHODOLOGY

Methodology description

The general design of the study is that of a cross-sectional survey conducted in MSL Project areas in the four project-beneficiary countries: The survey consisted of:

- Collecting primary data from women and men aged 15-49 in Benin, DRC and Tanzania. In Ethiopia, collection of primary data from households was not feasible due to governmental restrictive and regulatory reasons. Only secondary data was therefore collected.
- Collecting secondary data in all the health facilities in the project catchment area as well as from the midwives' associations of midwives in each country.

To conduct this study, MSL Project Management team initially issued a Request for Proposals (RFP) to recruit a consultancy firm to carry out the baseline study which was contracted by the third week of September 2016. However, over time this firm demonstrated difficulties in carrying out its assignments. Considering the deadlines set by the donor for the presentation of the study, the delays in the study and the inability of the firm to compensate them quickly, the project management was required to terminate the consultant and conduct the survey internally. The baseline study was then taken over by the MSL MEAL Manager who oversaw the data collection and entry conducted by consultants in all countries. The latter were mandated to recruit, train and supervise data collectors. They also supervised their fieldwork and data entry in Tanzania.

Justification and limits

In line with the scope of the project, data collection was carried out in the four countries by four different data collection teams. Not all data were available or comparable across all countries. For example, sex-disaggregated data for some PMF indicators such as number of new-borns or early initiation of breastfeeding were not available since such data was not disaggregated in the National Health Information System HMIS. It should also be noted that the poor quality of entries in the registers of health facilities prevented the collection of all required information. The recording of information on referred cases was not always standardized in specific registers or charts. As well, there was no information available on counter-referral or the outcome of referred cases. These findings led either to a reformulation or change in some of the PMF indicators.

Among potential biases to this survey, we can name:

- **Translation bias**. The questionnaires were in French or English, but in the survey areas most people speak languages such as *Fon* in Benin, *Lingala* in DRC and *Swahili* in Tanzania. To minimize this bias, the interviewers were recruited on the basis of language proficiency, and during the training several simulation exercises were conducted to administer the questionnaire in local language;

- **Investigator's bias**: The opinions of investigators could possibly influence the responses of the respondents. To minimize this bias, investigators were asked to keep neutrality with the answers, and not to suggest them;
- **Respondent's bias:** Respondents could give "acceptable" answers out of fear or to provide the answer they think the interviewer wants to hear. To minimize this, investigators explained to the respondents that they were free to answer questions or withdraw at any time and that their answers were taken anonymously, and their identity would not be revealed anywhere;
- **Confidentiality bias:** When sensitive issues are addressed (use of family planning), people may be ashamed to respond. To minimize this risk, investigators had to administer the questionnaire alone with the respondent in places where no one else could hear their conversation.
- **Recall bias:** Respondents were asked questions regarding past events or experiences. Lack of information, lack of knowledge, courtesy or poor memory may have affected the accuracy or completeness of some responses, particularly concerning family planning, prenatal control visits or delivery.

The data collection work was carried out under the field supervisors who were responsible for ensuring that the questionnaires were administered in accordance with the instructions.

Primary and secondary data sources

The data collected varied from one target to another. For the purpose of this study, primary and secondary data were collected.

Primary data were collected from both men and women, as well as health care workers in maternity wards. This brought together information on knowledge and practices of reproductive health in the project catchment areas.

Secondary data was collected in health facilities and provided quantitative information on issues such as prenatal consultations, referral, use of the partograph or care of new-born, which are all indicators of interest in assessing the quality of health care.

Target population and sample size

The baseline survey covered the four midwives' associations and was conducted in the project catchment areas. Sampling was based on the survey's target populations. These include a household survey for men and women in the project's catchment area in Benin (PAK region), DRC (Kinshasa), Tanzania (Shinyanga and Simiyu) and Ethiopia (Assosa and Bale) as well as interviews with community health workers, association leaders and data collection in health facilities.

Household survey.

For the household survey, interviews were conducted in the project catchment with women of childbearing age (15-49 years) who had experienced a previous pregnancy, and also with men having been involved with at least one pregnancy in Benin, DRC and Tanzania. The household survey collected information on the level of knowledge of

men and women regarding complications during pregnancy and childbirth, birth planning, family planning and women's satisfaction with care received during delivery.

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The sample size for each country was calculated using the following calculation:

$n =$ N = (Z (1-α 2) ² P (1-p)) / d 2

Where:

P = proportion of target population with measured characteristics (key indicator value set at 50% by default)

 d = level of accuracy (+/- 5.5%)

        Z_ (1-α/2) ^ 2 = 3.85

The sample size obtained was 318 households.

Sampling method of households

Since a complete and adequate list of households does not exist for Benin, DRC and Tanzania households were selected by the field survey team using a random-walk technique. At each starting point, the interviewers selected the fourth household to the left. In the case of absence or refusal, the household would be replaced by the next house.

Selection of respondents

In households where there was more than one eligible person (i.e. more than one woman aged 15-49 with at least one pregnancy experience and / or a man having fathered one child), the interviewers selected the subject to be interviewed by using a Kish[1] grid, using a random pre-numbered table.

Health facilities.

In Benin, DRC and Ethiopia all health facilities within the project catchment area were visited. The total number of health facilities per country are provided below:

- Benin: 15 health facilities;
- Ethiopia: 20 health facilities;
- DRC: 55 health facilities;
- Tanzania: 20 health facilities.

        In health facilities, data were collected from monthly reporting registers, patient records including the partograph and archived reference records. Information collected included that of prenatal consultations, intra-hospital mortality, postnatal care, use of the partograph and use of the reference protocol. Health facility administrators support the data collection within these establishments.

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[1] Kish's method is a random selection method to select an individual from within a group of eligible individuals of a household.

Midwives' Associations - Project partners

In each country project, structured interviews were conducted with representatives of the midwives' associations to gather information on the current status of the association, regarding their organisational capacity, their membership (recruitment strategies and loyalty), the nature and level of their collaboration with other stakeholders in advocacy, public policy dialogue, curriculum revision, etc.

Table 1. Summary of interviews: per country and category

Country	Health facilities	Households	Associations	Midwives
Benin	15	318	1	15
DRC	55	318	1	55
Ethiopia	20	330	1	20
Tanzania	20	318	1	60
Total	**110**	**1284**	**4**	**150**

Data collection, Entry and Analysis

Prior to the field visits, steps were taken with the Ministries of Health, through their sub departments in the project areas, to obtain the administrative authorizations required for the conduct of the study. The data were collected through questionnaires developed around the baseline survey objectives and the performance measurement framework by the research team, and a specific tool for each target was developed. The questionnaires were translated into French and English.

Data from the household survey were double-processed under CSPro (Census and Survey Processing System), whereas data on the health facilities and the midwives' associations were processed with Excel. EpiInfo and Excel software were used for data analysis and graphical representations. The results are presented as a mean and median for the quantitative continuous data and percentage data with confidence intervals for the quantitative categorical data. The chi-square enabled comparison tests and the differences were significant at $P < 0.05$.

Data validation

In all countries, data where presented to stakeholders including Cuso Staff, Midwives Association, Midwifives, community health workers, other NGOs working in the area of RMNCAH. The participants unanimously approved the report and formulate some amendments and their recommendations where included in the final version of the report.

RESULTS

This section presents the results of the data analysis. These are data from the household survey, information collected from health facilities and the midwives' associations. The results in the tables are presented as percentages with a 95% confidence interval: % (95% CI)

1. Household Survey

The household survey provided basic information on men and women of childbearing age who had a previous pregnancy in Benin, DRC, Ethiopia and Tanzania.

Characteristics of Interviewees

The table below shows the socio-demographic characteristics of the men and women in the project catchment areas.

The final sample consisted of 213 women and 105 men in Benin, 153 women and 165 men in DRC, 110 men and 220 women in Ethiopia, 119 men and 199 women in Tanzania.

Table 2: Characteristics of Interviewees by age and education, % (CI 95%)

	Benin n= 318		DRC n= 318		Ethiopia n= 330		Tanzania n= 318	
	% Men n= 105	% Women n= 213	% Men n= 165	% Women n= 153	% Men n= 110	% Women n= 220	% Men n= 119	% Women n= 199
Current age of respondents								
Adolescents (15-19 years)	1.9 (0.23-6.71)	6.94 (3.94-11.2)	3.59 (1.33-7.66)	1.96 (0.41-5.62)	0	3.03 (1.42-6.11)	5.04 (1.87-10.65)	4.52 (2.09-8.41)
Persons over 19	98.1 (93.29-99.77)	93.06 (88.8-96.06)	96.41 (92.34-98.67)	98.04 (94.38-99.59	110	96.21 (92.93-98.06)	94.96 (89.35-98.13)	95.48 (91.59-97.91)
Respondents age at first pregnancy[2]								
Adolescents (15-19 years)		47.04 (41.65-52.5)		33.75 (28.79-39.1)		39.02 (33.15-45.21)		62.31 (55.18-69.07)
Persons over 19		52.96 (47.5-58.35)		66.25 (60.9-71.21)		59.09 (52.88-65.03)		37.69 (30.93-44.82)
Median age of first pregnancy		20		21		21		19
Level of education[3]								
No formal education	74.47 (64.43-82.91)	67.94 (61.15-74.21)	1.8 (0.37-5.16)	1.97 (0.41-5.66)			6.72 (2.95-12.82)	8.63 (5.11-13.46)
Primary	13.83 (7.57-22.49)	18.66 (13.62-24.61)	16.77 (11.44-23.31)	14.47 (9.3-21.09)			52.1 (42.75-61.34)	66.5 (59.44-73.05)
Secondary	10.64 (5.22-18.7)	13.4 (9.09-18.78)	62.28 (54.46-69.65)	56.58 (48.31-64.59)			34.45 (25.98-43.72)	23.86 (18.09-30.43)
University	1.06 (0.03-5.79)	0 (0-1.75)	19.16 (13.49-25.96)	26.97 (20.1-34.76)			6.72 (2.95-12.82)	1.02 (0.12-3.62)

[2] Women only
[3] Except Ethiopia

At the time of the survey, most subjects are aged over 19 years. Among adolescent males (15-19 years) in Benin, it was found that at least 1.9% of them affirmed having fathered a pregnancy. A higher percentage was recorded in the DRC (3.59%) and Tanzania (5.04%). For adolescent girls (15-19 years) interviewed in Benin, 6.94% reported having experienced a pregnancy at the time of the survey, while in the DRC this percentage was 1.96% and was 4.52% in Tanzania.

A significant proportion of women in all countries disclosed having their first pregnancy as a teenager; 47% in Benin, 30% in the DRC and 62% in Tanzania. The median age at first pregnancy was 20 years in Benin, 21 in the DRC and 19 in Tanzania. Among respondents, the earliest pregnancy was 12 years in Benin and the DRC and 14 in Tanzania.

In terms of education, 74% of women and 67% of men interviewed in Benin had not attended school – which may be explained by the fact that the project catchment area is in a rural area. In the DRC, 62% of men and 56% of women had attended secondary education, while in Tanzania, most subjects had completed primary level; 52% of men and 66% of women.

	Benin		DRC		Tanzania	
	Men	Women	Men	Women	Men	Women
Radio	75.2	77.7	75.2	8.5	64.4	66.6
TV	10.4	10.1	10.4	88.8	25.5	21
Community leaders	13.3	10.1	13.3	1.96	4.24	3.59
Government	0.95	1.39	0.95	0.65	1.69	4.1
Other					5.17	4.71
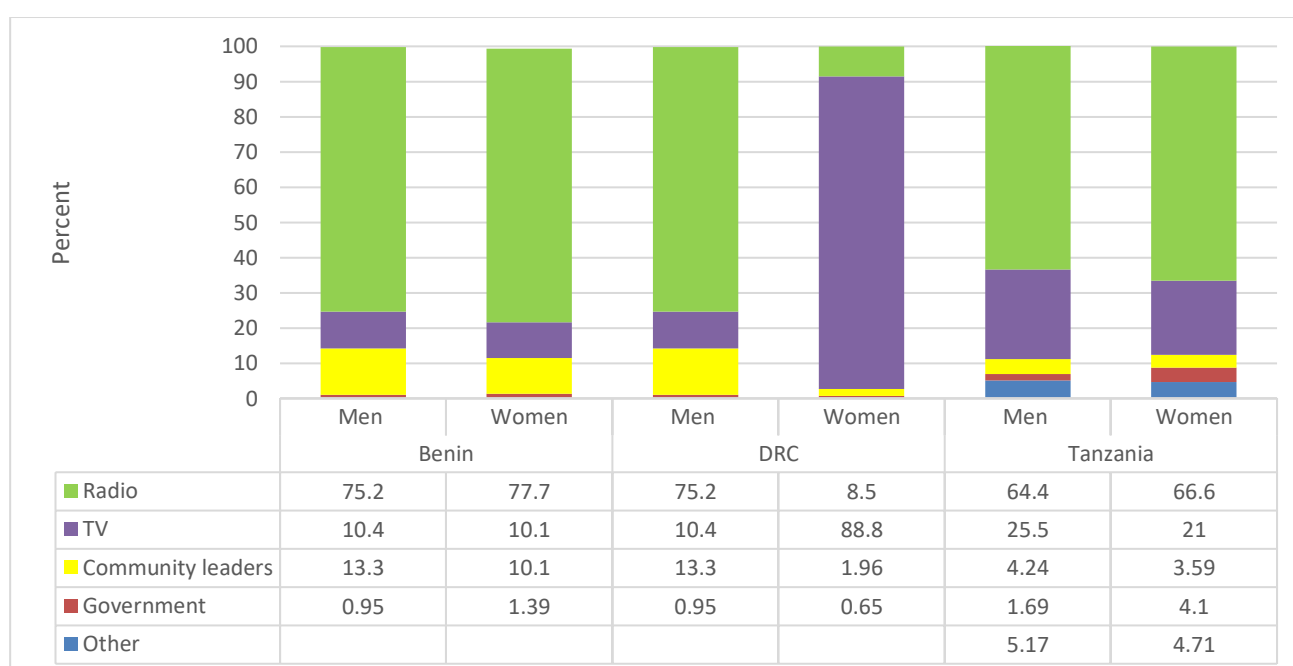
Figure 1: Main sources of information for men and women, %[4]

In terms of information sources, the chart above reflects the main channels by which men and women seek information. Overall, radio is the primary channel used in all project areas except for women in DRC who tend to seek information via the television (88.8%). The role of community leaders as source of information does not seem to play a major role: 13% for men in Benin, 10% for women and less than 5% in other countries.

An understanding of the community channels used by women and men to learn about health issues, and their participation in community health committee meetings was also investigated.

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[4] Except Ethiopia

Table 3: Information sources pertaining to health, % (CI 95%)

	Benin n= 318		DRC n= 318		Ethiopia n= 330		Tanzania n= 318	
	% Men n= 105	% Women n= 213	% Men n= 165	%Women n= 153	% Men n= 110	% Women n= 220	% Men n= 119	%Women n= 199
Health committee	55.91 (45.2-66.2)	49.3 (42.4-56.2)	35.3 (28.1-43.1)	50 (41.7-58.3)	30.8 (22.3-40.7)	32.95 (27.4-39.02)	27.1 (19.4-36.1)	32.3 (25.9-39.3)
Community Health workers	3.23 (0.67-9.14)	16.43 (11.7-22.1)	13.77 (8.94-19.95)	7.33 (3.72-12.74)	20.19 (13.20-29.43)	20.08 (15.52-25.53)	17.8 (11.37-25.91)	19.19 (13.95-25.38)
Community Groups	40.86 (30.77-51.54)	33.8 (27.5-40.6)	50.9 (43.06-58.7)	42.67 (34.64-50.99)	7.69 (3.62-15.04)	5.68 (3.33-9.39)	35.59 (27-44.93)	35.35 (28.71-42.45)

Community groups and health committees are preferred sources of health information among the communities surveyed. In Benin, about 50% of men and women receive health-related information through health committees; 27% men and 32% of women in Tanzania. In Ethiopia, they are 30% and 33% of women who receive health related information's through health committee. Community groups were also mentioned as an important source of health information, with more than 30% of men and women across all countries.

Knowledge of pregnancy-related complications

Study subjects were required to spontaneously recall complications related to pregnancy. The table below demonstrates the level of knowledge of the respondents.

Table 4: Knowledge of pregnancy-related complications, % (CI 95%)

	Benin n= 318		DRC n= 318		Ethiopia n= 330		Tanzania n= 318	
	% Men n= 213	% Women n= 105	% Men n= 153	% Women n= 165	% Men n=110	% Women n=220	% Men n= 119	% Women n= 199
Vaginal bleeding	40.93 (34.29-47.8)	14.2 (8.22-22.47)	33.33 (25.93-41.4)	16.17 (10.93-22.64)	52.88 (42.89-62.66)	57.20 (50.98-63.21)	34.17 (27.61-41.21)	26.89 (19.2-35.8)
Vaginal discharge (not blood)	0.47 (0.01-2.56)	0	9.8 (5.59-15.65)	4.19 (1.7-8.45)	22.12 (14.81-31.53)	24.62 (19.64-30.36)	15.08 (10.41-20.82)	10.08 (5.32-16.95)
Membrane rupture	0.47 (0.01-2.56)	0.95 (0.02-5.19)	17.65 (11.96-24.63)	9.58 (5.58-15.09)	11.54 (6.37-19.66)	17.42 (13.15-22.66)	2.51 (0.82-5.77)	1.68 (0.2-5.94)
Excessive vomiting	48.37 (41.52-55.27)	49.52 (39.62-59.45)	33.33 (25.93-41.4)	27.54 (20.93-34.98)	43.27 (33.70-53.34)	54.92 (48.70-60.99)	35.68 (29.03-42.76)	39.5 (30.66-48.87)
Abdominal pain	36.28 (29.85-43.09)	32.38 (23.57-42.21)	30.07 (22.93-38)	23.95 (17.7-31.16)	52.88 (42.89-62.66)	53.03 (46.82-59.15)	14.07 (9.56-19.69)	12.61 (7.23-19.94)
High fever	67.44 (60.74-73.66)	34.29 (25.3-44.19)	53.59 (45.36-61.68)	45.51 (37.8-53.38)	35.58 (26.61-45.63)	33.33 (27.74-39.41)	44.22 (37.2-51.41)	45.38 (36.2-54.76)
Difficult breathing	48.84 (41.98-55.73)	37.14 (27.91-47.12)	30.72 (23.52-38.68)	27.54 (20.93-34.98)	15.38 (9.31-24.08)	16.67 (12.49-21.84)	19.6 (14.32-25.8)	5.88 (2.4-11.74)
Visual disturbances	56.74 (49.83-63.46)	32.38 (23.57-42.21)	46.41 (38.32-54.64)	44.31 (36.64-52.19)	15.38 (9.31-24.08)	17.80 (13.49-23.07)	28.64 (22.47-35.46)	26.05 (18.4-34.89)
Severe weakness	17.21 (12.42-22.93)	1.9 (0,23-6.71)	31.37 (24.12-39.36)	23.35 (17.16-30.51)	37.50 (28.36-47.58)	39.02 (33.15-45.21)	7.54 (4.28-12.13)	16.81 (10.6-24.76)
High blood pressure	20.93 (15.7-26.99)	27.62 (19.34-37.2)	24.18 (17.63-31.76)	16.77 (11.44-23.31)	21.15 (14-30.48)	20.45 (15.85-25.93)	26.63 (20.63-33.35)	16.81 (10.58-24.7)
Swellling of hands and feet	3.26 (132-6.59)	2.86 (0.59-8.12)	7.19 (3.64-12.5)	2.99 (0.98-6.85)	27.88 (19.75-37.67)	24.24 (19.29-29.95)	23.12 (17.45-29.6)	15.97 (9.9-23.81)
Convulsion / Tremors	40.93 (34.29-47.82)	14.29 (8.22-22.47)	33.33 (25.93-41.4)	16.17 (10.93-22.64)	8.65 (4.28-16.21)	8.33 (5.41-12.51)	13.57 (9.14-19.12)	3.36 (0.92-8.38)

Overall, a low level of knowledge regarding danger signs in pregnancy was observed across all the countries, and particularly among men.

Complications require immediate transfer and emergency treatment (vaginal bleeding, convulsions, severe headaches, abdominal pain and difficult breathing), were not spontaneously recalled by 50% of the respondents - reflecting a low level of knowledge about danger signs requiring an urgent medical intervention.

Of particular note is the proportion of individuals who were unable to spontaneously recall any of the dangers signs that may occur in pregnancy: in Benin, 8% of men and 3% women were unable to respond, 9% of men and 7% of women in the DRC, 10% of men and 8% of women in Tanzania, and 0% both men and women and Ethiopia

	Benin		DRC		Ethiopia		Tanzania	
	Men	Women	Men	Women	Men	Women	Men	Women
Any sign	16.2	37.2	13.2	28.8	0	0	12.6	20.6
1-3 signs	76.2	59.5	83.2	68.6	69.81	53.65	77.3	71.4
More than 3 signs	7.6	3.3	3.6	2.6	30.19	46.35	10.1	8

Figure 2: Number of danger signs during pregnancy recalled by men and women, %

The differences observed between men and women were found to be significant throughout all countries with women scoring a higher level of knowledge than men (P <0.05), except Ethiopia where we have the highest level of knowledge both men and women in Ethiopia.

figure 3 compares the level of knowledge between adolescents and adults. Overall, less than 20% of adolescents in all countries are able to cite 3 signs of danger, particularly in Tanzania where only 6,7% can mention 3 danger signs and 26% were not able to cite a single sign.

	Adolescent	Adult	Adolescent	Adult	Adolescent	Adult	Adolescent	Adult
	Benin		DRC		Ethiopia		Tanzania	
■ Any sign	0	5	0	3.2	0	0	26.7	7.9
■ 1-3 signs	82.4	64	88.9	75.9	56.4	49.7	66.7	73.8
■ More than 3 signs	17.6	31	11.1	20.9	43.6	50.3	6.7	18.2
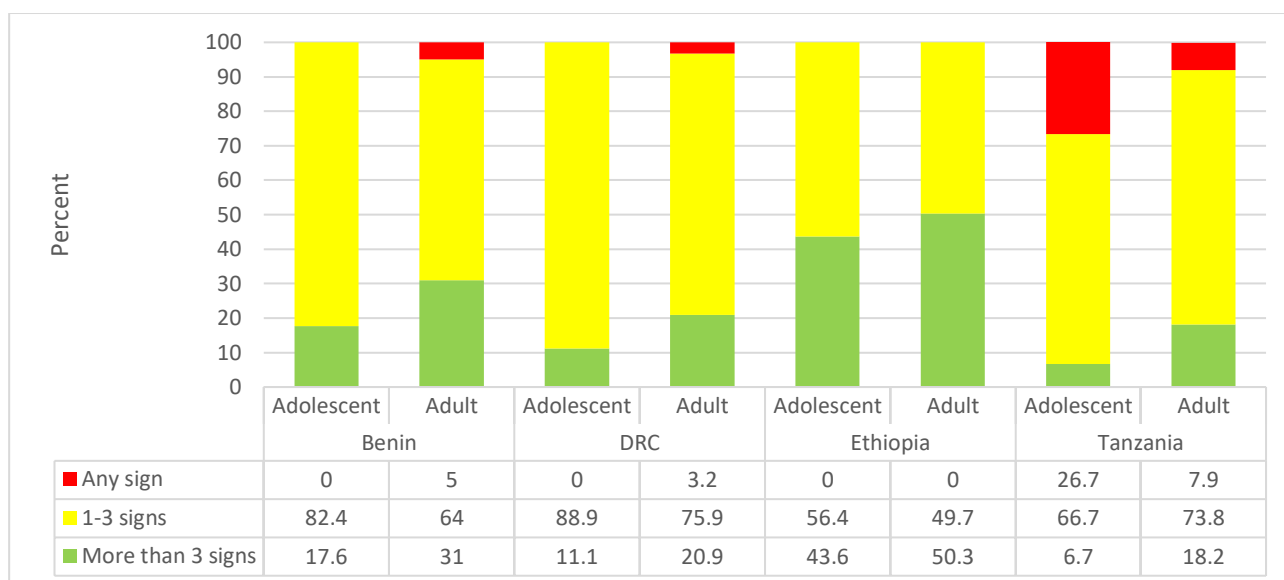
Figure 3: Number of danger signs during pregnancy recalled by adolescents and adults, %

The level of knowledge between adolescents and persons over 19 is not significant (P> 0.05) for Benin and the DRC, but not significant for Tanzania and Ethiopia.

Prenatal visits and decision-making regarding place of delivery

Of women respondents, 8.1% in Benin, 2.81% in DRC and 2.02% in Tanzania did not receive any pre-natal care during their last pregnancy. Of those who did receive antenatal care questions were asked to understand women decision making power regarding choice of birthplace. Results are illustrated below.
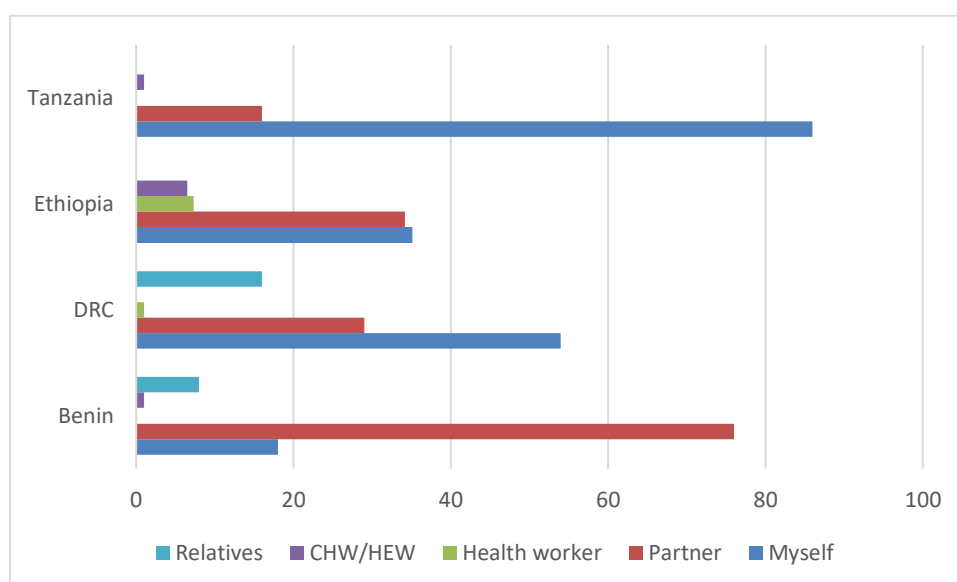
Figure 4: Decision making around birthplace according to women, %

In Benin, 75.5% of women reported that their partner decided where the woman would birth versus 30% in the DRC and 12% in Tanzania

Women's satisfaction and respectful care received during pregnancy.

Results demonstrating women's satisfaction with antenatal care received at health units (HU) is presented in the diagram below.

The reliability of these results was evaluated using Cronbach's Alpha[5] which produced an alpha coefficient of 0.9 for both Benin and Tanzania and 0.8 for the DRC – all indicating a high reliability of criteria pertaining to satisfaction of services.

The graph below represents the proportion of women who expressed full satisfaction with care received during pregnancy. Overall satisfaction of care received during pregnancy is 11% in Ethiopia, 23% in the DRC, 46% in Tanzania and 64% in Benin.
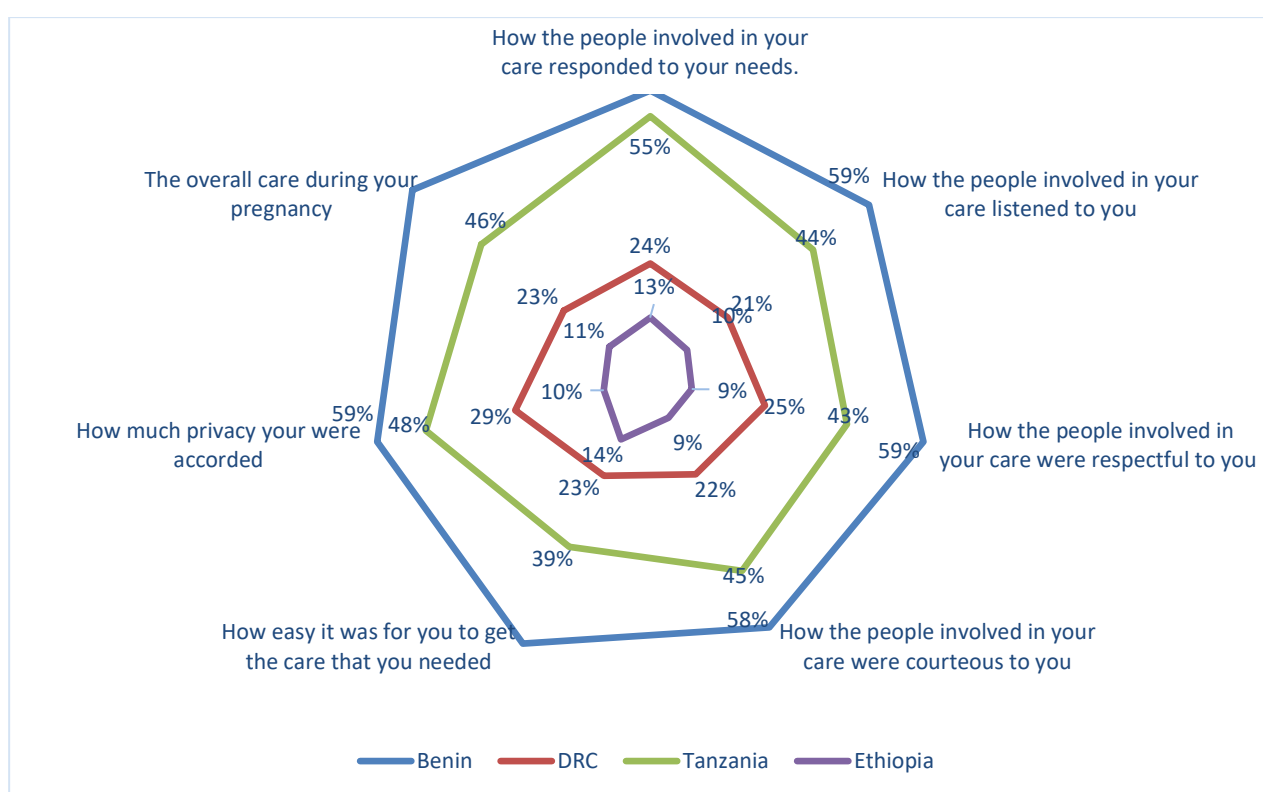
Figure 5: Women's satisfaction of care received during last pregnancy, %

Preparation for childbirth

With regard to preparation for childbirth, the table below presents of spontaneous responses from men and women.

Cronbach's alpha coefficient, sometimes referred to simply as a coefficient, is a statistic used especially in psychometrics to measure the internal consistency (or reliability) of questions asked in a test (answers to questions on the same subject needing correlation).

Table 5: Knowledge of the components of a birth plan, % (CI 95%)

	Benin n= 318		DRC n= 318		Ethiopia n= 330		Tanzania n= 318	
	% Men n= 213	%Women n= 105	% Men n= 153	%Women n= 165	% Men n=110	%Women n=220	%Men n= 119	%Women n= 199
Identification of danger signs	64.32 (57.49-70.75)	50 (40.03-59.97)	47.71 (39.58-55.93)	29.34 (22.56-36.87)	9.62 (4.96-17.38)	10.61 (7.29-15.12)	25.13 (19.26-31.75	31.09 (22.93-40.23
Identify place of delivery and skilled attendant	19.72 (14.6-25.7)	21.15 (13.76-30.26)	35.29 (27.75-43.42)	20.96 (15.05-27.92)	27.88 (19.75-37.67)	25 (19.99-30.76)	25.63 (19.72-32.28	18.49 (11.96-26.64
Plan a means of transport	7.04 (3.99-11.35)	2.88 (0.6-8.2)	33.99 (26.53-42.07)	19.16 (13.49-25.96)	19.23 (12.41-28.38)	14.02 (10.18-18.94)	60.8 (53.65-67.63	56.3 (46.91-65.37
Identification of blood donor	2.35 (0.77-5.39)	2.88 (0.6-8.2)	9.15 (5.09-14.88)	4.79 (2.09-9.22)	53.85 (43.83-63.58)	47.73 (41.60-53.93)	8.54 (5.06-13.33	3.36 (0.92-8.38)
Save money	60.09 (53.18-66.72)	58.65 (48.58-68.23)	72.55 (64.76-79.45)	74.25 (66.92-80.7)	26.92 (18.91-36.66)	24.62 (19.64-30.36)	65.83 (58.79-72.39	60.5 (51.13-69.34

The results provided during the study indicate that men and women have very little information about how to prepare for childbirth.

	Men	Women	Men	Women	Men	Women	Men	Women
	Benin		DRC		Ethiopia		Tanzania	
■ Any component	1.9	1.8	0.6	0	6.70	1.65	8.4	6
■ 1-3 components	96.1	91.2	91	74.5	85.7	87.5	78.9	69.8
■ More than 3 components	1.9	6.9	8.3	25.4	7.6	10.85	12.1	24.1
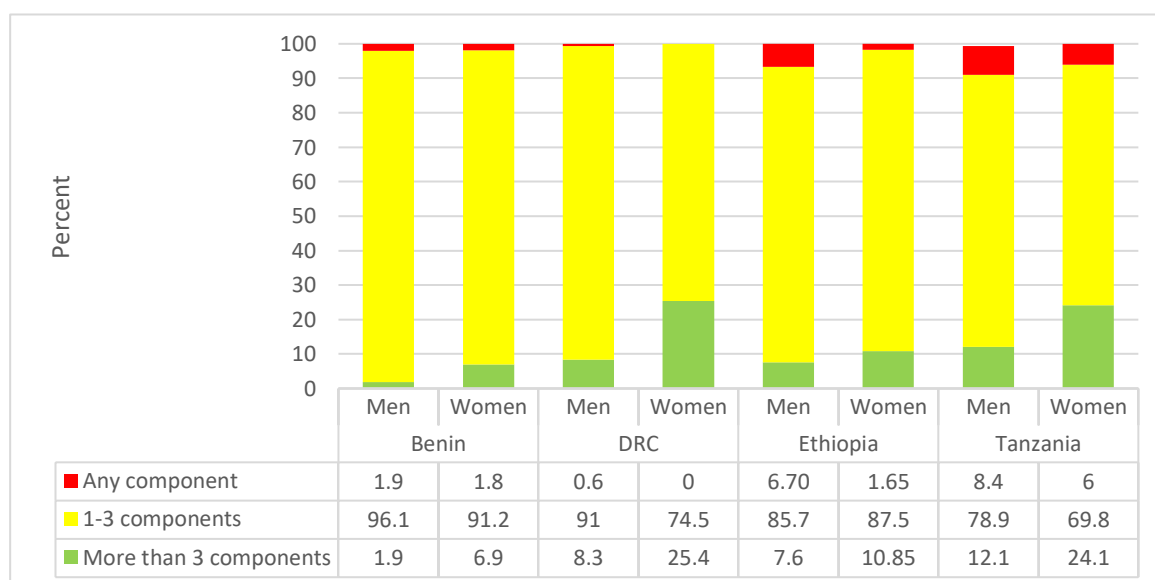
Figure 6: Knowledge of components of birth planning and preparedness among men and women, %

The household survey reflects low knowledge in communities of required actions to be taken in the event of an obstetric emergency – such as arranging transport or identifying a blood donor. Responses from all the countries demonstrated that community members are mainly preoccupied with saving money first, without forecasting any

emergencies. A great majority of people in all countries were able to spontaneously name just one or two components of birth planning. Of particular note is that Tanzania had the highest result of respondents who were unable to name any component of birth planning; 8% of men and 6% of women.

Knowledge of obstetric complications

During delivery, women experience complications that can determine the outcome of the fetus. The table below demonstrates the level of spontaneous knowledge of people surveyed in the project catchment areas regarding pregnancy and childbirth related complications.

Table 6: Level of knowledge about signs of danger during childbirth, % (CI 95%)

	Benin n= 318		DRC n= 318		Tanzania n= 318		Ethiopia n= 330	
	% Men n= 213	%Women n=105	% Men n= 153	%Women n= 165	%Men n= 119	%Women n= 199	% Men n=110	%Women n=220
Decreased fœtal movement	9.26 (5.75-13.94)	3.81 (1.05-9.47)	17.65 (11.96-24.63)	4.79 (2.09-9.22)	14.57 (9.98-20.25	5.04 (1.87-10.65)	20.19 (13.20-29.43)	21.59 (16.88-27.14)
Prolonged labour	43.98 (37.25-50.88)	17.14 (10.49-25.73)	18.3 (12.52-25.35)	8.98 (5.11-14.38)	31.6 (25.2-38.4)	19.33 (12.66-27.5831	34.62 (25.74-44.66)	35.98 (30.25-42.13)
Vaginal bleeding	48.61 (41.77-55.49)	10.48 (5.35-17.97)	52.94 (44.72-61.05)	37.13 (29.79-44.93)	51.7 (44.8-58.6)	49.58 (40.29-58.8951	61.54 (51.45-70.76)	66.29 (60.20-71.90)
Ruptured membranes	2.78 (1.03-5.95)	0.95 (0.02-5.19)	15.03 (9.77-21.7)	6.59 (3.33-11.48)	21.6 (16.4-27.8)	9.24 (4.71-15.9421	15.38 (9.31-24.08)	19.70 (15.18-25.12)
High fever	55.09 (48.2-61.85)	18.1 (11.26-26.81)	62.75 (54.57-70.42)	25.15 (18.77-32.44)	49.75 (42.6-56.9)	38.66 (29.87-48.02	18.27 (11.63-27.31)	17.42 (13.15-22.66)
High blood pressure	16.67 (11.95-22.32)	1.9 (0.23-6.71)	45.75 (37.68-53.99)	19.16 (13.49-25.96)	31.66 (25.26-38.61)	30.25 (22.17-39.35)	17.31 (10.85-26.25)	17.42 (13.15-22.66)
Fistula	0	0	0	0	0	0	0	0
Abnormal presentation	0	0	0	0	0	0	0	0
Convulsion /Fits	5.09 (2.57-8.93)	0	9.8 (5.59-15.65)	2.4 (0.66-6.02)	10.55 (6.65-15.68)	7.56 (3.52-13.87)	11.54 (6.37-19.66)	7.58 (4.81-11.64)

The men and women surveyed were found to have a low level of knowledge of pregnancy and childbirth problems. Vaginal bleeding and fever were the most commonly cited danger signs in all countries. Men and women in Tanzania, and women in DRC frequently identified blood pressure as a concern while convulsions was generally not well known, especially to women in Benin (0%). Of particular note is that obstetric fistulas and abnormal presentations was never identified as a problem among the population sampled.

	Benin		DRC		Ethiopia		Tanzania	
	Men	Women	Men	Women	Men	Women	Men	Women
■ Any sign	1	0	0.6	0	0	0	5	5
■ 1-3 signs	99	49.1	99.4	43.8	53.1	46.8	86.6	62.3
■ More than 3 signs	0	50.9	0	56.2	46.9	53.2	8.4	32.7
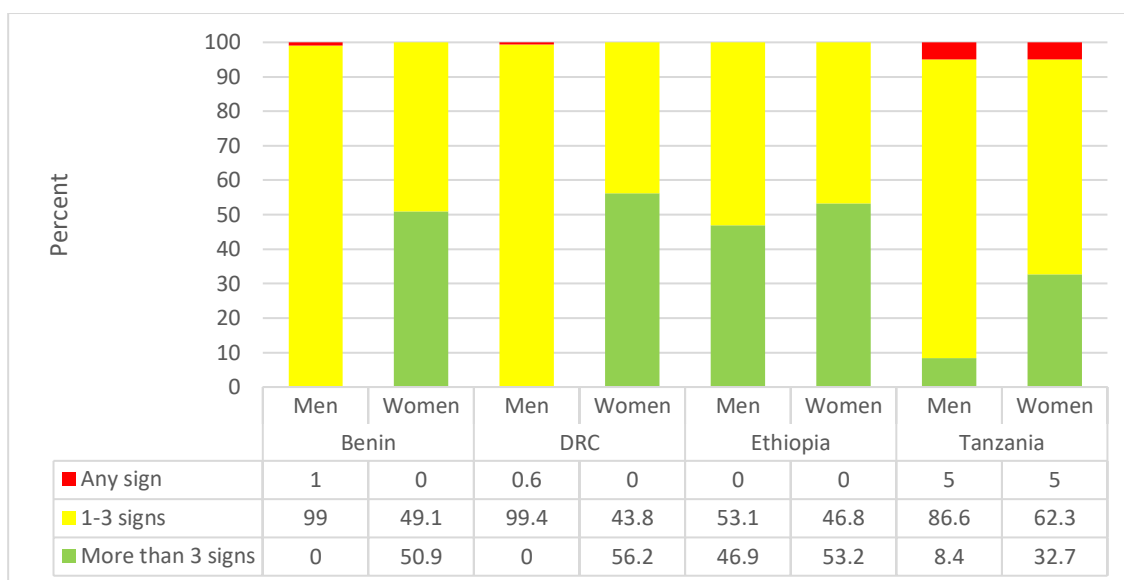
Figure 7: Knowledge of danger signs during childbirth among men and women, %

Overall, men were able to provide between one to three danger signs during childbirth where a good number of women were able to provide between one to three danger signs and more. Women's level of knowledge of danger signs at the time of childbirth remained higher than men's (P<0.05) in all countries except Ethiopia when we consider the knowledge of at least 3 danger signs.

	Benin		DRC		Ethiopia		Tanzania	
	Adolescent	Adult	Adolescent	Adult	Adolescent	Adult	Adolescent	Adult
■ Any sign	15	0.3	0	0.3	0	0	27.7	4
■ 1-3 signs	64.7	65.5	66.7	73	56.4	49.7	60	71.9
■ More than 3 signs	20.3	34.2	33.3	26.7	43.6	50.3	13.3	24.2
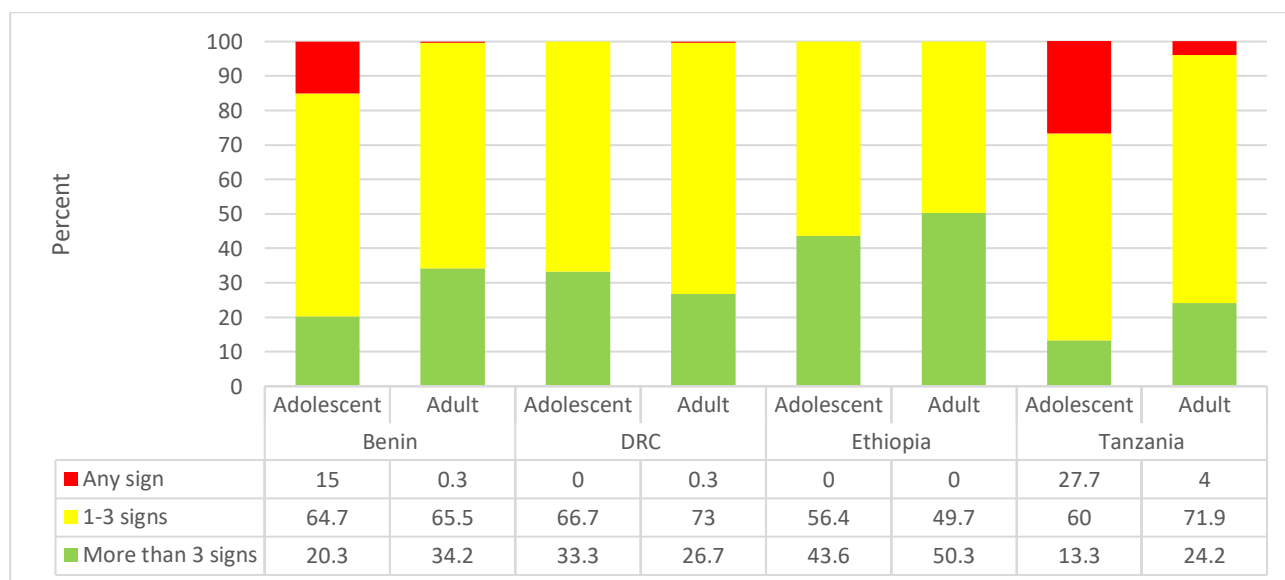
Figure 8: Knowledge of danger signs during childbirth by respondents' age, %

Fifteen percent of adolescents in Benin and 26% in Tanzania were unable to spontaneously name and danger signs during childbirth. In the DRC, the differences observed are not statistically different, whereas the level of knowledge of adults in Tanzania and Benin was significantly higher than that of adolescents. Ethiopia recorded the highest level of knowledge in adults and adolescents and this difference is not significant.

In terms of newborn problems, the table below provides the results of spontaneous responses of men and women regarding their knowledge of newborn problems that arise during the first seven days of life.

Table 7: Knowledge of newborn problems among men and women, % (CI 95%)

	Benin n= 318		DRC n= 318		Ethiopia n= 330		Tanzania n= 318	
	% Men n= 105	% Women n= 213	% Men n=165	% Women n=153	% Men n=110	% Women n=220	% Men n= 119	%Women n= 199
Bleeding of the umbilical cord	12.38 (6.76-20.24)	9.26 (5.75-13.94)	10.78 (6.51-16.5)	23.53 (17.06-31.06)	35.58 (26.61-45.63)	42.42 (36.43-48.64)	8.4 (4.1-14.91)	16.58 (11.7-22.49)
Refusal to feed	17.14 (10.49-25.73)	43.98 (37.25-50.88)	8.98 (5.11-14.38)	18.3 (12.52-25.35)	57.69 (47.61-67.19)	59.09 (52.88-65.03)	41.18 (32.24-50.57)	48.74 (41.61-55.91)
Low weight	11.43 (6.05-19.11)	45.83 (39.06-52.73)	7.19 (3.77-12.22)	13.07 (8.17-19.46)	22.12 (14.81-31.53)	17.05 (12.83-22.26)	13.45 (7.88-20.91)	37.19 (30.46-44.3)
Jaundice	6.67 (2.72-13.25)	15.74 (11.15-21.3)	11.98 (7.47-17.89)	28.76 (21.74-36.62)	9.62 (4.96-17.38)	13.26 (9.53-18.09)	10.08 (5.32-16.95)	18.59 (13.44-24.71)
Itching	0	0	23.95 (17.7-31.16)	22.22 (15.91-29.64)	28.85 (20.60-38.69)	30.68 (25.25-36.68)	9.24 (4.71-15.94)	26.63 (20.63-33.35)
Loss of consciousness	16.19 (9.72-24.65)	41.2 (34.57-48.08)	3.59 (1.33-7.66)	5.88 (2.72-10.87)	11.54 (6.37-19.66)	10.23 (6.97-14.69)	0	5.53 (2.79-9.68)
Convulsions	2.86 (0.59-8.12)	11.57 (7.63-16.61)	11.98 (7.47-17.89)	13.07 (8.17-19.46)	9.62 (4.96-17.38)	12.12 (8.56-16.82)	5.88 (2.4-11.74)	10.55 (6.65-15.68)
Fever	51.43 (41.47-61.3)	71.3 (64.77-77.23)	59.88 (52.03-67.38)	77.78 (70.36-84.09)	40.38 (31.01-50.47)	43.94 (37.90-50.16)	5.88 (2.4-11.74)	10.55 (6.65-15.68)
Respiratory difficulties	9.52 (4.66-16.82)	25 (19.37-31.33)	14.37 (9.43-20.62)	13.73 (8.7-20.21)	25 (17.26-34.62)	33.33 (27.74-38.41)	6.72 (2.95-12.82)	3.52 (1.43-7.11)
Cold /stuffiness	26.67 (18.51-36.19)	18.98 (13.98-24.86)	40.12 (32.62-47.97)	46.41 (38.32-54.64)	25.96 (18.08-35.65)	26.14 (21.03-31.95)	21.01 (14.08-29.43)	15.58 (10.84-21.38)
Cough	33.33 (24.43-43.2)	26.85 (21.07-33.29)	44.31 (36.64-52.19)	43.14 (35.17-51.38)	30.77 (22.29-40.69)	32.95 (27.38-39.02)	10.08 (5.32-16.95)	10.55 (6.65-15.68)

The newborn problems identified among the sampled population varied. The most common responses among respondents in all countries included fever, cough and refusal to eat.

In Benin, fever was reported by 70% of women and 51% of men followed by refusal to eat and underweight. Fever was also commonly cited in DRC, 77% of women and 59% of men, followed by cough and colds by more than 40% of men and women. In Tanzania, fever was rarely mentioned – only 5% men and 10% women; respiratory difficulties were indicated by 3% of women and 6% of men.

	Benin		DRC		Ethiopia		Tanzania	
	Men	Women	Men	Women	Men	Women	Men	Women
■ Any sign	2.9	3.2	3.6	2	0	0	8.4	5.5
■ 1-3 signs	90.5	60.2	80.2	66	69.4	54.7	83.2	69.8
■ More than 3 signs	6.7	36.6	16.2	32	30.6	45.3	8.4	24.6
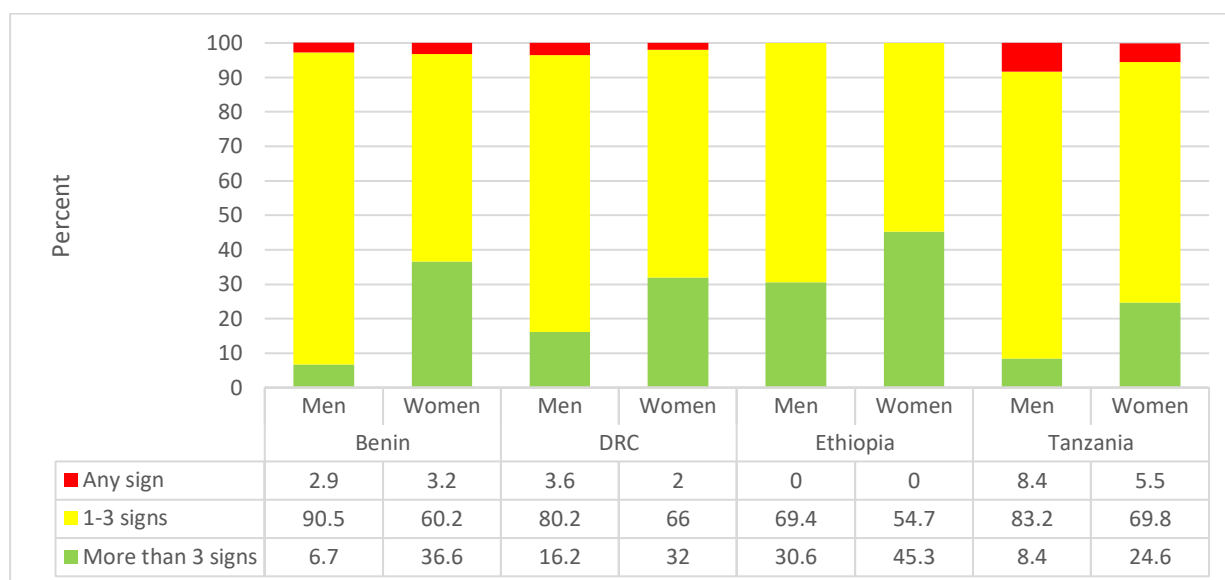
Figure 9: Knowledge of newborn danger signs among men and women, %

In general, women demonstrated a higher level of knowledge of newborn danger signs than men in all countries. Less than 20% of men and less than 40% of women can name more than three signs of danger in the newborn. In all countries, there were between two and eight percent of respondents who were unable to name any newborn danger signs.

	Benin		DRC		Ethiopia		Tanzania	
	Adolescent	Adult	Adolescent	Adult	Adolescent	Adult	Adolescent	Adult
■ Any sign	15	0.3	0	0.3	0	0	27.7	4
■ 1-3 signs	64.7	65.5	66.7	73	56.4	49.7	60	71.9
■ More than 3 signs	20.3	34.2	33.3	26.7	43.6	50.3	13.3	24.2
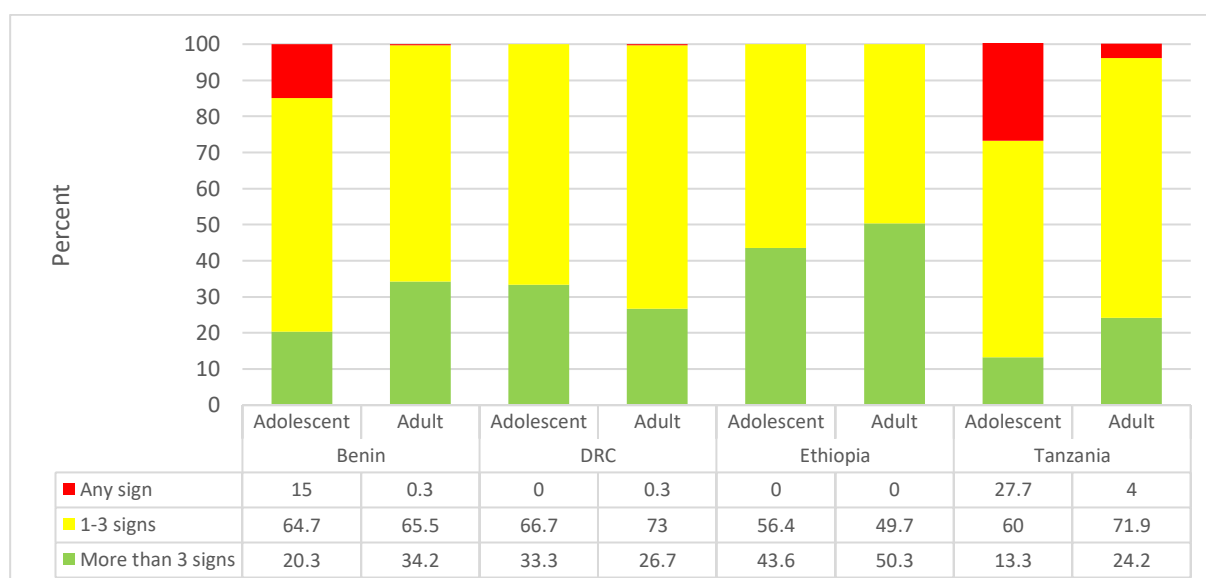
Although the difference was not significant in all countries, it was noted that adolescents have a lower level of knowledge than other age categories, particularly in Tanzania where 20% of adolescents did not identify any newborn danger sign.

The practice of newborn breastfeeding varied from one country to another. In Benin, 24% of mothers gave water as their first nourishment and 4%, other dairy product; in DRC and Ethiopia 85% breastfed. In all countries we have noted that breast milk is not always the first liquid administered to all children. In Benin, 24% receive water as first liquid and 11% in Ethiopia. In Tanzania the first nourishment to newborns looked slightly different: 39% of women provided other dairy products, 7.5% gave water, and 53% provided breastmilk.

	Benin	DRC	Ethiopia	Tanzania
■ Other	4	5	3.5	39
■ Water	24	9	11	8
■ Breastmilk	72	85	85.4	53
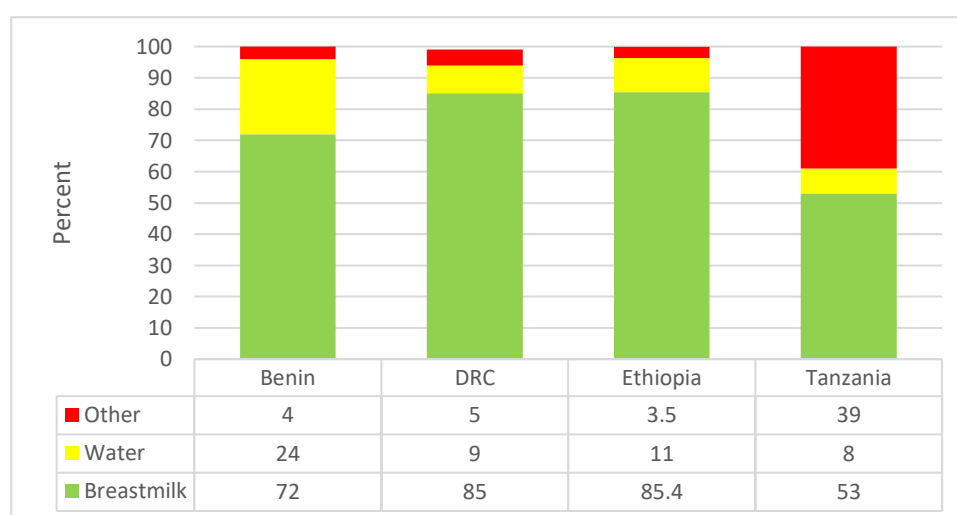
Figure 11: First nourishment provided to newborns, %

Family planning

The household survey conducted in the project catchment area also enquired about visits to health facilities to seek family planning services. Results varied and were generally low: 13.9% of women in Benin, 29.4% in the DRC, 39.7% in Tanzania and 41.5% in Ethiopia.

Regarding knowledge of modern family planning methods, such as male and female condoms, IUDs and injectables, it was revealed that in all countries, there are a quite men and women who cannot name any contraceptive method at all.

Figure 12 below shows that 32% of men and 17.6% of women in Benin, 11% of women and 7.8% of men in the DRC, and then 3.5% of women and 5% of men in Tanzania could not mention any modern family planning method.

		Benin		DRC		Ethiopia		Tanzania	
		Men	Women	Men	Women	Men	Women	Men	Women
■ Any method		32.4	17.6	7.8	11.1	0	0	5	3.5
■ One method		28.6	16.2	19.2	13.1	34.8	33	20.2	11.1
■ 2-3 methods		32.4	57.4	58.7	52.9	30	30.8	70.6	72.4
■ More than 3 methods		6.7	8.8	14.4	22.9	35.3	35.8	4.2	13.1
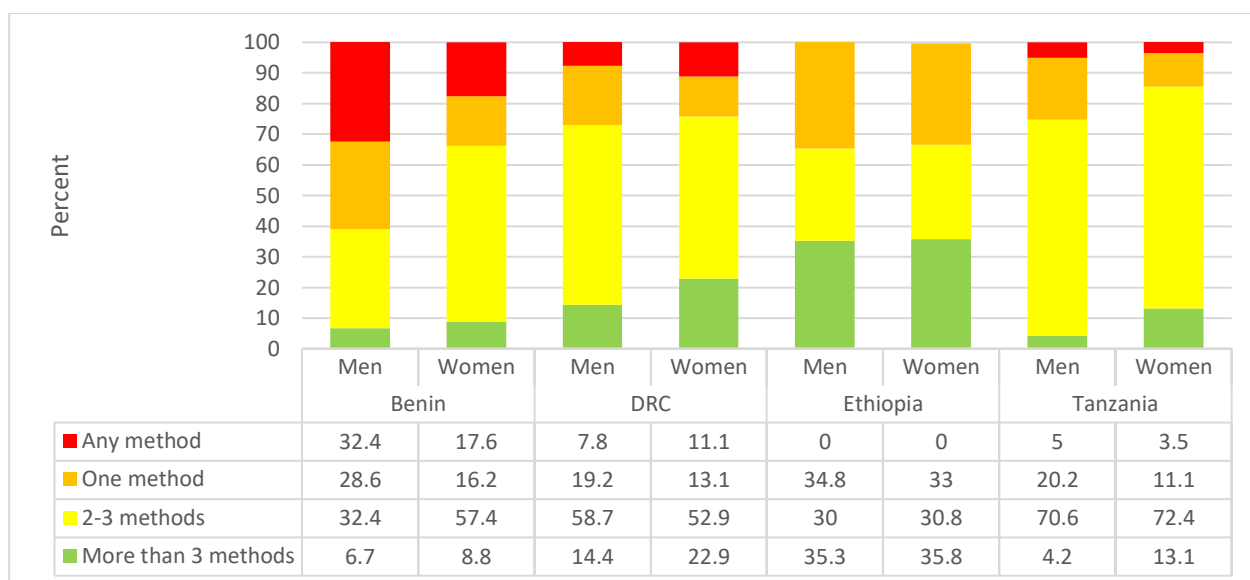
Figure 12: Knowledge of modern family planning methods identified among men and women, %

It was noted that there is a low number of women who had never used a modern method of family planning: 77% in Benin, 49% in DRC and 43% in Tanzania. The most commonly used method of family planning among women was found to be injectable contraceptives 6.6% in Benin, 29,1% in Tanzania 29.1%, while the birth control pill was the most common in DRC at 16.6%.

Among women who used a modern family planning, it was observed that the majority of their partners were aware; 71% in Benin, 77.9% in DRC, and more than 40% in Tanzania. In all countries it was reported that the partners who were aware of family plan use also contributed to the woman's choice of method.

2. Survey of Health Facilities

This section of the report presents the analysis of the data collected in health facilities (HF), in particular the knowledge and clinical management of obstetric care.

Knowledge of respectful maternity care

The knowledge of respectful maternity care (RMC) by midwives was assessed and the results indicated a low level of understanding of the concept of RMC throughout all facilities in the project catchment areas of all countries.
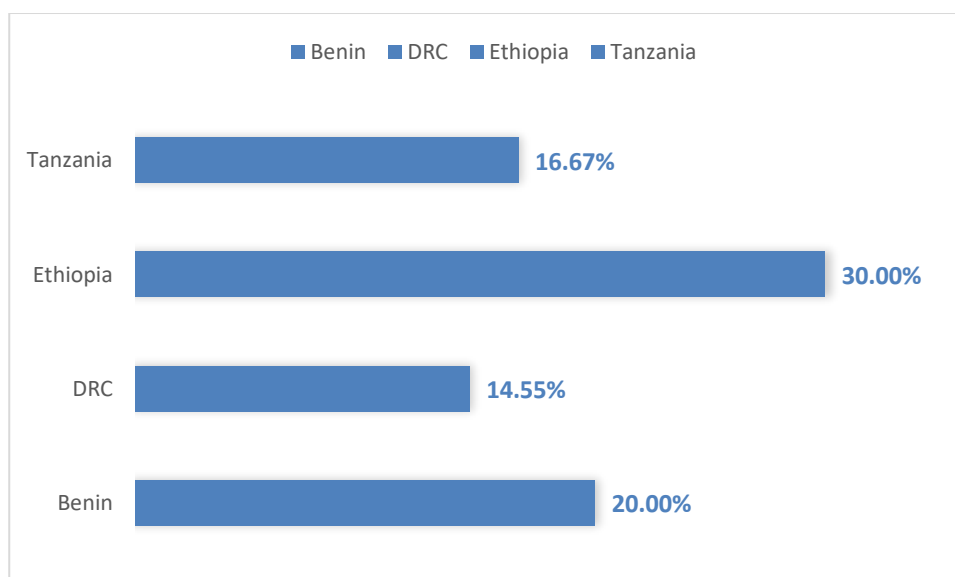
It was observed that less than 30% of midwives in all countries were able to spontaneously name three elements of RMC. The DRC and Tanzania had the lowest recall rate.

Use of a referral protocol

Forty-eight percent of midwives in Benin and 19% in the DRC reported to have been previously trained in the use of the reference protocol; however, in the DRC, 59% of midwives are experienced in the use of reference protocol. Among the trained personnel in DRC and Benin, 33% and 11% respectively, had reported to have received this training within the previous six months.

Table 7 below shows the main reasons for referral as identified in the health facility's referral register. It appears that the main reasons for referrals are haemorrhage, prolonged labour, complications related to abortion and pre-eclampsia.

Table 8: Referred obstetric cases, %

	Benin	DRC	Ethiopia	Tanzania
Ante-partum hemorrhage	15%	2%	7%	7%
Postpartum hemorrhage	7%	**45%**	4%	6%
Retained placenta	2%	3%	3%	4%
Prolonged labour	**25%**	1%	**43%**	21%
Ruptured uterus	3%	5%	1%	2%
Postnatal sepsis	5%	0%	1%	1%
Pre-eclampsia	17%	24%	8%	6%
Complication of abortion	1%	4%	2%	**25%**
Extra-uterine pregnancy	3%	0%	0%	2%
Other	22%	17%	31%	25%

Use of the partogram

Overall, less than 50% of midwives surveyed in all the MSL countries reported to have received previous training on the use of the partogram within the previous 12 months. The rates are: 27% in Benin, 13% in Ethiopia ,5.2% in DRC and 43% in Tanzania. This lack of training may explain the poor quality of documentation and completion of the partogram as shown in diagrams 13, 14, 15and 1- below.

Completion of partograms was evaluated as the proportion of components completed over a score of 15 (there were 15 components listed in the questionnaire). Completion of the partogram was considered satisfactory if at least 60% of its items were filled by midwives who provided care. Using this criterion, it was noted that 7% of the partographs were satisfactory in Benin, 16% in DRC, 52% in Ethiopia and 50% in Tanzania.

The present analysis demonstrates that information is either partially filled or not at filled all and that, overall, very few partograms were completely filled. The charts below demonstrate the quality of documentation of key components of the partogram, by country.

	Feotal heart rate (every 30 minutes)	Contraction (10 minutes during labour)	Cervical dilatation (2 hours and 4 hours)	Descent (2 hours and 4 hours)	Blood pressure (every 4 hours)	Pulse rate (every 30 minutes)	Temperature (every 4 hours)
Totaly filled	25	25	42	11	32	14	26
Partially filled	54	49	42	41	57	50	40
Not filled	21	26	16	48	11	36	33
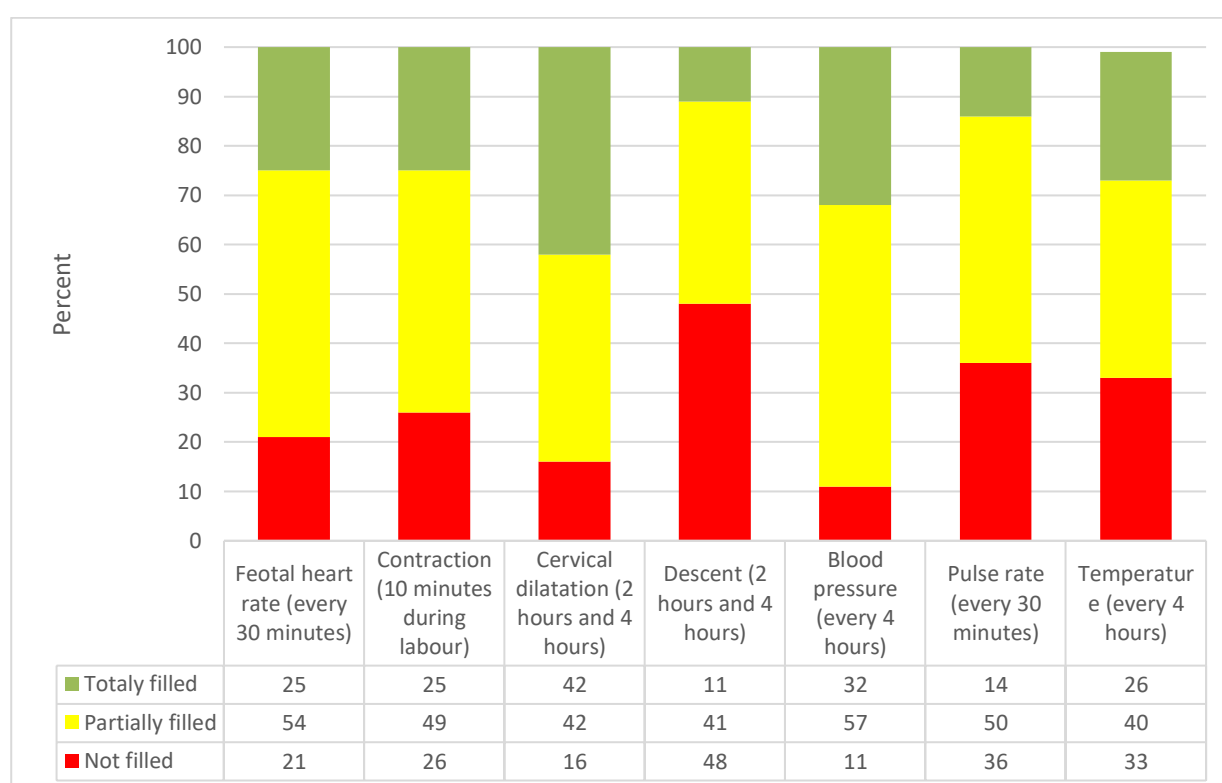
Figure 13: Quality of partograph documentation in the DRC, %

In the DRC, the most commonly recorded items of the partograph were the measurement for cervical dilatation and blood pressure, resulting in 42% and 32% respectively.
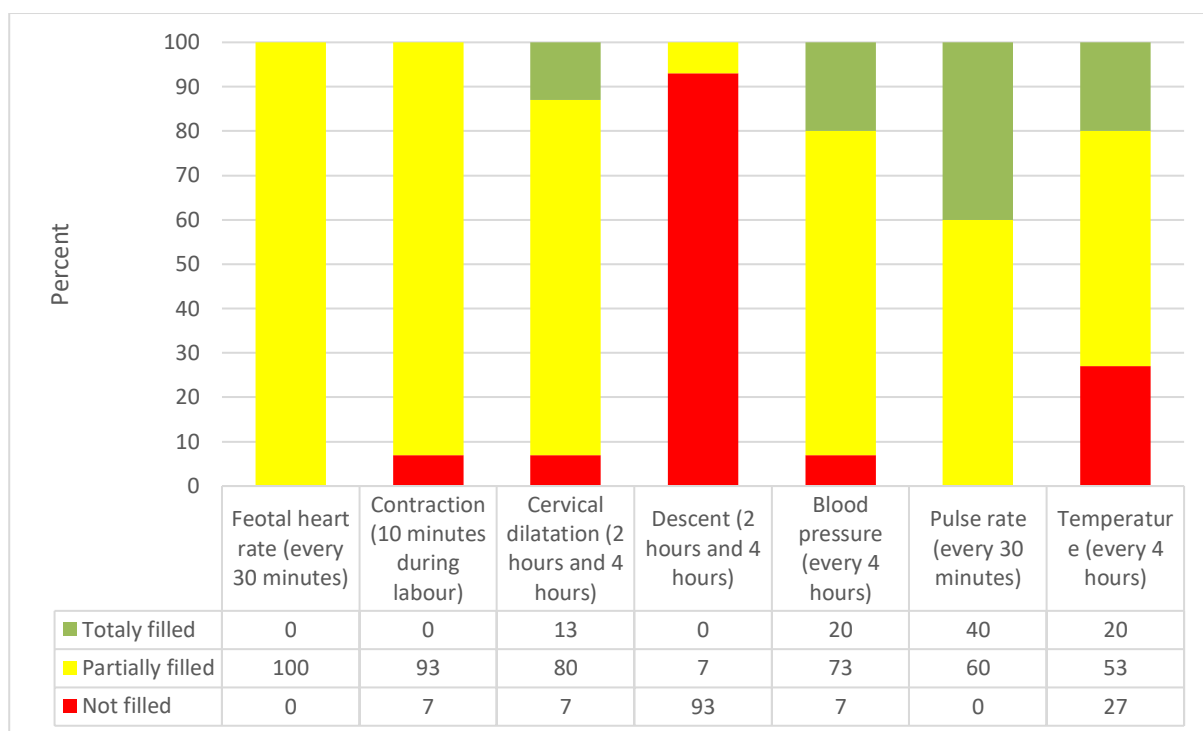
Figure 4: Quality of partograph documentation in Benin, %

	Feotal heart rate (every 30 minutes)	Contraction (10 minutes during labour)	Cervical dilatation (2 hours and 4 hours)	Descent (2 hours and 4 hours)	Blood pressure (every 4 hours)	Pulse rate (every 30 minutes)	Temperature (every 4 hours)
■ Totaly filled	0	0	13	0	20	40	20
■ Partially filled	100	93	80	7	73	60	53
■ Not filled	0	7	7	93	7	0	27

In Benin, the most commonly recorded items of the partograph were information regarding pulse 40%, blood pressure 20% and temperature 20%.

In Ethiopia, fetal heart rate, contractions and cervical dilation were completed in about 70% of the charts reviewed. Measurement of station was the weakest.

	Feotal heart rate (every 30 minutes)	Contraction (10 minutes during labour)	Cervical dilatation (2 hours and 4 hours)	Descent (2 hours and 4 hours)	Blood pressure (every 4 hours)	Pulse rate (every 30 minutes)	Temperature (every 4 hours)
■ Totaly filled	70	76	72	38	64	61	41
■ Partially filled	14	9	9	10	19	13	12
■ Not filled	15	15	18	52	17	26	47
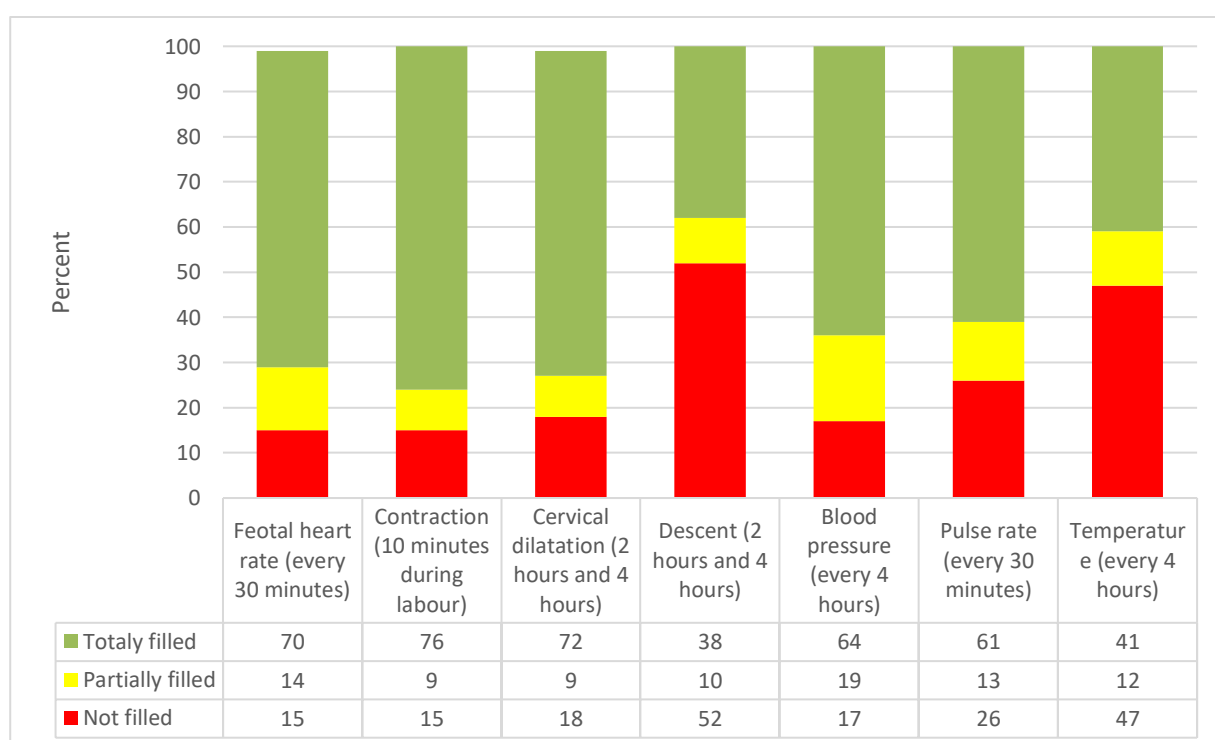
Figure 15: Quality of partograph documentation in Ethiopia, %

The results from Tanzania were very different than the other three countries in that charts were generally completed well with the measurement being the lowest – at 70%. Also in Tanzania we found a big difference between Shinyanga and Simiyu,

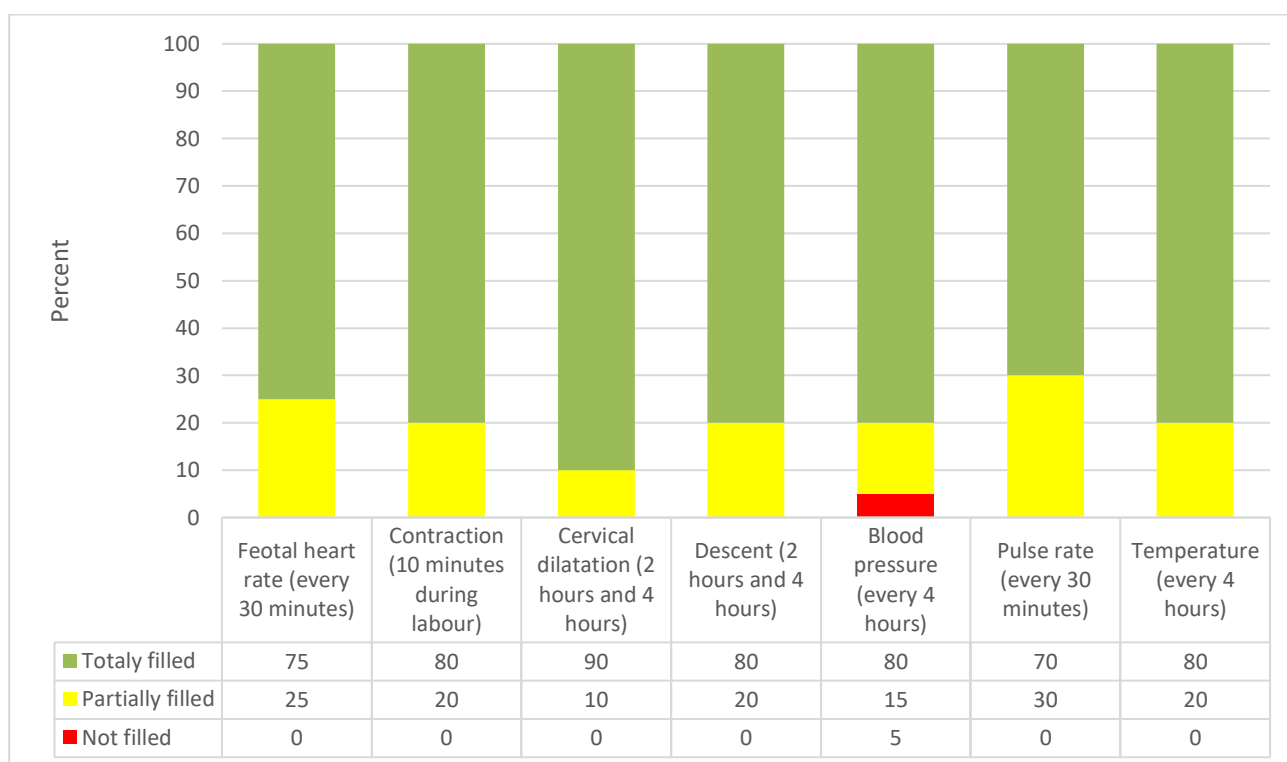| Percent	Feotal heart rate (every 30 minutes)	Contraction (10 minutes during labour)	Cervical dilatation (2 hours and 4 hours)	Descent (2 hours and 4 hours)	Blood pressure (every 4 hours)	Pulse rate (every 30 minutes)	Temperature (every 4 hours)
■ Totaly filled	75	80	90	80	80	70	80
■ Partially filled	25	20	10	20	15	30	20
■ Not filled	0	0	0	0	5	0	0

Figure 16: Quality of partograph documentation in Tanzania, %

3. Survey of the midwives' associations

One of the three pillars of the MSL project consists of strengthening the organisational capacity of the midwives' associations in each of the four countries. These midwives' associations are identified as implementing partners in the project catchment areas. The MSL Project's midwives' associations are the ASFB (Association des sages-femmes du Benin), SCOSAF (Société Congolaise de la pratique sage-femme, formerly known as the Union of Obstetricians and Gynecologists of Congo - UNAAC), EMwA (Ethiopian Midwives Association) and TAMA (Tanzanian Midwives Association).

In terms of their organizational capacity, all the associations are equipped with a membership which elects an executive council. Each association is recognized nationally and has developed a strategy for the recruitment of its members and collects membership fees. How each association functions varies; for example, EMwA and TAMA have a strong history in financial audits and relations with donors, whereas this is not the case for SCOSAF and ASFB. Similarly, the organizational capacity of each of the four associations also varies with respect to the availability of strategic documents. Some may have a strategic plan, but the implementation of the plan hasn't really taken place.

All these associations are involved in activities with the Ministry of Health, as well as with UNFPA – which works globally with national midwives' associations to support their activities. For example, the ASFB has previously

received funding from UNFPA to develop its strategic plan. Beyond meetings with the Ministry of Health, all associations have also been involved in activities to promote the International Confederation of Midwives (ICM) standards, with efforts to update training curricula at a national level.

In terms of advocacy efforts to promote the profession of midwifery and issues of their membership, all the associations have been involved with organizing various annual events such as International Women's Day, and International Day of the Midwife, as well as participating in meetings and conferences. Nonetheless, all those activities do not necessarily fit into a clearly defined advocacy strategy. At present, ASFB and SCOSAF has Cuso International/CAM and UNFPA as their only partners, unlike TAMA and EMwA, who have already had several other partners for the implementation of certain projects.

DISCUSSION

This baseline survey highlights the behaviour and knowledge of men and women, and health providers in the project catchment areas.

When considering the characteristics of the subjects at the time of the survey, a significant proportion (more than 40% in all countries) reported having become a parent before the age of 19. According to the WHO, pregnancy and childbirth complications are the second leading cause of death for girls aged 15 to 19 worldwide. In addition, children of teenage mothers have a higher risk of mortality than those born to women aged 20-24. It is therefore important to take steps to improve on the quality of care for adolescents and youth throughout the childbearing year and beyond.

The knowledge of danger signs during pregnancy, childbirth and during the postpartum period is generally low among men and women. Therefore, the risk of not responding to an obstetric or newborn emergency is high at the community level and may also lead to delayed case management which results in poorer health outcomes.

At the health facilities level, the results demonstrate a poor awareness of respectful maternity care by the midwives interviewed, which may result in low level of women's satisfaction of the care received during childbirth. It is acknowledged that low quality of services, lack of respect and courtesy, fear for exposing one's body to strangers, perception of service costs, and fear of being accompanied by a man during childbirth, are barriers to attendance of the health facilities for childbirth. Efforts are needed to improve midwives' attitudes and skills as well to understand the environment in which they work and may prevent them from providing RMC.

According to the WHO, mortality is high in countries where the proportion of women assisted by skilled professionals during childbirth is low. The results of this study show poor quality in the completion of the partograph, poor awareness of a referral protocol and low levels of professional development – less than 50% of midwives in this study have received refresher training in the previous six months. If we want to encourage women and their families to seek health services at the time of delivery, specific actions regarding training and post training support of midwives need to take place.

In terms of the midwives' associations, action should be taken to improve on their capacity to take into account the needs of members in terms of continuous training or midwifery valuation.

CONCLUSION

In accordance with its objectives, this survey has assessed the baseline of the MSL Project indicators. It also provided information on the present situation of the project's targets, identification of key communication channels for project community activities, gaps in community's knowledge and health seeking practice of reproductive health and areas of focus for in-service training of midwives. In addition, the study made it possible to have information about reproductive health cases (births, mortality, prenatal visits, family planning, referrals etc.) in the project catchment areas' health facilities.

This baseline survey will be the foundation upon which the end-line survey will enable us evaluate changes that could be attributed to the MSL project.

The following points can be highlighted from the data and data analysis:

- Low level of awareness of problems related to pregnancy within communities (especially the four leading causes of mortality);
- Absence of training / refresher courses for in-service maternity staff;
- Low level of satisfaction of care in relation to services provided by health care providers;
- Little knowledge of childbirth preparedness;
- Poor documentation in client charts and poor use of the partograph;
- Poor quality of filling of registers;

Recommendations

Based on the results of this survey, we can recommend the following (presented according to the three pillars of the project):

1100 Improved delivery of environmentally sound and gender responsive quality respectful health services for women of reproductive age, mothers, pregnant women and newborns in target regions, by:

- Taking specific actions to provide respectful maternity care to women and adolescents in particular;
  - o Improving the quality of services by focusing on the attitude of midwives and maternity health care staff;
  - o Building the capacity of midwives and maternity health care staff in quality documentation
  - o Providing training in the use of referral protocols.

1200 Improved utilization of quality gender responsive and environmentally sound health services by empowered women of reproductive age, mothers, pregnant women and newborns in target regions, by:

- Developing messages in RH for people with low levels of education, and using appropriate channels such as radio in Benin and Tanzania, and the television in the DRC;
- Carrying out specific sensitization programmes for men and adolescents on problems that go with pregnancy and childbirth;
- Carrying out sensitization campaigns on family planning;
- Promoting knowledge and use of birth plan among communities and health care staff;

- Carrying out specific informative campaigns for men and adolescents on danger signs in the newborn and when to seek health care.

1300 Strengthened capacity and influence of midwives to enhance national standards of care and increased recognition of midwifery by RMNCAH stakeholders as a cost effective, high quality path to improved reproductive, maternal and newborn health in target countries (RMNCAH), by:

- Improving on the communication capacities of midwives' associations to better consider the needs of members

There are further areas of research, in particular qualitative research that would support the implementation of the project activities:

1. Community perceptions about midwives, the profession and midwifery care
   a. Why or why not women and their families use the services of midwives at time of delivery?

2. Client satisfaction and respectful maternity care
   a. What does the community think of the care being provided at the health facility that may affect their decision to seek care?
   b. How can members of community become involved in participating in ensuring quality midwifery/maternal health care?

3. Midwives realities of their work environments
   a. Do they work in an enabling environment that allows them to provide respectful care?
   b. What impedes them in their work to provide respectful care?

4. Responsiveness of midwives' associations to their membership
   a. How can the association work for their members?
   b. What do they think the role of the association is?
   c. Do midwives understand what the association does and what the benefits to membership are?

5. Role of midwives' associations as advocates for the profession
   a. What are the issues that are important to midwives working in health centres?
   b. What issues need to be presented to midwives' associations so that the association can advocate on behalf of their membership?
   c. What do midwife members want their associations to work on?

ANNEXES

Annex 1: Changes to the Performance Measurement Framework

code	Indicator	New formulation	Reason
1100.1	Percentage of newborns disaggregated by sex put to the breast within 24 hours of birth	Percentage of newborns put to the breast within one hour of birth.	The original indicator included desegregation and was to cover 24 hours after birth. A revision of country data available (DHS and MICS) demonstrated that, this indicator is captured to reflect the situation within One hour following birth. Moreover, in the HIS, this information is reported monthly and it is not disaggregated by sex. Taking these observations into consideration we removed the disaggregation aspect and we changed the range of the indicator from 24 hours to one hour following birth. We also decided to ignore the household survey given that there is a memory bias attached to those statistics and that this data is available monthly through the HIS.

This indicator is one of the indicators that was listed in the call for proposals from Global Affairs and demonstrates good care provided to mothers as it promotes attachment parenting and respectful care to the mother and her newborn.

Health advocates recognize a connection between respectful maternity care and breastfeeding. Quoting the White Ribbon Alliance; "The respect and dignity afforded a pregnant woman during pregnancy and childbirth is critical in ensuring that she feels supported during the first hours and days after giving birth, when the breastfeeding relationship is being established. When a woman gives birth in a respectful, supportive environment, where her rights are protected, and her dignity is preserved, she is empowered to take care of herself, her baby and breastfeed". |
| 1100.2 | Proportion of Women attended by midwives satisfied with services | Reported level of satisfaction of Women attended by midwives who are satisfied by care they received for delivery | The wording of the indicator was modified to reflect that it is the Women and not the midwives who are satisfied with care. The target was also changed from "75% of women attended by midwives report being satisfied" to "15% increase in the level of satisfaction"

The rational for this change is that in some countries like DRC or Tanzania, the percentage of Women reporting satisfaction with care (23% and 46% respectively) is low, and therefore, it is over ambitious to project a 75% satisfaction at the end of project. The revised target aims for a 15% increase from the baseline level. |

code	Indicator	New formulation	Reason
1100.3	Proportion of live births attended by skilled health personnel in facilities in targeted areas.	Proportion of mothers and their newborn receiving post-natal care within three days2 postpartum and subsequent visits	During the baseline data collection, it was identified that the value of indicator as originally stated was more than 90% in all the MSL countries. Recognizing that the base-line for post-natal visits was low, it was decided that this new indicator would be a better measurement for use of health services.3
1200.1	Number of health facility clients disaggregated by sex who adopt a contraceptive method	Proportion of women who have visited a family planning service in the last six months	Data on the original indicator is not available in HIS. Only the data on women visiting health facilities to discuss family planning is available monthly. The data source for this indicator remains the attendance registers for family planning as the registers will demonstrate people's behaviour change (utilization of services) through the numbers of people attending the clinic: less, same or more. The numerator would be the number of women attending the clinic and the denominator would be the number of Women of reproductive age in the community.
1200.3	Proportion of target communities with a functional health committee discussing RMNCAH issues	Proportion of target communities with a functional health committee discussing utilization of health services with health authorities	This indicator was adjusted to make the connection between a functional health committee and the use of health services clearer.
1110.2	Percentage of midwives who can correctly define respectful RMNCAH care	Midwives' awareness of respectful RMNCAH care	This indicator is being captured qualitatively, hence it is not possible to measure it with a percentage
	1120-2 Percentage of midwives who can correctly identify cases requiring referral to the higher level	1120-2 Percentage of midwives who can spontaneously identify 3 cases requiring referral to the higher level	
1120.3	Percentage of women presenting with complications related to one of four direct causes of maternal death who were referred.		This indicator has been removed because the data is either not available or not consistent across all health facilities.
1210.1	Level of awareness among men, women and Community Health	Level of awareness among men and women regarding	

code	Indicator	New formulation	Reason
	Workers (CHW) regarding RMNCAH issues	signs of danger during pregnancy	
1210.2	Level of awareness among men, women and CHW regarding the importance of birth plans (including measures in case of complications) in target communities	Level of awareness among men and women regarding the importance of birth plans (including complications) in target communities	
1322.1	Number of technical expert days focusing on midwifery standards and scope of practice provided to members of the midwifery associations to support regulation efforts	Number of technical expert/mentoring days focusing on midwifery standards and scope of practice provided to members of the midwifery associations to support regulation efforts.	The word "mentoring" is added to clarify what the activity entails. CAM may recruit experts to provide technical support and mentoring as well as to develop tools or other products.
1335.1	Number of technical expert days focusing on mechanisms to reach members provided to the secretariat of the midwives' associations to support capacity building	Number of technical expert/mentoring days focusing on mechanisms to reach members provided to the secretariat of the midwifery associations to support capacity building.	The word "mentoring" is added to clarify what the activity entails. CAM may recruit experts to support partner associations in exploring innovative strategies to achieve greater self-reliance.
1220.3	Number of forums organized by health committees to be reported to the community	*(deleted)*	
1221	Workshops delivered for women, men and community leaders	Workshops delivered for women, men and community leaders to enhance advocacy capacity of members of community health committees	Clarify what the workshop is about: The idea is to deliver workshops for members of Community Health Committees (Women, Men and community leaders) that will enhance their capacity to assess the quality of health services, advocate on behalf of the community and report back.
1222	The word "mentoring" is added to clarify what the activity	Training and mentoring activities to health authorities that aim to	

code	Indicator	New formulation	Reason
	entails. CAM may recruit experts to support partner associations in exploring innovative strategies to achieve greater self-reliance.	strengthen their capacity of dialogue with the community.	
1311	Curriculum, evaluation and clinical practice guidelines evaluated in collaboration with key stakeholders and gaps identified	Collaborative workshops and meetings carried out to evaluate national curricula and review clinical practice guidelines	The expected result at the immediate outcome level is "an increased capacity to collaborate with key stakeholders to strengthen curricula and clinical practice guidelines." The indicator is changed to emphasize the evaluations themselves rather than the collaboration.
1312	Action plan collaboratively designed through mentoring and training support	Collaborative workshops carried out; and mentoring and training support provided to design action plan.	The expected result at the immediate outcome level is "an increased capacity to collaborate with key stakeholders to strengthen curricula and clinical practice guidelines." The indicator is changed to emphasize the action plans themselves rather than the collaboration.
1330	Increased capacity of midwives' associations to ensure leadership and advocacy for midwives	(deleted)	

Annex 2: Performance Measurement Framework

Expected results (LM)	Indicators	Baseline data[6]	Targets[7]	Data source	Data collection methods	Frequency	Responsibility
Ultimate Outcome							
1000 Contribute to the reduction of maternal and child mortality in targeted regions of Benin, DRC, Ethiopia and Tanzania.	Maternal mortality ratio	**Benin[8]:** 397 per 100 000 **DRC[9]:** 846 per 100 000 **Ethiopia[10]:** 676 per 100 000 **Tanzania:** 556 per 100 000	Bénin: 125 per 100 000 DRC: 548[11] per 100 000 Ethiopia: 199 per 100 000 Tanzania: 292 per 100 000	National strategic plans	Data review	Baseline-Endline	MSL MEAL Manager
	Neonatal mortality rate	**Benin:** 42 per 1,000 **DRC:** 58 per 1,000 **Ethiopia:** 37 per 1,000 **Tanzania:** 25 per 1,000[12]	Bénin: 10[13] per 1,000 DRC: 25[14] per 1,000 Ethiopia: 10[15] per 1,000 Tanzania: 16[16] per 1,000	National strategic plans	Data review	Baseline-Endline	MSL MEAL Manager
Intermediate Outcome							
1100 Improved delivery of gender responsive quality respectful health	1100.1 Percentage of newborns in targeted health facility put to the breast within one hour of birth	**Benin:** 36.9% **DRC:** 51.3%	Increase of 1.2%[17] per year	Health facility registry	Desk review	Baseline - Yr3Q2 -Endline	MSL MEAL Manager

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[6] To be completed following baseline.

[7] Targets to be revised after baseline data collection is completed

[8] DHS 2011

[9] DHS 2013

[10] DHS 2011

[11] PNDS (Plan national de développement sanitaire de la RDC 2016 – 2020).

[12] DHS 2015,

[13] http://www.nationalplanningcycles.org/sites/default/files/country_docs/Benin/benin_pnds_2009-2018_last_year_version_-_fr.pdf

[14] MSP. RDC – Plan d'action chaque nouveau-né 2018 – 2020. Avril 2018

[15] https://www.globalfinancingfacility.org/sites/gff_new/files/Ethiopia-health-system-transformation-plan.pdf

[16] https://www.globalfinancingfacility.org/sites/gff_new/files/Tanzania_One_Plan_II.pdf

[17] Pour cet indicateur, l'OMS recommande une augmentation 1,2% minimum par an.

Expected results (LM)	Indicators	Baseline data[6]	Targets[7]	Data source	Data collection methods	Frequency	Responsibility
services for women of reproductive age, mothers, pregnant women and newborns in target regions.		**Ethiopia**: *Bale*=52.6% *Assosa*=42.0% **Tanzania**: *Simiyu*=29.0% *Shinyanga*=33.0%					
	1100.2 Percentage of women attended by midwives in targeted health facilities who report being satisfied with service	**Benin**: 63.9% **DRC**: 22.9% **Ethiopia**: *Bale*=75.4% *Assosa*=15.4% **Tanzania**: *Simiyu*=50.5% *Shinyanga*=39.3%	15% increase in the number of women who are attended by midwives and report level of satisfaction with service	Sample of women attended by midwives	Client satisfaction surveys/focus groups	Baseline - Yr3Q2 -Endline	MSL MEAL Manager
	1100.3 Percentage of mothers and their newborns in target health facility receiving post-natal care within three days postpartum and subsequent visits[18]	**Benin**: Mother=65.0% Newborn=21.3% **DRC**: Mother=63.8% Newborn=19.4% **Ethiopia**: Mother *Bale*=5.0% *Assosa*=9.3% Newborn *Bale*= 6.5% *Assosa*= 14.5% **Tanzania** Mother:	15% increase in targeted health facilities	Health facility registry	Desk review	Baseline - Yr3Q2 -Endline	MSL MEAL Manager

Expected results (LM)	Indicators	Baseline data[6]	Targets[7]	Data source	Data collection methods	Frequency	Responsibility
		Simiyu = 30.7% *Shinyanga* = 8.9% Newborn: *Simiyu* = 40.5% *Shinyanga* = 15.1%					
1200 Improved utilization of gender responsive health services by empowered women of reproductive age, mothers, pregnant women and newborns in target regions.	1200.1 Percentage of women visiting targeted health facilities seeking family planning in targeted health facilities.	**Benin:** 13.9% **DRC:** 29.4% **Ethiopia:** *Bale*=28.2% Assosa=40.9% **Tanzania:** *Simiyu*=42.3% *Shinyanga*=36.9%	15% increase in targeted health facilities	Household survey	Interview	Baseline – Y3Q2 -Endline	MSL MEAL Manager
	1200.2 Percentage of women having received at least four antenatal visits in targeted health facilities	**Benin:** 42.0% **DRC:** 52.0% **Ethiopia:** Bale=34.0% Assosa=19.0% **Tanzania :** *Simiyu*=34.0% *Shinyanga*=36.4%	15% increase in targeted health facilities	Health facility registry	Desk review	Baseline - Yr3Q2 -Endline	MSL MEAL Manager
1300 Strengthened capacity and influence of midwives to enhance national standards of care and increased recognition of midwifery by RMNCAH stakeholders as a cost effective, high quality path to improved	1300.1 Number of new national documents integrating ICM standards for midwifery	**Benin :** 0 **DRC :** 0 **Ethiopia :** 0 **Tanzania :** 0	1 new document per country as a minimum	Review of reports	Desk review	Baseline - Annually - Endline	MSL MEAL Manager
	1300.2 Number of meetings organised by leadership of local midwifery association with teaching institutions and MoH to discuss clinical guidelines issues	**Benin:** 0 **DRC:** 0 **Ethiopia:** 0 **Tanzania:** 0	At least two meetings by the end of the project	Review of reports	Desk review	Baseline - Annually - Endline	CAM`s Project Officer
	1300.3 Number of meetings organised by leadership of local midwifery association	**Benin:** 0	At least one meeting per year/	Review of reports	Desk review	Baseline - Annually - Endline	CAM`s Project Officer

Expected results (LM)	Indicators	Baseline data[6]	Targets[7]	Data source	Data collection methods	Frequency	Responsibility
reproductive, maternal and newborn health in target countries.	with teaching institutions and MoH to discuss curriculum	**DRC:** N/A[19] **Ethiopia:** 0 **Tanzania:** 0	country (except DRC)				
	1300.4 Number of meetings organised by representatives of the midwifery associations to discuss midwifery regulatory and licensing issues	**Benin:** N/A **DRC:** 0 **Ethiopia:** 0 **Tanzania:** 0	At least one meeting per year / per country (except Benin)	Review of reports	Desk review	Baseline - Annually - Endline	CAM`s Project Officer
Immediate Outcomes							
1110 Enhanced skills/competencies of midwives to provide timely quality and respectful RMNCAH care, including basic emergency obstetric newborn care (BEmONC).	1110.1 Percentage of partographs correctly filled by midwives in project catchment area	**Benin:** 7.3% **DRC:** 16.0% **Ethiopia:** *Bale*=53.0% *Assosa*=52.0% **Tanzania**: *Simiyu*=71.8% *Shinyanga*=33.3%	At least 75 % of partographs are correctly filled	Partographs in health facilities	Review of partographs (form)	Baseline-Yr3Q2-Endline	MSL MEAL Manager
	1110.2 Percentage of trained midwives, in targeted facilities, who can spontaneously recall three elements of respectful RMNCAH care	**Benin:** 20.0% **DRC:** 16.4% **Ethiopia:** *Bale*=30.0% *Assosa*=30.0% **Tanzania**: *Simiyu*=20.3% *Shinyanga*=12.7%	50% of trained midwives can spontaneously recall three elements of RMNCAH in all countries	Midwives	Interviews	Baseline-Yr3Q2-Endline	MSL MEAL Manager

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[19] This indicator is not being measured in DRC. UNFPA has recently conducted a significant activity which resulted in a newly revised curriculum. The project in DRC has decided to focus on improving clinical practice coaching of student midwives.

Expected results (LM)	Indicators	Baseline data[6]	Targets[7]	Data source	Data collection methods	Frequency	Responsibility
1120 Increased skills of midwives to provide timely referrals of women suffering complications during pregnancy and delivery to secondary and tertiary services.	1120.1 Percentage of midwives, from targeted facilities, who know the referral protocol	**Benin:** 13.3% **DRC:** 3.6% **Ethiopia:** *Bale*=20.0% *Assosa*=10.0% **Tanzania :** *Simiyu*=15.0% *Shinyanga*=10.9%	At least 75% of midwives know the referral protocol	Midwives	Interviews	Baseline-Yr3Q2-Endline	MSL MEAL Manager
	1120.2 Percentage of midwives in targeted health facilities who can spontaneously identify three obstetric emergencies requiring referral to a higher facility level	**Benin:** 20.0% **DRC:** 21.8% **Ethiopia:** *Bale*=40.0% *Assosa*=20.0% **Tanzania**: *Simiyu*=43.3% *Shinyanga*=21.8%	At least 75% of midwives know what cases require referral	Midwives	Interviews	Baseline-Yr3Q2-Endline	MSL MEAL Manager
1210 Increased awareness of men, women, and CHWs to effectively support the health needs of women of reproductive age, mothers, pregnant women and newborns.	1210.1 Percentage of men, and women in targeted communities who can properly identify three pregnancy danger signs	**Benin:** F=36.9% M=16.1% **DRC:** F=19.6% M= 11.5% **Ethiopia:** *Bale:* F=51.4% M=24.5% Assosa : *F=41.8%* *M=37.2%*	Increase of 5 % in target group can identify at least three danger signs[20] in pregnancy	Household members	Interviews/survey with sample of target beneficiaries	Baseline – Yr3Q2 – Endline	MSL MEAL Manager and Cuso Int.'s in-country project focal point

[20] Example pregnant women and their partners know 3 or more maternal danger signs; mothers know when to put a newborn to breast for the first time; know optimal time for exclusive breastfeeding.

Expected results (LM)	Indicators	Baseline data[6]	Targets[7]	Data source	Data collection methods	Frequency	Responsibility
		Tanzania: *Simiyu:* F=8.7% M=16.0% *Shinyanga:* F=51.8% M=27.3%					
	1210.2 Percentage of men and women in targeted communities who know three elements of the birth plan (including provisions for complications)	**Benin:** F=6.9% M=1.9% **DRC:** F=25.4% M= 8.4% **Ethiopia:** *Bale:* F=21.8% M=15.2% *Assosa:* F=6.4% M=0 **Tanzania:** Simiyu F=12.3% M=3.1% Shinyanga F=28.2% M=22.7%	Increase of 15% of target group can identify at least three key elements of a birth plan (including planning for emergencies)	Household members	Interviews/survey with sample of target beneficiaries	Baseline – Yr3Q2 – Endline	MSL MEAL Manager and Cuso Int.'s in-country project focal point
1220 Increased capacity of men and women to participate in evaluating the quality of local reproductive, maternal, newborn and child health care services.	1220.1 Proportion of target communities with a functional health committee discussing utilization of health services with health authorities	**Benin:** 0/15 **DRC:** 0/9 **Ethiopia:** 0/6 **Tanzania:** 0/10	At least 50% of communities have a functional[i] health committees	Activity report	Desk review	Baseline-Endline	MSL MEAL Manager and Cuso Int.'s in-country project focal point
	1220.2 Percentage of people (M/F) within targeted communities who can identify the role of health committees.	**Benin:** F=15.3% M=11.4% **DRC:**	15% increase	Household survey	Interviews/survey with sample of target beneficiaries	Baseline – Yr3Q2 – Endline	MSL MEAL Manager and Cuso Int.'s in-country

Expected results (LM)	Indicators	Baseline data[6]	Targets[7]	Data source	Data collection methods	Frequency	Responsibility
		F=17.6% M=10.2% **Ethiopia:** *Bale*: F=20.0% M=19.6% *Assosa*: F=30.0% M=25.0% **Tanzania:** *Simiyu*: F=28.1% M=16.5% *Shinyanga*: F=18.8% M=15.8%					project focal point
1310 Increased capacity of Midwives Associations to collaborate with stakeholders to strengthen curricula and clinical practice guidelines.	1310.1 Number of meetings regarding clinical practice guidelines or curricula with key stakeholders organized by midwives' associations	**Benin:** N/A **DRC:** 0 **Ethiopia:** 0 **Tanzania:** 0	At least one meeting per year / per country (except Benin)	Activity report	Desk review	Bi-annually	MSL MEAL Manager
	1310.2 Percentage of Midwifery Association representatives who report they can develop an action plan after a key stakeholder meeting	**Benin:** 40.0% **DRC:** 40.0% **Ethiopia:** 50.0% **Tanzania:** 50.0%	50% increase	MA assessment	Self-assessment tool	Baseline-Endline	MSL MEAL Manager
1320 Increased ability of Midwifery Associations to contribute to strengthening Midwifery regulatory	1320.1 Percentage of midwives' association representatives who report they can plan, initiate and lead policy dialogue forums with key national RMNCAH actors	**Benin:** 40.0% **DRC:** 20.0% **Ethiopia:** 40.0% **Tanzania:** 40.0%	50% increase (in applicable countries – Tanzania, DRC)	MA assessment	Self-assessment tool	Baseline-Endline	MSL MEAL Manager

Expected results (LM)	Indicators	Baseline data[6]	Targets[7]	Data source	Data collection methods	Frequency	Responsibility
and licensing infrastructure.	1320.2 Percentage of midwives' association representatives who report they can plan, initiate and carry out meetings regarding midwifery licensing and regulation with key stakeholders	**Benin:** 0 **DRC:** 40.0% **Ethiopia:** 50.0% **Tanzania:** 50.0%	50% increase (in applicable countries – DRC, Ethiopia, Tanzania)	MA assessment	Self-assessment tool	Baseline-Endline	MSL MEAL Manager
1330 Increased capacity of Midwifery Associations to provide leadership and advocate on behalf of midwives.	1330.1 Number of advocacy initiatives launched/implemented by midwifery associations	**Benin:** 0 **DRC:** 0 **Ethiopia:** 0 **Tanzania:** 0	At least three advocacy initiatives per country receive attention in public media	Activity report	Analysis of press releases and other materials produced by the media	Bi-annual	CAM`s Project Officer
	1330.2 Number of members belonging to the midwives' association	**Benin** 497 **DRC:** 4,530 **Ethiopia:** 5,000 **Tanzania:** 4,500	Increase of 10% per year	MA Assessment	Pre and post project survey	Bi-annual	CAM`s Project Officer

Outputs

Expected results (LM)	Indicators	Baseline data[6]	Targets[7]	Data source	Data collection methods	Frequency	Responsibility
1111 Training, mentoring and equipment delivered to midwifery instructors within health facilities.	1111.1 Number of midwifery instructors (F/M) trained on teaching methodologies, RMNCAH clinical updates and respectful and environmentally sound care.	**Benin:** 0 **DRC:** 0 **Ethiopia:** 0 **Tanzania:** 0	B 16 D 25 E 50 T 24 Tot 115	Training report	Desk review	Bi-annually	Cuso Int.'s in-country project focal point
	1111.2 Percentage of participants who report being satisfied with training	**Benin:** N/A **DRC:** N/A **Ethiopia:** N/A **Tanzania:** N/A	75% of participants report being satisfied with training	Evaluation forms	Desk review	Bi-annually	Cuso Int.'s in-country project focal point
1112 Training and mentoring delivered to in-service midwives.	1112.1 Number of in-service midwives (F/M) trained in RMNCAH clinical updates and respectful and environmentally sound care.	**Benin:** 0 **DRC:** 0 **Ethiopia:** 0 **Tanzania:** 0	B 100 D 350 E 350 T 460 Tot 1260	Training report	Desk review	Bi-annually	Cuso Int.'s in-country project focal point

Expected results (LM)	Indicators	Baseline data[6]	Targets[7]		Data source	Data collection methods	Frequency	Responsibility
	1112.2 Percentage of participants who report being satisfied with training	**Benin**: N/A **DRC**: N/A **Ethiopia**: N/A **Tanzania**: N/A	75% of participants report being satisfied with training		Evaluation forms	Desk review	Bi-annually	Cuso Int.'s in-country project focal point
1113 Training and mentoring delivered to health administrators.	1113.1 Number of health administrators (F/M) trained on RMNCAH clinical updates and respectful and environmentally sound care.	**Benin**: 0 **DRC**: 0 **Ethiopia**: 0 **Tanzania**: 0	B	55	Training report	Desk review	Bi-annually	Cuso Int.'s in-country project focal point
			D	45				
			E	126				
			T	100				
			Tot	326				
	1113.2 Percentage of participants who report being satisfied with training	**Benin**: N/A **DRC**: N/A **Ethiopia**: N/A **Tanzania**: N/A	75% of participants report being satisfied with training		Evaluation forms	Desk review	Bi-annually	Cuso Int.'s in-country project focal point
1114 Training and mentoring delivered to Midwives Associations/MoH.	1114.1 Number of technical expert days provided to MoH/midwives' associations to enhance model of midwifery supervision and standards of care	**Benin**: 0 **DRC**: 0 **Ethiopia**: 0 **Tanzania**: 0	B	350	Activity reports	Desk review	Bi-annually	Cuso Int.'s in-country project focal point
			D	348				
			E	N/A				
			T	46				
			Tot	744				
1121 Training, mentoring and resource materials delivered to HCP's on referral/counter referral protocols.	1121.1 Number of health care professionals (F/M) trained on referral and counter-referral protocols	**Benin**: 0 **DRC**: 0 **Ethiopia**: 0 **Tanzania**: 0	B	100	Training report	Desk review	Bi-annually	Cuso Int.'s in-country project focal point
			D	350				
			E	64				
			T	680				
			Tot	1194				
	1121.2 Percentage of participants who report being satisfied with training	**Benin**: N/A **DRC**: N/A **Ethiopia**: N/A **Tanzania**: N/A	75% of participants report being satisfied with training		Evaluation forms	Desk review	Bi-annually	Cuso Int.'s in-country project focal point
1122 Interdisciplinary RMNCAH networks and forums created and facilitated.	1122.1 Number of interdisciplinary forums organized	**Benin**: 0 **DRC**: 0 **Ethiopia**: 0 **Tanzania**: 0	B	3	Activity report	Desk review	Bi-annually	Cuso Int.'s in-country project focal point
			D	13				
			E	3				
			T	7				
			Tot	26				
1211 Sensitization campaigns delivered through CHW's for	1211.1 Number of sensitization activities delivered	**Benin**: 0 **DRC**: 0 **Ethiopia**: 0	B	3 per com	Activity report	Desk review	Bi-annually	Cuso Int.'s in-country
			D	12 per com				
			E	12 per com				

Expected results (LM)	Indicators	Baseline data[6]	Targets[7]		Data source	Data collection methods	Frequency	Responsibility
men, women and former TBAs.		**Tanzania**: 0	T	3 per com				project focal point
			Tot	30activites				
	1211.2 Number of communities targeted for sensitization activities	**Benin**: 0 **DRC**: 0 **Ethiopia**: 0 **Tanzania**: 0	B	16	Activity report	Desk review	Bi-annually	Cuso Int.'s in-country project focal point
			D	9				
			E	150				
			T	273				
			Tot	328				
1212 Gender sensitive workshops and trainings delivered through CHWs, for women, men & TBAs.	1212.1 Number CHWs, men, women and TBAs (F/M) trained in birth planning and positive newborn care practices	**Benin**: 0 **DRC**: 0 **Ethiopia**: 0 **Tanzania**: 0	B	600	Training report	Desk review	Bi-annually	Cuso Int.'s in-country project focal point
			D	1010				
			E	320				
			T	200				
			Tot	2130				
1213 Workshops with men and boys developed and delivered on gender dimensions of three delays and harmful traditional practices.	1213.1 Number of men and boys trained in gender inequality and harmful traditional practices	**Benin**: 0 **DRC**: 0 **Ethiopia**: 0 **Tanzania**: 0	B	600	Training report	Desk review	Bi-annually	Cuso Int.'s in-country project focal point
			D	720				
			E	360				
			T	273				
			Tot	1,953				
1221 Workshops delivered for women, men and community leaders to enhance advocacy efforts of community health committees' members.	1221.1 Number of women, men and community leaders (F/M) who attend workshops in strengthening advocacy efforts of community health committees' members	**Benin**: 0 **DRC**: 0 **Ethiopia**: 0 **Tanzania**: 0	B	75	Activity report	Desk review	Bi-annually	Cuso Int.'s in-country project focal point
			D	540				
			E	150				
			T	245				
			Tot	1,010				
1222 Training and mentoring activities to health authorities that aim to strengthen their capacity of dialogue with the community.	1222.1 Number of local health authorities (F/M) trained to strengthen their capacity to respond to community's concerns related to local RMNCAH services.	**Benin**: 0 **DRC**: 0 **Ethiopia**: 0 **Tanzania**: 0	B	55	Training report	Desk review	Bi-annually	Cuso Int.'s in-country project focal point
			D	36				
			E	90				
			T	100				
			Tot	281				
	1222.2 Percentage of participants who report being satisfied with training	**Benin**: N/A **DRC**: N/A **Ethiopia**: N/A **Tanzania**: N/A	75% of participants report being satisfied with training		Evaluation forms	Desk review	Bi-annually	Cuso Int.'s in-country project focal point

Expected results (LM)	Indicators	Baseline data[6]	Targets[7]		Data source	Data collection methods	Frequency	Responsibility
1311 Collaborative workshops and meetings carried out to evaluate national curricula and review clinical practice guidelines.	1311.1 Number of national curricula (NC) and/or clinical practice guidelines (CPG) reviewed in collaboration with key stakeholders	**Benin**: 0 **DRC**: 0 **Ethiopia**: 0 **Tanzania**: 0	<table><tr><td></td><td>NC</td><td>CPG</td></tr><tr><td>B</td><td>0</td><td>2</td></tr><tr><td>D</td><td>N/A</td><td>N/A</td></tr><tr><td>E</td><td>2</td><td>2</td></tr><tr><td>T</td><td>2</td><td>4</td></tr><tr><td>Tot</td><td>4</td><td>8</td></tr></table>		Activity report	Desk review	Bi-annually	Cuso Int.'s in-country project focal point
	1311.2 Number of gap analysis reports produced	**Benin**: 0 **DRC**: N/A **Ethiopia**: 0 **Tanzania**: 0	<table><tr><td>B</td><td>1</td></tr><tr><td>D</td><td>N/A</td></tr><tr><td>E</td><td>2</td></tr><tr><td>T</td><td>3</td></tr><tr><td>Tot</td><td>6</td></tr></table>		Activity report	Desk review	Bi-annually	Cuso Int.'s in-country project focal point
1312 Knowledge and sharing workshops to training institutions/Ministry of Education on revising curriculum and clinical practice guidelines.	1312.1 Number of meetings organized by midwives' association to present proposals to revise midwifery education/curriculum/clinical practice guidelines to stakeholders.	**Benin**: 0 **DRC**: 0 **Ethiopia**: 0 **Tanzania**: 0	<table><tr><td>B</td><td>2</td></tr><tr><td>D</td><td>31</td></tr><tr><td>E</td><td>2</td></tr><tr><td>T</td><td>4</td></tr><tr><td>Tot</td><td>39</td></tr></table>		Activity report	Desk review	Bi-annually	Cuso Int.'s in-country project focal point
1321 Regulatory and licensing review meetings conducted.	1321.1 Number of meetings organized by midwives' association to present proposals to revise midwifery regulation/accreditation to stakeholders	**Benin**: 0 **DRC**: 0 **Ethiopia**: 0 **Tanzania**: 0	<table><tr><td>B</td><td>3</td></tr><tr><td>D</td><td>17</td></tr><tr><td>E</td><td>3</td></tr><tr><td>T</td><td>6</td></tr><tr><td>Tot</td><td>29</td></tr></table>		Activity reports	Desk review	Bi-annually	Cuso Int.'s in-country project focal point
1322 Training, technical assistance, mentoring, and resources provided to Midwifery Association representatives to support midwifery regulation.	1322.1 Number of technical expert days focusing on midwifery standards and scope of practice provided to members of the midwifery associations to support regulation efforts.	**Benin**: 0 **DRC**: N/A **Ethiopia**: 0 **Tanzania**: 0	<table><tr><td>B</td><td>30</td></tr><tr><td>D</td><td>N/A</td></tr><tr><td>E</td><td>30</td></tr><tr><td>T</td><td>30</td></tr><tr><td>Tot</td><td>90</td></tr></table>		Activity report	Desk review	Bi-annually	Cuso Int.'s in-country project focal point
1323 Policy dialogue forums implemented on midwifery	1323.1 Number of forums organized with key national RMNCAH actors	**Benin**: 0 **DRC**: 0 **Ethiopia**: 0 **Tanzania**: 0	<table><tr><td>B</td><td>N/A</td></tr><tr><td>D</td><td>N/A</td></tr><tr><td>E</td><td>N/A</td></tr><tr><td>T</td><td>10</td></tr></table>		Activity report	Desk review	Bi-annually	Cuso Int.'s in-country project focal point

Expected results (LM)	Indicators	Baseline data[6]	Targets[7]			Data source	Data collection methods	Frequency	Responsibility
regulation and licensing.			Tot	10					
1331 Association needs identified and strategic and operational plans completed and implemented.	1331.1 Number of annual work plans developed and completed by the midwives' associations and approved by its membership	**Benin**: 0 **DRC**: 0 **Ethiopia**: 0 **Tanzania**: 0	B 3 D 3 E 2 T 2 Tot 10			Activity report	Desk review	Bi-annually	Cuso Int.'s in-country project focal point
1332 Policy priorities identified, policy papers developed and advocacy campaigns delivered.	1332.1 Number of advocacy campaigns organized by the midwives' associations to promote professional interests of midwives and the role of midwives to the public	**Benin**: 0, 0 **DRC**: N/A **Ethiopia**: N/A ,0 **Tanzania**: 0, 0	PP* AC* B 2 4 D N/A N/A E N/A 3 T 4 4 Tot 6 11 PP=Policy Paper AC=Advocacy campaign			Activity report	Desk review	Bi-annually	Cuso Int.'s in-country project focal point
1333 Midwifery studies conducted and finding disseminated.	1333.1 Number of studies on midwifery profession conducted and results disseminated[21]	**Benin**: 0 **DRC**: 0 **Ethiopia**: 0 **Tanzania**: 0	B 1 D 20 E 1 T 2 Tot 24			Activity report	Desk review	Bi-annually	Cuso Int.'s in-country project focal point
1334 Local, regional and international knowledge sharing events organized.	1334.1 Number of local and regional knowledge sharing events organized by midwives' associations to support the professional development of their members	**Benin**: 0 **DRC**: 0 **Ethiopia**: 0 **Tanzania**: 0	B 6 D 12 E 12 T 6 Tot 36			Activity reports	Desk review	Bi-annually	Cuso Int.'s in-country project focal point
1335 Technical and mentoring support provided to midwifery representatives to	1335.1 Number of technical expert days focusing on the midwives' association's mechanisms to respond to the needs/demands of its' members	**Benin**: 0 **DRC**: 0 **Ethiopia**: 0 **Tanzania**: 0	B 240 D 630 E 900 T 600 Tot 2370			Activity reports	Desk review	Bi-annually	Cuso Int.'s in-country project focal point

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[21] ``Valuing midwives' assessments`` ou Étude des perceptions entourant la profession des sages-femmes

Expected results (LM)	Indicators	Baseline data[6]	Targets[7]	Data source	Data collection methods	Frequency	Responsibility
meet member needs.							

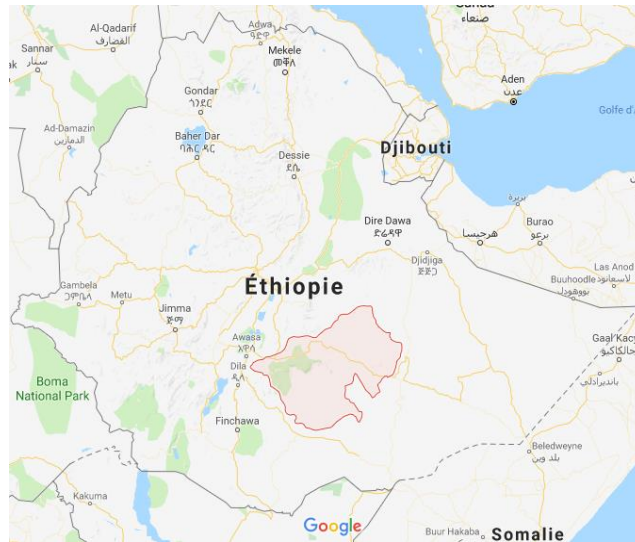**Midwives Save Lives –Project Sites, Benin**
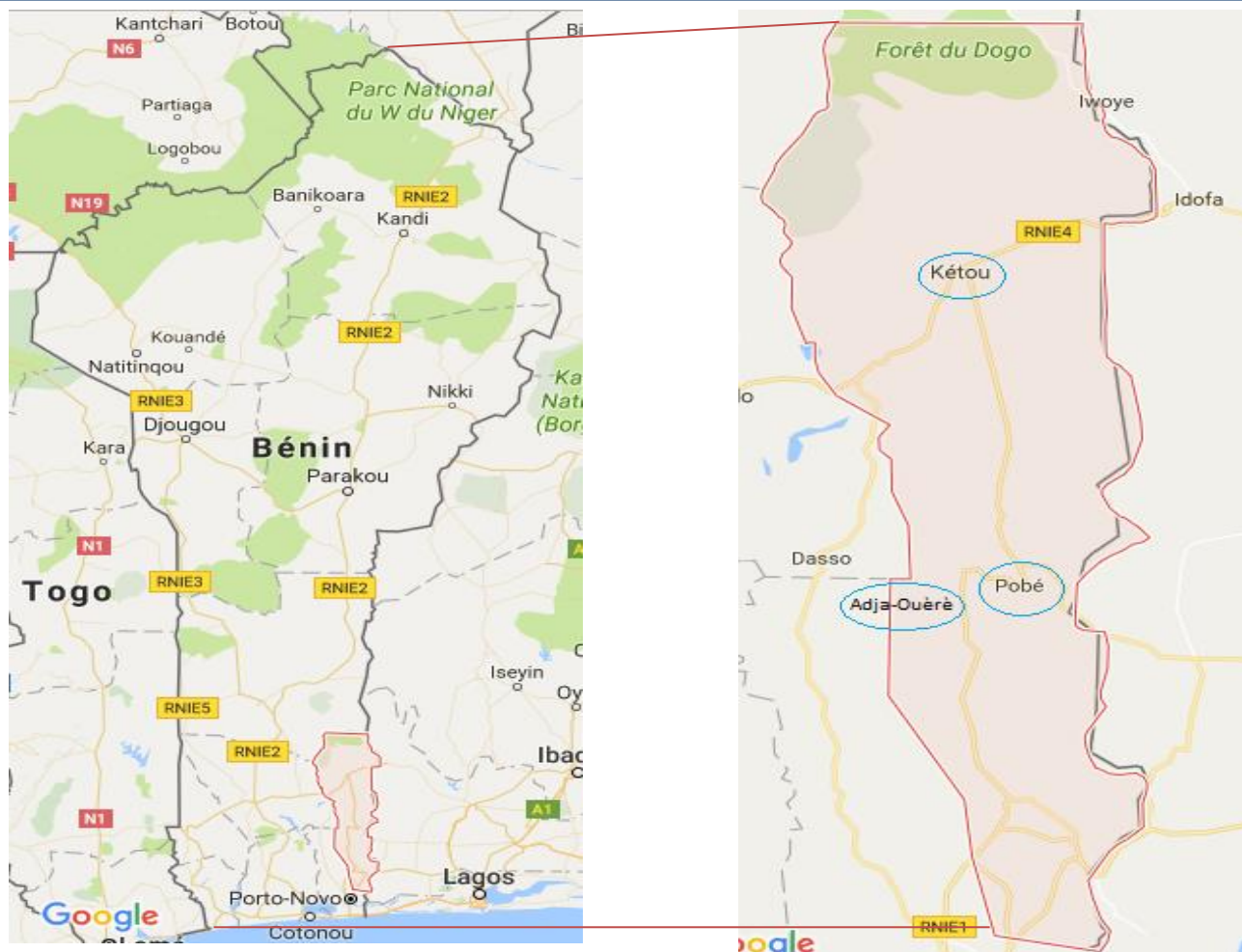
Bale region

Beninshangul Gumuz region

Midwives Save Lives –Project Sites

Tanzania

Location of Simiyu region in Tanzania

Location of Shinyanga region in Tanzania

Annex 4: Evaluation of the functioning of the midwives' associations

	Benin	DRC	Ethiopia	Tanzania
Organization	General Meeting, Board of Directors, Executive Board. Branches, with focal points at the level of all the 12 departments of the country	General Assembly, Board of Directors, Executive Committee and Provincial Committees (Branches); 18 branches out of the DRC's 26 provinces.	11 chapters/ branches, 9 are regional and 2 are in administrative towns	President, General Secretary, Treasurer, Six Members in the Executive Committee; Branches in all 26 Regions of Tanzania Mainland
Number of members	497 at national level	4530 members	more than 5,000 members	About 4500 Members
Meeting with medical education institutions to discuss curriculum and training guides	Several meetings were held with INMES (National Medical Health Institute)	The association is weakly involved in workshops to set up continuing education modules (standards and guidelines) in the field of maternal health by the Tenth Directorate of the Ministry of Health in charge of reproductive health, adolescents and specific groups	Midwifery curriculum review workshop organized by FMOH for different higher education officials and other stake holders: Nov 1-2,2016; Midwifery and nursing standards review workshop prepared by FMOH: August 2016; Standard curriculum workshop prepared by FMOH to have model curriculum for teaching institutions: 14-17, 2016	Since January 2016 we have attended two meetings to discuss about Midwifery Education in the country – meetings organized by the Ministry of Health, Community Development, Gender, Elderly and Children. The output of these two meetings was the establishment of a Task force to review the system of Nursing and Midwifery Education in the country
Meetings to discuss curriculum and training guide	Not available	The association is involved in workshops to help in setting up regulatory documents (standards and guidelines) in maternal health by the Tenth Directorate of the Ministry of Health in charge of reproductive health, adolescents and specific groups.	Courses for health professionals developed to function as part of ongoing learning process for participants as community workers. Midwifery curriculum review workshop organized by FMOH for different officials of higher education and other stakeholders: Nov 1-2, 2016;	All the Nursing and Midwifery Curriculum are owned by the MoHCDGEC and regulated by the Tanzania Nursing and Midwifery Council. Hence the Medical Officer of Health does not deal with Nursing and Midwifery curriculum

	Benin	DRC	Ethiopia	Tanzania
			Midwifery and nursing standards review workshop prepared by FMOH: Aug 2016; Standards curriculum workshop prepared by FMOH to prepare model curriculum for teaching institutions: 14-17/ 2016; AYH implementation manual development workshop by FMOH: Dec 12-17/2016	
Meeting with medical training institutions or other individual stakeholders to discuss Midwifery and Nursing training regulations	Meetings were held with the INMES	From 2011 to 2013, the association was involved in revising the midwifery training programme in DRC, initiated by the Ministry of Higher Education, with UNFPA technical and financial support.	EMwA attended one regulatory / licensing related meeting organized by MOH; meeting attended by other stakeholders, on the theme "Licensing and policy issues" organised by FMOH: Dec 23-24,2016	Two Meetings were organized by the Ministry of Health, which brought together Principals of Nursing and Midwifery Schools
Initiatives to address issues requiring special attention; and media coverage	Awareness raising campaigns and modern contraceptive methods free of charge in the different regions of the country (23-27 September 2014) Each year, during the International Midwives Day festivities (May 05); Awareness raising for adolescents and young people on responsible sexuality and reproductive health in colleges (Every year on the International Midwives Day occasion: May 05)	Integrated family planning service package coupled with voluntary screening of breast and cervical cancer in line with advanced strategies. (4 campaigns in 2016); Celebration of the 2016 IMD through free delivery services, mass sensitization on midwifery on Radio-TV broadcasts; Conference debate ... with the financial support Cuso International and UNFPA (May 02 to May 7, 2016)	Launched two issues, one alone, the other with other institutions, supported by Project Save The Children; EMwA has carried out advocacy activities by starting "Moving Beyond Birth: Midwives, Stewards of Next Generation" (October 7, 2016). Strengthening perinatal partnership intervention, an initiative of EMwA, Ethiopian Pediatrics Society and Ethiopian Society of Obstetrics and Gynecology (2016).	Conducted Advocacy Meetings for Regional and District Leaders in Lake Zone regions to support the constant availability of Essential Equipment and Medicine for provision of RMNCAH Services (July to August 2015); Conducted Advocacy Meetings during the International Day of Midwives for Policy Makers to increase the number of midwives in the health units and provide a conducive working environment for Midwives (The Guest of honour was the former Prime Minister Honourable Mizengo Pinda (May 2015)

	Benin	DRC	Ethiopia	Tanzania
Developed national documents integrating the standards of the International Confederation of Midwives	Several documents were prepared under the leadership of the Ministry of Health	Midwives Training Curriculum (Training Programme) 09-14-2013	"Midwifery Programme Level Standard Guideline" (2015/2016)	Disseminated the Midwifery competencies to Regional and District leaders to support in lobbying for the Government to establish a Stand-alone Midwifery Framework (12/ 2016); Launched the Revised Midwifery Competencies (May 2016)
During the past one-year, which organizations have you worked with in any form, with a focus on improving on reproductive, maternal and new-born health?			Jhpiego: strengthening pre-service and in-service midwifery activities, capacity building of midwives and curriculum review; UNICEF: strengthening midwives' services provision by providing BEmONC in all regions; Worked on quality service provision, supportive provision; UNFPA: improved quality of sexual and reproductive health service delivery, midwifery education, midwives' services provision by providing RMC training, experience sharing, FP; producing documents on aspects such as practices, success stories. Danone Nutricia: supported general assembly meetings, providing training on RMC, maternal nutrition, breast feeding celebrations; supported participation in Ethiopian Great Run to support the association. GE health care: improved skills of midwives working at the pre-service to improve quality of	Association of Obstetricians and Gynecologists (AGOTA) to conduct research on the management of PPH four regions (Mtwara, Lindi, Mwanza and Simiyu) Amref Africa: to advocate for the Campaign on Stand Up for African Mothers Jhpiego: to train In-Service Midwives on Clinical Mentorship and Respective Maternity Care in Lake Zone Regions White Ribbon Alliance to advocate for increase of budget for health centres to meet the needs of the pregnant Women and children

	Benin	DRC	Ethiopia	Tanzania
			MNH services on limited ultrasound Merk Sharp & Dohme B.V FP service: "implanon next insertion technique" to 4000 health extension workers and health care workers in Amhara region. Cuso International- MSL project: quality service delivery for Women of reproductive age mothers.	